# Pharmacy

**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 Originally enacted by the Social Security amendments of 1965 (Public Law 89-97), Title XIX was approved on July 30, 1965.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](http://www.dmas.virginia.gov), under Managed Care Benefits.

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

Managed Care Enrollment Broker (Maximus)

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

- **Medallion 4.0**

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

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

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

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

- **CCC Plus**

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

MCO Provider Reimbursement

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

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

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

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

Eligibility and MCO Enrollment Verification

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

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

Continuity of Care

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


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

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

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

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


**Family Access to Medical Insurance Security (FAMIS) Plan**

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

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

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

<u>FAMIS Covered Services</u>

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

The following services are covered for FAMIS enrollees:

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

   Assistive technology

   Blood lead testing

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

   Intensive in-home services

   Therapeutic day treatment

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

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

physician's office, or outpatient hospital department

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

Member Copays

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

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

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

*Other co-payments may apply to other services.

## EMERGENCY MEDICAID SERVICES FOR ALIENS

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

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

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

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

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

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

## Client Medical Management (CMM)

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

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

Providers may refer Medicaid patients suspected of inappropriately using or abusing

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

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

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

Written referrals should be mailed to:

> Lead Analyst, Recipient Monitoring Unit
>
> Division of Program Integrity
>
> Department of Medical Assistance Services
>
> 600 East Broad Street, Suite 1300
>
> Richmond, Virginia 23219

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

## Sources of Information

MediCall Automated Voice Response System

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

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

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

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

Automated Response System (ARS)

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

HELPLINE

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

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

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

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

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

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

## ELECTRONIC FILING REQUIREMENTS

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

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

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

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

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

## Provider Manual Updates

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

## Notice of Provider Responsibility

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

## THE VIRGINIA MEDICAL ASSISTANCE MEDICALL SYSTEM

### GENERAL INFORMATION

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

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

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

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

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

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

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

> 2:00 a.m. to 4:00 a.m. Daily          2:00 a.m. to 6:30 a.m. Thursday
>
> 10:00 p.m. Saturday to 6:00 a.m. Sunday

The telephone numbers are:

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

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

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

## HOW TO USE THE SYSTEM

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

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

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

- Member Medicaid Number (12 digits) <u>or</u> 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 (Pharm)

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 (Pharm)

A participating provider is a pharmacy licensed by the Virginia Board of Pharmacy and having a current, signed participation agreement with the Department of Medical Assistance Services (DMAS).

## Provider Enrollment (Pharm)

All providers of services must be enrolled in the Medicaid Program prior to billing for any services provided to Medicaid members.

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 <u>Chapter V</u> of this provider manual to review the new billing procedures related to the implementation of these new screening requirements.**

## Requests for Participation (Pharm)

An original signature of the individual provider is required.  An agreement must be signed by the provider or by the authorized agent of the provider. Participating providers are required to complete new agreement forms when a name change or change of ownership occurs.  For a sample Pharmacy Participation Agreement, see the exhibits at the end of this chapter.

**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.

## 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.

## Participation Conditions (Pharm)

All pharmacies enrolled in the Virginia Medicaid Program must adhere to the conditions of participation outlined in their provider agreements.  A copy of a provider agreement form may be found at the end of this chapter.  The paragraphs which follow outline special participation conditions which must be agreed to by pharmacies.

Requirements for pharmacy providers for participation include, but are not limited to:

- A license from the Virginia State Board of Pharmacy to operate in accordance with State statutes; drugs are to be dispensed by a pharmacist authorized to practice pharmacy under the laws of the state in which the applicant is licensed and practicing;
- Provision of services to Medicaid members without regard to race, color, religion, or national origin;
- Keeping of records necessary to fully disclose the extent of services provided to individuals receiving assistance under the State Plan;
- Provision of information to DMAS as requested and access to records and facilities by personnel of DMAS, the Office of the Attorney General, and federal personnel;
- Submission of claims for drugs dispensed to Medicaid members for reimbursement by Medicaid based on the pharmacy's usual and customary charge to the public not to exceed the upper limits established by DMAS;
- Medicaid participation is limited to providers who accept, as payment in full, the amounts paid by DMAS plus any deductible, copayment, or coinsurance required by the State Plan to be paid

by the individual;
- Agreement to abide by Medicaid policies and procedures; and
- Allowance of freedom of choice in the selection of a provider service.

## Certification of Unit-Dose Dispensing (Pharm)

To be certified as a unit-dose provider to nursing facilities, the pharmacy should contact the Pharmacy Supervisor and request that certification information and forms be sent to the pharmacy.  The address is:

Pharmacy Supervisor

Department of Medical Assistance Services

600 East Broad Street, Suite 1300

Richmond, Virginia  23219

To be considered for certification, the pharmacy must submit the form, Unit-Dose Distribution Services (Form DMAS-32), that describes the unit-dose system to be utilized, identifies the facilities and location of each, and identifies the unit-dose dosage forms.  A certification statement must be signed by the pharmacy owner or official indicating agreement to meet the requirements and to provide a **prompt** (within 30 days) written notification to the Pharmacy Supervisor if there are any changes in the method of dispensing to the facilities.

Requirements for Certification

The requirements for certification are as follows:

- Each dose must be packaged individually;
- Each dose must be labeled identifying the drug and strength;
- Packaging/labeling must meet the requirements established by the State Board of Pharmacy for unit-dose dispensing;
- Up to a seven day supply can be dispensed to the facility;
- A multiple-day dose (e.g., greater than seven days and up to 30-day supply) **system** does **not** qualify for unit-dose certification;
- The facility must be identified as a nursing facility;
- Unit-dose dispensing to a home for the aged, adult day care residence, or assisted living facilities does **not** qualify for unit-dose    certification.

## Requirements of Section 504 of the Rehabilitation Act (ARTS)

Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. § 794), provides that no individual with a disability shall, solely by reason of the disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal assistance. As a condition of participation, each Medicaid provider has the responsibility for

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

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

# Utilization of Insurance Benefits (Pharm)

## Insurance Information

On paper claims, pharmacy providers are to disregard the information on billing primary insurance carriers for reimbursement in the drug program. The Insurance Company Codes and the Type of Coverage in Chapter III do not apply to pharmacy providers when preparing claims for the dispensing of drugs. Bill primary insurance carriers only for durable medical equipment. For Instructions for Point-of-Service (POS) submission, see Chapter IV.

## Workers' Compensation

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

## Liability Insurance for Accidental Injuries

The Virginia Medicaid Program will seek repayment from any settlements or judgments in favor of Medicaid members who receive medical care as the result of the negligence of another. If a member is treated as the result of an accident and DMAS is billed for this treatment, Medicaid should be notified promptly so action can be initiated by Medicaid to establish a lien as set forth in § 8.01-66.9 of the Code of Virginia.

When the provider bills and accepts payment by Virginia Medicaid in liability cases, the provider, under federal regulations, must accept Virginia Medicaid payment as payment in full; however, providers can initially choose to bill the third-party carrier or file a lien in lieu of billing Virginia Medicaid.

# Documentation of Records (Pharm)

The provider agreement requires the provider to maintain records that fully disclose the services provided to Medicaid members. Pursuant to federal law [42 CFR § 440.120(a)(2)], Medicaid can only provide payment for drugs dispensed by a licensed pharmacist in accordance with the State Medical Practice Act. In Virginia, this means that Medicaid can provide payment only for prescribed drugs dispensed and documented in accordance with the Drug Control Act and the Board of Pharmacy Regulations. Documentation supporting Medicaid claims must be maintained for a minimum of **five (5) years**. The following elements constitute Medicaid policy regarding documentation.

## Original Prescriptions

Original prescriptions must include the following information:

- Name and address of the member receiving the service;
- Name and address of the prescriber;
- Prescription number, name, strength, and quantity of the drug dispensed;
- Directions for use;
- Date dispensed and initials of the dispensing licensed pharmacist; and
- "Brand Medically Necessary" in the prescriber's handwriting on the face of the prescription, when required.

  NOTE:  The "Brand Medically Necessary" documentation requirement also applies to telephoned prescriptions.  Pharmacists must document in indelible ink on the face of the oral prescription the prescriber's instructions in regards to the substitution.

## Prescription Refills

Refills of prescriptions must include the following information on the back of the prescription:

- The refill date and initials of the dispensing licensed pharmacist;
- The quantity dispensed, if different from the face amount; and
- A notation of the refill authorization by the prescriber, if different from that on the face of the prescription.

## Automated Records

In lieu of maintaining refill documentation on the back of the prescription, pharmacies with an automated data processing system must have online retrieval (via CRT display or hard-copy print-outs) documenting the following:

- The prescription number, name, strength, and quantity of the drug dispensed;
- The refill date and code or initials of the dispensing licensed pharmacist;
- The total number of refills authorized by the prescriber and the balance number of refills remaining;
- The name of both the member and the prescriber; and
- The address of both the member and the prescriber, if not on file elsewhere in the pharmacy.

## Records of Dispensing to Nursing Facilities

Physician orders must be on file for each drug dispensed for a member residing in a nursing facility.

### Non-Unit-Dose

Non-unit-dose packaged drugs provided to the facilities by either unit-dose certified pharmacies or

non-unit-dose pharmacy providers are to be documented in the prescription records as described above or in a patient profile as described below for unit-dose.

### Unit-Dose

In lieu of the foregoing described documentation, certified unit-dose pharmacies must maintain records (patient profiles) which include the following information:

- The name and address of the member receiving the service;
- The name of the prescriber and his or her address, if not available elsewhere in the pharmacy;
- The prescription number, name, strength, and quantity of the drug dispensed;
- The directions for use; and
- Documentation on a daily basis of the delivery of a 24-hour supply of each drug.

### Non-Legend Drugs

Documentation requirements described above apply to both legend and covered non-legend (over-the-counter) drugs.

### Discontinued Drugs

Pursuant to the Board of Pharmacy regulations, records must show dispensed medications, which have been discontinued and not administered to the patient, as having been returned to the pharmacy.  Billing records must reflect an adjustment in payments where appropriate.

### Signature Log

Pharmacy providers must maintain a log containing the following information:

- Member's name;
- The signature of the member or that of his representative; and
- The date of receipt of the prescription.

The log must effectively differentiate between prescriptions received by a member for which counseling was accepted and provided, and those for which counseling was offered and was declined. This log must be retained for review by DMAS or DMAS' agent for five (5) years and is subject to audit. The signature log serves as verification of the member receiving the prescription billed. The absence of the appropriate signature indicates the member did not receive the prescription, and funds may be subject to recoupment.

Prescription signature records for shipped prescriptions must be retained for a period of five (5) years and must include the delivery confirmation for audit purposes.

## Tamper-Resistant Prescription Pads (Pharm)

In 2007, Congress enacted Section 7002 (b) of the U.S. Troop Readiness, Veterans' Health Care,

Katrina Recovery and Iraq Accountability Appropriations Act (P.L. 110-28), which mandates that federal reimbursement be denied to states for Medicaid patients' outpatient prescriptions that are not written on tamper-resistant prescription pads/paper. **To comply with this federal mandate, the Virginia Medicaid and FAMIS Fee-For-Service Program requires the use of tamper-resistant pads/paper on all non-electronic, outpatient prescriptions (excluding e-prescribing, fax, or telephone), effective April 1, 2008.**

**Affected Medicaid/FAMIS Clients**

For prescriptions written on or after April 1, 2008, the use of tamper-resistant prescription pads is mandated for the Medicaid, FAMIS fee-for-service, and FAMIS Plus fee-for-service populations. Based on CMS guidance, the tamper-resistant pad requirement applies to all outpatient drugs, **including over-the-counter drugs**, whether Medicaid is the primary or secondary payor of the prescription. This includes prescriptions for "dual eligibles" where a Medicare Part D plan is the primary payor and Virginia Medicaid is the secondary payor. While the law specifies the term "prescription pad", the Centers for Medicare and Medicaid Services (CMS) have stated that these requirements also apply to computer-generated prescriptions that are printed using paper inserted into the printer.

**Exemptions to Requirement:**

According to CMS, the following are <u>exemptions</u> to the tamper-resistant prescription pad requirements:

· Prescriptions paid by a Medicaid/FAMIS managed care entity (this means prescriptions written for patients enrolled in any of Virginia's contracted managed care organizations are not subject to this requirement). Dentists contracted through Doral Dental are NOT exempt from this requirement.

· Prescriptions transmitted to the pharmacy via e-prescribing, fax, or telephone (faxing is the preferred method). (Please note, however, that Drug Enforcement Administration regulations require Schedule II controlled substances to be written prescriptions); In addition, Guidance Document 110-35 from the Virginia Board of Pharmacy, http://www.dhp.virginia.gov/Pharmacy/guidelines/110-35%20Requirements%20for%20prescriptions.doc, provides further guidance on faxed and electronically transmitted prescriptions; and

· Drugs provided in nursing facilities, intermediate care facilities for the mentally retarded, and other specified institutional and clinical settings, as long as the patient never has the opportunity to handle the written prescription.

**What Qualifies As A Tamper-Resistant Prescription Pad?**

Although this is a federal law, there is not a single national regulation. Each State Medicaid Agency must determine which tamper-resistant features will be required. Virginia Medicaid has reviewed the recommendations of the industry and of states that currently use tamper-resistant prescription pads/paper. Effective April 1, 2008, Virginia Medicaid will require that all prescription pads/paper used for Medicaid and FAMIS fee-for-service members contain at least one of the following three

characteristics:

1) One or more industry-recognized features designed to prevent unauthorized copying of a completed or blank prescription form,

2) One or more industry-recognized features designed to prevent the erasure or modification of information written on the prescription by the

   prescriber, or

3) One or more industry-recognized features designed to prevent the use of counterfeit prescription forms.

Prescription pads/paper are required to contain at least one feature in all of the three categories above.  Providers who write prescriptions for Medicaid and FAMIS fee-for-service members should contact their vendor to secure an appropriate supply of prescription pads/paper that will meet the above requirements.  Table 1 is a summary of features that could be used on a tamper-resistant pad/paper in compliance with the CMS guidelines within the timeframe required. They are categorized according to the three types of tamper-proof features as described by CMS. Features in bold tend to be less costly and easier for physicians to implement than other features.

**Table 1**

Note: Features in bold tend to be less costly and easier for physicians to implement than other features.

Category 1 - One or more industry-recognized features designed to prevent unauthorized copying of a completed or blank prescription form.

| Feature | Description |
| --- | --- |
| **Uniform non-white background color** | **Background is one color. This will inhibit a forger from physically erasing written or printed information on a prescription form. If someone tries to erase or copy, the consistent background color will look altered.** |
| "Void" or "Illegal" pantograph | The word "Void" appears when the prescription is photocopied. Due to the word "Void" on faxed prescriptions, this feature requires the pharmacy to document if the prescription was faxed. |
| Reverse "RX" or White Area on prescription | "Rx" symbol or white area disappears when photocopied at light setting. This feature is normally paired with the "Void" pantograph to prohibit copying on a light setting. |
| Coin-reactive ink | Ink that changes color when rubbed by a coin. This is an expensive option. |

| | |
|---|---|
| Security Back print | Printed on the back of prescription form. The most popular wording for the security back print is "Security Prescription" or the security back print can include the states name. |
| Watermarking (fourdrinier) | Special paper containing "watermarking". |
| Diagonal lines (patented "Void") | Diagonal lines with the word "void" or "copy". Can be distracting or expensive. |
| Micro printing | Very small font writing, perhaps acting as a signature line. This is difficult to photocopy and difficult to implement if using computer printer. It is also difficult for a pharmacist to see. |

Category 2 - One or more industry-recognized features designed to prevent the erasure or modification of information written on the prescription by the prescriber.

| Feature | Description |
|---|---|
| **Quantity check off boxes** | **In addition to the written quantity on the prescription, Quantities are indicated in ranges. It is recommended that ranges be multiples of 25 with the highest being "151 and over". The range box corresponding to the quantity prescribed MUST be checked for the prescription to be valid.** |
| **Refill Indicator (circle or check number of refills or "NR")** | **Indicates the number of refills on the prescription. Refill number must be used to be a valid prescription.** |
| **Pre-print "Rx is void if more than___ Rxs on paper" on prescription paper** | **Reduces the ability to add medications to the prescription. - Line must be completed for this feature to be valid. Reduces the ability to add medications to the prescription. Computer printer paper can accommodate this feature by printing "This space intentionally left blank" in an empty space or quadrant.** |
| **Quantity Border and Fill (for computer generated prescriptions on paper only)** | **Quantities are surrounded by special characters such as an asterisk to prevent alteration, e.g. QTY \*\*50\*\* Value may also be expressed as text, e.g. (FIFTY), (optional)** |
| **Refill Border and Fill (for computer generated prescriptions on paper only)** | **Refill quantities are surrounded by special characters such as an asterisk to prevent alteration, e.g. QTY \*\*5\*\* Value may also be expressed as text, e.g. (FIVE), (optional)** |

| | |
|---|---|
| **Chemically reactive paper** | **If exposed to chemical solvents, oxidants, acids, or alkalis to alter, the prescription paper will react and leave a mark visible to the pharmacist.** |
| Paper toner fuser | Special printer toner that establishes strong bond to prescription paper and is difficult to tamper. |
| Safety or security paper with colored pattern | White (or some other color) mark appears when erased. This is expensive paper. |

Category 3 - One or more industry-recognized features designed to prevent the use of counterfeit prescription forms.

| Feature | Description |
|---|---|
| **Security features and descriptions listed on prescriptions** | **Complete list of the security features on the prescription paper for compliance purposes. The pharmacy community, as represented by the American Pharmacist Association (APhA), National Association of Chain Drug Stores (NACDS), and National Community Pharmacist Association (NCPA) strongly believe this feature would be helpful to include to aid the pharmacist in identifying a tamper-resistant prescription.** |
| Form Batch Numbers | Each batch of prescriptions has a unique identifier. This feature is only effective in states with an approved vendor listing. |
| Serial number | Number issued by printer of prescription, may or may not be sequential. This feature is most effective where serial numbers are reported to the state. |
| Encoding techniques (bar codes) | Bar codes on prescription. Serial number or Batch number is encoded in a bar code. |
| Logos | Sometimes used as part of the background color or pantograph. |
| Metal stripe security | Metal stripe on paper, difficult to counterfeit. |
| Heat sensing imprint | By touching the imprint or design, the imprint will disappear. |
| Invisible fluorescent fibers/ink | Visible only under black light. |
| Thermo chromic ink | Ink changes color with temperature change. This is expensive paper and problematic for storage in areas not climate controlled. |
| Holograms that interfere with photocopying | May interfere with photocopying or scanning. |

# Termination of Provider Participation (Pharm)

A participating provider may terminate participation in Medicaid at any time; however, written notification must be provided to the DMAS Director and to PES thirty (30) days prior to the effective date. Such action precludes further payment by DMAS for services subsequent to the date specified in the termination notice. Notice should be sent to these addresses:

Director

Department of Medical Assistance Services

600 East Broad Street, Suite 1300

Richmond, Virginia 23219

Virginia Medicaid -PES

P.O. Box 26803

Richmond, Virginia 23261-6803

DMAS may terminate a provider from participation upon thirty (30) days' written notification.  Such action precludes further payment by DMAS for services provided members subsequent to the date specified in the termination notice.

Section 32.1-325(D)(2) of the Code of Virginia mandates that "Any such (Medicaid) agreement or contract shall terminate upon conviction of the provider of a felony."

**Appeals of Provider Termination or Enrollment Denial:**

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

## Appeals of Adverse Actions

**Definitions:**

**Administrative Dismissal** – means:

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

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

Contractor.

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

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

**Appeal** – means:

1) A member appeal is:

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

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

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

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

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

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

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

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

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

## MEMBER APPEALS

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

## PROVIDER APPEALS

### Non-State Operated Provider

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

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

Program Operations Division

Department of Medical Assistance Services

600 East Broad Street,

Richmond, Virginia  23219

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

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

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

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

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

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

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

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

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

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

    o  Fax to (804) 452-5454.

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

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

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

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

Repayment of Identified Overpayments

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

**State-Operated Provider**

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

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

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

or his/her designee will review this information, requesting additional information as necessary. If either party so requests, an informal meeting may be arranged to discuss a resolution.

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

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

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

## Client Appeals

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

## Medicaid Program Information

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

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

Virginia Medicaid - PES

PO Box 26803

Richmond, Virginia 23261-6803

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

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

## 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 |

| Provider Type | Risk Level | |
|---|---|---|
| Home Health Agency - Private Owned | Moderate –Revalidating | Y |
| | High – Newly enrolling | |
| Hospice | Moderate | Y |
| Independent Laboratory | Moderate | Y |
| Local Education Agency | Limited | N |
| Pharmacy | Limited | N |
| Prosthetic Services | Moderate –Revalidating | Y |
| | High – Newly enrolling | |
| Renal Unit | Limited | Y |
| Adult Day Health Care | Limited | N |
| Private Duty Nursing | Limited | N |
| Federally Qualified Health Center | Limited | Y |
| Health Department Clinic | Limited | N |
| Rural Health Clinic | Limited | Y |
| Developmental Disability Waiver | Limited | N |
| Alzheimer's Assisted Living Waiver | Limited | N |
| Treatment Foster Care Program | Limited | N |
| Qualified Medicare Beneficiary (QMB) | Limited | N |
| ICF-Mental Health | Limited | Y |
| ICF-MR Community Owned | Limited | Y |
| ICF-MR State Owned | Limited | Y |
| Intensive Care Facility | Limited | Y |
| Skilled Nursing Home | Limited | Y |
| SNF-Mental Health | Limited | Y |
| SNF-MR | Limited | Y |
| Psych Residential Inpatient Facility | Limited | Y |
| Consumer Directed Service Coordination | Limited | N |
| Personal Care | Limited | N |
| Respite Care | Limited | N |
| Personal Emergency Response System | Moderate –Revalidating | Y |
| | High – Newly enrolling | |
| Case Management DD Waiver | Limited | N |
| CMHP Transition Coordinator | Limited | N |
| Transition Coordinator | Limited | N |
| PACE | Limited | N |
| Family Caregiver Training | Limited | N |
| Mental Retardation Waiver | Limited | N |
| Mental Health Services | Limited - all others | Y - only for Mental Health Clinics |
| | Moderate -- Community Mental Health Centers | |
| Early Intervention | Limited | N |
| Group Enrollment | Limited | N |
| Group Enrollment | Limited | N |
| Ambulatory Surgical Center | Limited | Y |
| Ordering, Referring, or Prescribing Provider | Limited | N |

# Member Eligibility

Updated: 2/22/2019

## Determining Eligibility

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

Inquiries from persons who wish to apply for medical assistance should be referred to the LDSS in the locality in which the applicant resides, to the Cover Virginia Call Center at 1-855-242-8282, or the Cover Virginia website at [www.CoverVA.org](http://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. <u>Under no circumstances can an employee of, or an entity hired by, a medical service provider who stands to obtain Medicaid payment file a Medicaid application on behalf of an individual who cannot designate an authorized representative.</u>

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

## Non-Medicaid Patient Relationship

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

## Newborn Infant Eligibility

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

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

An easy, streamlined way for hospitals to report the birth of the newborn is through the Medicaid Web Provider Portal [www.virginiamedicaid.dmas.virginia.gov](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](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 (Pharm)

Updated: 12/21/2021

This chapter describes the pharmacy services available under the Commonwealth of Virginia's State Plan for Medical Assistance (Medicaid). Pharmacy services are provided in accordance with the requirements of Social Security Act §1927 and are available to all categorically and medically needy individuals determined to be eligible for assistance. All medications and supplies must meet the pharmacy coverage criteria and the Virginia Administrative Code (VAC).

For the purpose of the Virginia Medical Assistance Program, a pharmacy provider is a Medicaid enrolled provider that is primarily engaged in dispensing prescription and over the counter medications and supplies outside of an institutional setting.

The policies described in this chapter apply to all enrolled providers of pharmacy services. Drugs, both legend and non-legend, covered by Virginia Medicaid will be dispensed through a licensed pharmacy or a dispensing physician, in accordance with Virginia State Board of Pharmacy procedures and licensure, if written on a tamper-resistant prescription pad/paper by a practitioner qualified to prescribe.

## Virginia Medicaid Web Portal

The Virginia Medicaid Web Portal is the gateway for providers to transact all Medicaid and FAMIS (Family Access to Medical Insurance Security Plan) business via one central location on

the Internet. The web portal provides access to Medicaid Memos, Provider Manuals, providers search capabilities, provider enrollment applications, training and education. Providers must register through the Virginia Medicaid Web Portal in order to access and complete secured transactions such as verifying Medicaid eligibility, service limits and service authorization or by submitting a claim. The Virginia Medicaid Web Portal can be accessed at: www.virginiamedicaid.dmas.virginia.gov.

**Freedom of Choice**

Virginia Medicaid individuals are free to choose a pharmacy provider enrolled in their fee-for-service or managed care plan when medications are a covered service. Provision of "free" items or incentives to Medicaid individuals as an enticement for their business may violate federal law and is prohibited. If a pharmacy provider is utilizing this practice, the Department of Medical Assistance Services (DMAS) may impose a civil money penalty sanction against the pharmacy provider.

**Managed Care**

Most individuals enrolled in the Virginia Medicaid program for Medicaid and FAMIS have their services furnished through contracted Managed Care Organizations (MCOs) and their network of providers. A provider eligibility check will occur during the submission of point-of-sale (POS) pharmacy claims, but all providers should check eligibility prior to rendering services that will be billed as medical claims to confirm which MCO the individual is enrolled in. The MCO may require a referral or prior authorization for the individual to receive services. All providers are responsible for adhering to this manual for Members enrolled in FFS, their provider contract with MCOs for Members enrolled in managed care and all relevant state and federal regulations.

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

· Medallion 4.0: https://dmas.virginia.gov/for-providers/managed-care/medallion-40/

· CCC Plus: https://www.dmas.virginia.gov/for-providers/managed-care/ccc-plus/

· PACE: https://dmas.virginia.gov/for-members/for-adults/aged-blind-or-disabled/pace/

# COVERAGE AND LIMITATIONS (Pharmacy)

## GENERAL REQUIREMENTS

**Medical Necessity**

Only medications that are determined to be medically necessary may be covered for reimbursement by DMAS. The following criteria must be satisfied through the submission of adequate and verifiable documentation satisfactory to DMAS, or its contractor. Medically necessary prescription orders shall be:

· Ordered by an authorized practitioner;

· A reasonable and medically necessary part of the individual's treatment plan;

· Consistent with the individual's diagnosis and medical condition; and

· Consistent with generally accepted professional medical standards (i.e., not experimental or investigational).

**Prescription Requirements**

Prescriptions may be written on a tamper-resistant pad or paper or may be transmitted to the pharmacy by any means which comply with the regulations of the Board of Pharmacy. If the prescription is not received as a written document, the information must be reduced to writing and filed sequentially by the pharmacy, as with any legend drug order. All legal requirements for storage and retrieval of documents must be observed. The drug must be labeled according to the prescriber's order and appropriate counseling must be offered to the member.

**Automatic Refills and Shipments**

Automatic refills and automatic shipments are not allowed for Fee-For-Service or Managed Care Members. Medicaid does not pay for any prescription (original or refill) based on a provider's auto-refill policy. Medicaid does not pay for any prescription without an explicit request from a member or the member's responsible party, such as a caregiver, for each refilling event. The pharmacy provider shall not contact the member in an effort to initiate a refill unless it is part of a good faith clinical effort to assess the member's medication regimen. The possession, by a provider, of a prescription with remaining refills authorized does not in itself constitute a request to refill the prescription. Members or providers cannot waive the explicit refill request and enroll in an electronic automatic refill program. Any prescriptions filled without a request from a member or their responsible party may be subject to recovery. Any pharmacy provider who pursues a policy that includes filling prescriptions on a regular date or any type of cyclical procedure may be subject to audit, claim recovery or possible suspension or termination of their provider agreement.

**Days' Supply Limitations**

Covered drugs are covered for a maximum of a 34-day supply per prescription with the following exceptions:

- Select maintenance legend and non-legend drugs may be covered for a maximum of a 90-day supply per prescription per patient after two 34-day or shorter duration

fills. Current list of qualified drugs may be found in Appendix E or on the DMAS pharmacy website at https://www.virginiamedicaidpharmacyservices.com/provider/documents.

- https://www.virginiamedicaidpharmacyservices.com/provider/documents.
- Routine contraceptives may be covered for up to a 12-month supply.

For prescription orders whose quantities exceed the allowed days' supply, refills may be dispensed in sufficient quantity to fulfill the prescription order within the limits of federal and state laws and regulations.

For unit-of-use drugs (i.e., inhalers, eye drops, insulin pen boxes) where the calculated days' supply exceeds the maximum allowed above, the entire unit should be dispensed for the maximum days' supply allowed for that medication.

**Mandatory Generic Edit**

The DMAS State Plan requires that prescriptions for multiple-source drugs be filled with generic drugs unless the physician or other licensed, certified practitioners certify in their own handwriting "Brand Medically Necessary" or if the brand name drug is listed on DMAS' PDL as the preferred product.

The prescription must be on file in the pharmacy and made available for review by DMAS Program auditors. This requirement also applies to telephone orders (the pharmacist should write "Brand Medically Necessary" on the telephoned order when instructed by the prescriber).

The Point-of-Sale (POS) system denies claims with a "substitute less costly generic" edit when a brand-name drug is dispensed without a "1" in the DAW field. For single-source drugs, providers should use a "0" in the DAW field when the prescriber does not designate "Brand Medically Necessary." If the pharmacist dispenses the brand name, because no generics are available in the marketplace (generic is not currently manufactured, distributed, or is temporarily unavailable), and the prescriber does not specify "Brand Medically Necessary," the pharmacist may enter a "9" or an "8" in the DAW field for proper reimbursement.

# COVERAGE REQUIREMENTS (Pharmacy)

**Requirements for Legend Drugs:**

All legend drugs are covered with the following exclusions:

· OBRA '90 non-rebated drug products - Drugs distributed or manufactured by certain

drug manufacturers or labelers that have not agreed to participate in the Federal Drug Rebate Program (See the Requirements for Rebatable Drugs section below)

·   Agents used for anorexia or weight gain (an exception may be made for EPSDT members);

·   Agents used to promote fertility;

·   DESI (Drug Efficacy Study Implementation) drugs considered by the Food and Drug Administration (FDA) to be less than effective. Compound prescriptions, which include a DESI drug, are not covered;

·   Drugs which have been recalled;

·   Drugs used for hair growth;

·   Drugs used for erectile dysfunction;

·   Experimental drugs or non-FDA-approved drugs;

·   Drugs used only for cosmetic purposes;

- Drug products dispensed after the labeled expiration date of the product.

## Requirements for Rebatable (Legend or Non-Legend) Drugs

Virginia collects drug rebates on covered Medicaid prescriptions dispensed. These rebates are shared with the federal government on the basis of federal funds expended by Virginia Medicaid. Pharmacists must adhere to the following guidelines:

- The NDC code entered on the pharmacy claim must be the NDC code for the actual drug dispensed.
- The NDC code entered on the pharmacy claim must be the correct NDC code for the drug at the time of dispensing (Obsolete NDC codes do not capture rebates).
- Drug use data must be well documented (pharmaceutical manufacturers will not pay Virginia drug rebates on products if data are not well documented. Manufacturers can request program audits to determine what specific products have been dispensed).
- Drugs must be FDA approved.

Virginia Medicaid, Virginia Medicaid Managed Care Organizations, the Centers for Medicare and Medicaid Services (CMS), and the drug manufacturers may all request audits of provider records.

## Requirements for Non-Legend Drugs

Virginia Medicaid covers certain FDA approved over-the-counter (OTC) drugs when used as therapeutic alternatives to more costly legend drugs. This policy allows the use of cost-saving alternatives in the Pharmacy program. Therefore, these products should only be prescribed for

outpatients when the provider otherwise would have used a more expensive legend product. The choice of whether or not to use these additional products is to be determined by the member's prescribing health care provider. This expansion of OTC coverage in the outpatient population does not affect the current coverage standards for categories of drugs included for OTC coverage in the nursing facility environment.

Requests for OTC drugs are handled in the same manner as legend drugs (see the General Requirements section above). Drugs covered under this program must be supplied by companies participating in the CMS Medicaid rebate program.

Coverage of over-the-counter drugs is described below:

- Family planning drugs and supplies, insulin, and insulin syringes and needles are covered for all members except those residing in nursing facilities.
- Diabetic test strips are covered for members under 21 years of age only.
- Select drugs in the following specific therapeutic categories are covered when used as less costly alternatives to prescription drugs:

  - Analgesics

  - Antacids

  - Anti-Diarrheals

  - Anti-Emetics

  - Anti-Vertigo

  - Anti-Inflammatory Agents

  - Anti-Itch, topical

  - Antibiotics, topical

  - Antiflatulents

  - Antifungals, topical

  - Antihistamines (loratadine and various others)

  - Antivirals

  - Contraceptives

  - Dermatological Agents – various

  - Eye and Ear Preparations

  - Hemorrhoid Preparations

- o Iron Supplements

- o Laxatives, Cathartics, Bulk Producers, Stool Softeners

- o Mineral Supplements (calcium and various others)

- o Pediatric Electrolyte Solution

- o Pediculicides

- o Scabicides

- o Vitamins and Minerals (various)

- Non-legend Schedule V drugs are covered as legend regardless of the quantity dispensed.
- The Medicaid Pharmacy Program does not cover the following non-legend items:

  - o Dietary items, such as sugar or salt substitutes;

  - o Enteral nutrition products covered under Durable Medical Equipment (DME);

  - o Supplies, including (but not limited to) antiseptics (e.g., hydrogen peroxide, merthiolate, tincture of iodine, mercurochrome, rubbing alcohol, antiseptic soaps, boric acid), first aid preparations (e.g., band-aids, gauze, adhesive tape), and miscellaneous supplies, such as cervical collar, asepto syringe, IV sets, and support stockings (certain supplies and items are considered to be DME);

  - o Drug products dispensed after the labeled expiration date of the product;

  - o Hair growth products;

  - o Personal items, including (but not limited to) dentifrices, dental adhesives, toiletries, and other items generally classified as cosmetic; mouthwash and gargles; shampoos (non-legend) and soaps; cough drops; depilatories, suntan lotion, and hair bleaches;

  - o Products used for cosmetic purposes;

  - o Non-FDA approved OTC medications; and

  - o Alcoholic beverages.

For OTC formulary coverage in Fee For Service:

https://www.virginiamedicaidpharmacyservices.com/provider/drug-lookup.

For members enrolled in Managed Care Organizations please contact the relevant MCO or review the relevant website.

See the Preferred Drug List (PDL) Program section for more information.

**Requirements for Physician Administered Drugs (PADs)**

Drugs which cannot be self-administered should be billed as a medical benefit to Virginia Medicaid by the physician or provider administering the drug. For details on coverage requirements under the medical benefit, please refer to Chapter IV of the Physicians Manual. Claims submitted for drugs deemed non-self-administered are denied and the message returned is "Medical Benefit: Provider to Bill as Medical Claim= (DMAS Edit Code = 394 or NCPDP Edit Code = 70.

DMAS allows select physician administered drugs (PADs) to be billed by pharmacies. Only PADs on the DMAS PDL will be covered under the pharmacy benefit in the FFS program. DMAS will continue to cover physician/practitioner administered drugs and devices not on the DMAS PDL through the medical benefit. For Managed Care Members, please contact the relevant MCO.

**<u>Specific Requirements for Individual Legend Drugs</u>**

· **Atypical Antipsychotics in Children Under the Age of Eighteen (18)**

- The Department of Medical Assistance Services (DMAS) requires specific clinical criteria be met for atypical antipsychotics prescribed to new patients under the age of eighteen (18). This requirement applies to both Fee-For-Service and Managed Care Members. DMAS has established the following service authorization (SA) criteria:

  o The drug must be prescribed by a psychiatrist or neurologist or the prescriber must supply proof of a psychiatric consultation <u>AND,</u>
  o The member must have an appropriate diagnosis, as indicated on the attached SA form <u>AND,</u>
  o The member(s) must be participating in a behavioral management program <u>AND,</u>
  o Written, informed consent for the medication must be obtained from the parent or guardian.

  Service Authorizations will be authorized for six (6) months, after which a new SA will need to be obtained. If the SA criteria listed above are not met, a thirty (30) day emergency fill will be allowed and the SA request will be reviewed by a board certified Child and Adolescent Psychiatrist. A copy of the Service Authorization form may be found at https://www.virginiamedicaidpharmacyservices.com/asp/authorizations.asp.

· **Weight Loss Drugs**

- Drugs approved by the FDA for weight loss may be covered for members who meet specific criteria in the FFS program. For information on coverage for Managed Care Members, please contact the relevant MCO. Such coverage shall be provided only when a service authorization has been approved based on a certificate of medical need and the supporting documentation. Providers should consider the following factors in determining the need for the use of anti-obesity drugs:
  - conformity of the member's condition to the Social Security Administration

(SSA) definition of obesity as a disability as found in Disability Evaluation Under Social Security (SSA Publication 64-039), Part III, § 9.09, which requires a weight in excess of 100 percent of the SSA-defined desired level and a concurrent condition defined in the same section of SSA definitions relating to impairment by virtue of endocrine systems and obesity;

- Presence of a life-threatening condition, documented by the treating physician; compliant with General Regulation 18 VAC 85-20-90, Pharmacotherapy for weight loss as set forth by the Virginia Board of Medicine, as delineated in its Board Briefs, Newsletter #52 (Spring 1997);
- The manufacturer's directions for the specific drug's therapy;
- Assessment of the risk-benefit ratio related to the member's commitment to compliance in treatment.

Documentation presented for consideration should include, but is not limited to:
- o  Physical evaluation, including age, height, eight, body mass index (BMI);
- o  Psychiatric or psychosocial evaluation;
- o  Documented medical record evidence of functional disability;
- o  Documented medical evidence of previous conservative medical management;
- o  Documentation that other causes of obesity have been ruled out (for example, hypothyroidism);
- o  Documentation of the extent of concurrent medical problems; and
- o  Documentation of the attending physician certifying the determination that the member's life is at risk due to obesity.

# PREFERRED DRUG LIST PROGRAM (PDL)

DMAS' PDL Program provides clinically effective and safe drugs to its members in a cost-effective manner. The PDL is a list of preferred drugs by select therapeutic class for which the Medicaid program allows payment without requiring service authorization (SA) except where medically necessary. The PDL applies to all Medicaid and FAMIS Members enrolled in both fee-for-service (FFS) and managed care (MCO).

Based on reviews by the DMAS P&T Committee, medication classes may be added to the PDL as either closed or open classes, or may be excluded from the PDL. Medicaid Members may access preferred products on the PDL without meeting any service authorization criteria, unless DMAS deems a clinical service authorization necessary for the safety of the member. To access non-preferred medications on the PDL, the Medicaid Member must meet the service authorization requirements. The FFS program will always cover the posted PDL exactly. MCO plans must cover closed classes identically to the posted PDL, whereas the MCO plans may add additional preferred products to their formulary in open classes. Non-PDL classes are managed separately by FFS and the MCO plans. Therefore, preferred products and requirements for accessing medications in non-PDL classes may vary across MCO plans.

The complete list of pharmaceutical products included on the Virginia Medicaid's PDL may be

accessed at https://www.virginiamedicaidpharmacyservices.com/provider/preferred-drug-list.
 Comments regarding this program may be emailed to the P&T Committee at
pdlinput@dmas.virginia.gov. Service authorization forms can be found on the DMAS web portal at
https://www.virginiamedicaid.dmas.virginia.gov/wps/portal under the provider services drop down
in the provider forms section, or at:

www.virginiamedicaidpharmacyservices.com/provider/authorizations.

While Medicaid MCO plans are required to use the same service authorization criteria as the FFS
program for drugs on the PDL, methods of submitting service authorizations may vary. Please
contact the relevant MCO for any queries related to submitting service authorizations for Managed
Care Members.

## Step Therapy Criteria

The P&T Committee and DUR Board have approved step therapy criteria for several drug classes
included on the PDL. Preferred drugs with additional step therapy criteria may require the
submission of a service authorization. The drug classes with step therapy criteria can be viewed at
https://www.virginiamedicaidpharmacyservices.com.

## Process for Reviewing New Drugs in Classes Subject to the PDL

12VAC30-130-1000 requires the Pharmacy and Therapeutics (P&T) Committee to review any drug
in a class subject to the Preferred Drug List (PDL) that is newly approved by the Food and Drug
Administration (FDA) provided there is at least thirty (30) days notice of approval prior to the
biannual meeting. As the FDA approves new drug products, the following process will be utilized to
review for inclusion on the PDL:

1) If the new drug product belongs in a class of drugs that has been previously reviewed by
   the P&T Committee, the drug will immediately be classified as non-preferred and will
   require service authorization in order to be dispensed. Further determination of the status
   of the drug will be conducted by the P&T Committee.
2) A drug will be considered eligible for review if it meets one of the following criteria:
   - It is a "new brand" drug defined by the FDA as having the new drug application
     (NDA) approved which indicates that the product may be marketed in the United
     States. Once the new brand drug name appears on the FDA web site as approved it
     will be eligible for review.
   - It is a "new brand of an established generic" and has met the FDA definition above
     of "new brand".
   - It is deemed a "First Generic" on the monthly FDA update of "Generic Drug
     Approvals". First Generics are those drug products that have not previously been
     approved as generic drug products and are new to the marketplace.
3) New, non-branded generic drugs within an established generic drug class that have been
   previously evaluated by the P&T Committee will not be reviewed. These new generics will
   be deemed the same PDL status (preferred or non-preferred) as the existing generic drugs
   in the related class.
4) Product line extensions of drugs on the PDL, including strength and form, will be reviewed

by DMAS and approved by DMAS' Director or his/her designee who will determine if a drug review by the P&T Committee is necessary.

5)  The P&T Committee will evaluate the drug for clinical effectiveness and safety at the next scheduled annual review of the drug class. If the P&T Committee determines that the new drug represents a substantial breakthrough in therapy, the Committee can review the drug at its next scheduled meeting even if the annual review of the drug class is not being conducted.

6)  The Committee will review appropriate studies and publications as part of the decision process. In addition, the Committee will be provided with information such as disease categories and demographics on the affected Medicaid population in order to assess the potential impact on the population. If the drug meets clinical efficacy and safety standards, the Committee will request applicable pricing information. Based on clinical information and pricing standards, the P&T Committee will determine if the drug will be included in the PDL.

7)  If the new drug product does not fall within a drug class previously reviewed by the P&T Committee, the DMAS' Director or his/her designee will make the determination as to whether the drug requires P&T Committee review.

## Service Authorization (SA) Process

A message indicating that a drug requires a SA is displayed at Point-of-Sale (POS) when a claim for a non-preferred drug is requested. Pharmacists should contact the member's provider requesting them to initiate the SA process. For FFS members, prescribers can initiate SA requests by mail, by faxing the SA form to 800-932-6651, or by contacting the Clinical Call Center at 800-932-6648 (available 24 hours a day, seven days a week). SA requests submitted by fax or mail will be responded to within 24 hours of receipt. SA forms for FFS members can be located on the DMAS web portal at https://www.virginiamedicaid.dmas.virginia.gov/wps/portal  under the provider services drop down in the provider forms section or at:

www.virginiamedicaidpharmacyservices.com/provider/authorizations.

For Medicaid Members enrolled in an MCO, please check with the appropriate plan for SA contact details and service authorization forms.

## Preferred Drug List (PDL) – 72-Hour-Supply Processing Policy

The PDL Program provides a process where the pharmacist may dispense a 72-hour supply of a non-preferred, prescribed medication if the physician is not available to consult with the pharmacist, including after hours, weekends, holidays, and the pharmacist, in his/her professional judgment consistent with current standards of practice, believes that the member's health would be compromised without the benefit of the drug.

Any non-preferred drug (including both PDL and non-PDL classes) may be eligible if the pharmacist, in his/her professional judgement consistent with the current standards of practice, must believe that the Member's health would be compromised without the benefit of the drug. The pharmacy provider must contact the Clinical Call Center at 800-932-6648 to obtain the necessary information required for processing the 72-hour supply for Fee-For-Service (FFS) Members, or the appropriate Managed Care Organization (MCO) for Managed Care Members.

In FFS, the member will be charged a co-payment for this 72-hour supply (partial fill). However, a co-payment will not be charged for the completion fill. For correct copays, the prescription must be processed as a "partial" and "completion" fill.

For unit-of-use drugs (i.e., inhalers, drops, etc.), the entire unit should be dispensed for the 72-hour supply.

## Preferred Drug List (PDL) – 72-Hour-Supply Dispensing Fee Process in FFS

Pharmacy providers are entitled to an additional dispensing fee (effective May, 2006) when filling the completion of a 72-hour-supply prescription for a non-preferred drug. To receive the additional dispensing fee, the pharmacist must submit the 72-hour supply as a partial fill, and when submitting the claim for the completion fill, enter "03" in the "Level of Service" (data element 418-DI) field. The additional dispensing fee is ONLY available (one time per prescription) to the pharmacist after dispensing the completion fill of a non-preferred drug when a partial (72-hour-supply) prescription was previously filled.

Any questions regarding the PDL process should be referred to the Clinical Call Center at 800-932-6648.

For the current dispensing fees, see 12 VAC 30-80-40:
http://leg1.state.va.us/cgi-bin/legp504.exe?000+reg+12VAC30-80-40.

## PDL/Service Authorization "Helpline" for FFS Members

The Clinical Call Center can be reached at 800-932-6648 (24 hours a day, seven days a week), to answer questions regarding the PDL and service authorizations. Providers can initiate an SA request by faxing the SA form to 800-932-6651, by contacting the Clinical Call Center at 800-932-6648 or via the internet. Information about the online SA process can be found at www.virginiamedicaidpharmacyservices.com. SA requests also can be mailed to:

Magellan Medicaid Administration

11013 West Broad Street

Glen Allen, VA 23060

ATTN: MAP Department/VA Medicaid

Please contact the relevant MCO for any questions on the service authorization process for Managed Care Members.


# Home Intravenous Therapy

All information in this section applies to the FFS program only. Please contact the relevant MCO for any questions regarding Managed Care Members.

## Home Infusion Therapy: Service Day Rate

Home infusion therapy is the intravenous administration of fluids, drugs, chemical agents, or nutritional substances to members in the home setting via intravenous (IV), central line or implanted pump/port. DMAS will reimburse for these services, supplies, and drugs only when they are determined to be:

- · Medically necessary to treat a member's medical condition;

- · In accordance with accepted medical practice; and

- · Not for the convenience of the member or the member's caregiver.

For a provider to use the home infusion therapy service-day-rate method of billing, the member must:

- · Reside in either a private home or a domiciliary care facility, such as an assisted living facility. Reimbursement for home infusion therapy for those in hospitals, nursing facilities, rehabilitation centers, and other institutional settings is not authorized;

- · Be under the care of a physician who prescribes the home infusion therapy and monitors the progress of the therapy;

- · Have body sites available for intravenous (I.V.) catheter or needle placement or have central venous access; and

- · Be capable of self-administration or have a caregiver who can be adequately trained, is capable, and is willing to administer/monitor home infusion therapy safely and efficiently, and follow the appropriate teaching and adequate monitoring. In those cases where the member is incapable of administering or monitoring the prescribed therapy and there is no adequate or trained caregiver, it may be appropriate for a home health agency to administer the therapy.

## Provider Eligibility

Providers must have a National Provider Identification (NPI) to participate in the home infusion therapy program. Providers eligible to participate in this program are:

- Infusion therapy providers;
- Home health agencies;
- Pharmacies;
- DME providers.

In addition to being a Virginia Medicaid provider, a participating provider must:

·     Meet any state licensing and certification requirements;

·     Render infusion therapy covered services;

·     Use Medicaid-established billing guidelines; and

·     Accept Medicaid reimbursement as payment in full.

## Therapy Coverage

Medicaid has assigned a service-day-rate code and reimbursement rate for each of the covered therapies:

·     Hydration Therapy;
·     Chemotherapy;
·     Pain Management;
·     Drug Therapy;
·     Total Parenteral Nutrition (TPN).

## Service-Day-Rate Definition

This payment methodology provides a fixed amount for each day of infusion therapy. The service day rate (per diem) reimburses for all services delivered in a single day. This payment methodology will be mandatory for the reimbursement of all home I.V. therapy services, unless the member is enrolled in one of the waivered services outlined under "Special Considerations." Service day rates are based on an average day of service, and there will be no additional reimbursement for special or extraordinary services.

The service-day-rate payment will be in two service categories: Durable Medical Equipment (DME) and Pharmacy.

## Durable Medical Equipment (DME):

·     For (Service Day Rate) DME Per Diem - submit on a CMS-1500, with DME provider number and use the appropriate national codes (refer to Appendix B of the *DME Provider Manual*).

·     Items in the DME service day rate include all supplies required to administer I.V. therapy, including but not limited to:
  o    I.V. pump/pole rental/control devices;
  o    Tubings, adapters, caps, needles, filters, cannulas, extension sets, and alcohol swabs;
  o    I.V. start kits and central venous catheter dressing kits.

Refer to Appendix B of the *DME* Provider Manual for the S codes, which can be found on the DMAS website at https://www.virginiamedicaid.dmas.virginia.gov/wps/portal.

**Pharmacy:**

· For (Service Day Rate) Pharmacy Per Diem, submit claims on the CMS-1500, with the Pharmacy provider number, the modifier "59" (in Block 24, field D under modifier), and use the appropriate S code.

· Pharmacy Per Diems are for services provided every 24 hours or less. For dosing schedules that are greater than 24 hours, the per diem should be billed separately for each visit. (i.e. q72hrs should be billed using the corresponding S code for q24hrs on each day of service).

· Items in the pharmacy service day rate include the:
  o Diluents for the therapeutic agent;
  o Mixing and compounding;
  o Flush kits and solutions (heparin and saline);
  o Cassettes and bags/mini-bags.

Service day rates, by type of therapy, for basic components as delineated above are available on the DMAS web site. In order to determine if a procedure is covered, active or has special indicators (prior authorized, specialty forms, etc,) providers should go to the DMAS website located at http://dmasva.dmas.virginia.gov and look to the right of the page and click on the section that says "Procedure Fee Files".

The user will need to determine whether or not to use the CSV or the TXT format. The CSV is comma separated value and the TXT is a text format. The TXT version is recommended for users who wish to download the document into a database application. The CSV Version opens easily in an EXCEL spreadsheet file. Click on either the CSV or the TXT version of the file. Scroll until you find the code you are looking for. To determine whether a service is covered by DMAS you need to access the Procedure Rate File Layouts page from the DMAS Procedure Fee Files. Flag codes are the section which provides you special coverage and/or payment information. A Procedure Flag of "999" indicates that a service is non-covered by DMAS.

## Drugs

Drugs providing the therapy's active ingredient are reimbursed according to Medicaid's payment methodology.

Dispensing fees shall be added to the drug cost when applicable. One dispensing fee per month per member per NDC will be allowed, and the member co-pay shall be deducted if applicable.

## Multiple Therapies

Multiple drug therapies of the same type of therapy are included in one service day rate of reimbursement. For example, if a member receives two antibiotics under drug therapy on the

same day, the provider may only bill one service day rate for the pharmacy services. The individual antibiotics may be billed separately as active ingredients on the Daily Pharmacy Drug Claim Ledger Form (DMAS-173 R6/03), Point-of-Sale (POS) online billing, or other approved electronic billing method.

In the event of incompatible drug administration, the provider should use separate HCPCS codes (See Appendix B of this Manual for the appropriate HCPCS codes to use) to allow for the rental of a second infusion pump and the purchase of extra administration tubing. When applicable, DMAS may be billed in addition to the service day rate codes for the rental of the second infusion pump and extra administration tubing. There must be documentation to support the use of these codes in addition to the service day rate on the I.V. Implementation Form (DMAS-354).

Multiple therapies of different therapies under DME will be reimbursed at 100% for the most expensive therapy and 50% for the second and each additional therapy. Bill for the active ingredient on the Daily Pharmacy Drug Claim Ledger Form (DMAS-173 R6/03), Point-of-Sale (POS) online billing, or other approved electronic billing method.

## **Pharmacy**

The service day rate for covered home I.V. services is explained below. The service day rate is billed on the CMS-1500 claim form. The rate for TPN therapy includes the usual components of this therapy. However, the service day rate does not include the fluids for hydration therapy or the active ingredient in chemotherapy, pain management, or drug therapies. Bill for these components separately as pharmacy claims on the Pharmacy Drug Claim Ledger Form (DMAS-173 R6/03), Point-of-Sale (POS) online billing, or other approved electronic billing method.

In this manner, the active ingredient is identifiable in the Drug Utilization Review (DUR) program, and the Center for Medicaid and Medicare Services (CMS) rebate program operated by the agency.

## **Hydration Therapy**

Hydration therapy is the intravenous administration of fluids, electrolytes, and/or other additives.

The pharmacy service day rate includes, but is not limited to:

· Drug component: Electrolytes and flushes (heparin and saline); and

· Cassettes/bags/mini-bags, mixing, and compounding.

Claims must be billed on the CMS-1500 (8-05) Claim Form using the correct HCPCS codes.

The hydration solution is billed on the Daily Pharmacy Drug Claim Ledger (DMAS-173 R6/03), DMAS-174 R6/03, Point-of-Sale (POS) online billing, or approved electronic billing method.

## **Pain Management**

Pain management is the intravenous administration of narcotics or other drugs to relieve pain.

The pharmacy service day rate includes, but is not limited to:

- · Drug component: diluent, and flushes (heparin and saline); and

- · Cassettes/bags/mini-bags, mixing, and compounding.

Claims must be billed on the CMS-1500 (8-05) Claim Form using the HCPCS codes S9325, S9326, S9327, and S9328.

## Chemotherapy

Chemotherapy is the administration of chemical agents designed to have a specific effect upon disease-causing cells or organisms.

The pharmacy service day rate includes, but is not limited to:

- · Drug components: diluent, and flushes (heparin and saline); and

- · Cassettes/bags/mini-bags, mixing, and compounding.

Claims must be bill on the CMS-1500 (8-05) Claim Form using the HCPCS codes S9329, S9330, and S9331.

*Special Notes*

- · Hydration solutions may be billed separately (see "Hydration Therapy").

## Drug Therapy

Definition: Drug therapy is the intravenous administration of antibiotics or other drugs.

The pharmacy service day rate includes, but is not limited to:

- · Drug components: diluent, and flushes (heparin and saline); and

- · Cassettes/bags/mini-bags, mixing, and compounding.

Claims must be billed on the CMS-1500 (8-05) Claim Form using the HCPCS codes S9338, S9348, S9490, S9494, S9497, S9500, S9501, S9502, S9503, and S9504.

## Total Parenteral Nutrition (TPN)

TPN is the administration of nutritional substances by intravenous infusion to nourish members who are malnourished or may develop malnutrition and who are not candidates for enteral support.  DMAS will reimburse for TPN and related services and supplies only when all of the following conditions are applicable:

- • · The TPN is used as the sole source of nutrition;

- ·  There is a physician's statement of medical necessity in the member record indicating the diagnosis with a brief clinical history;
- ·  The short- and long-term plans for the requested service are given; and
- ·  The name and address of the pharmacy supplying the prescriptions are given.

The pharmacy service day rate includes, but is not limited to, the:

- ·  Drug components: diluent, electrolytes, nutritional additives, lipids, and flushes (heparin and saline); and

- ·  Cassettes/bags/mini-bags, mixing, and compounding.

Claims must be billed on the CMS-1500 (8-05) Claim Form using the HCPCS codes S9364, S9365, S9366, S9367, and S9368.

*Special Notes*

- *  The pharmacy service allowance includes solutions, routine additives (such as potassium chloride (KCl), multivitamins (MVI)), and lipids (Insulin is an example of a medication that may be billed separately with TPN therapy).

## Procedures for Documentation Related to Total Parenteral Nutrition (TPN) Services

Providers do not need to submit documentation of medical necessity to the Director of Medical Support Services at DMAS for TPN services provided by pharmacies.

Prescribers must document the prescription order in the member's medical record and verify the medical necessity by providing a description of the related clinical symptoms and diagnosis in the record. These documentation procedures should expedite the provision of services to Medicaid members. DMAS will use its post-payment utilization review to verify compliance with these requirements.

## Valid Prescriber Identification Numbers Required

Claims for prescription services submitted by pharmacies provide the basis of several Medicaid programs, including Drug Utilization Review, Member Medical Management, and Provider Review. Inaccurate or incomplete data related to prescriber identification may negatively impact the success of these programs. Pharmacists are requested to ensure that all required information is submitted on the appropriate claim medium.

Pharmacists are required to enter a valid NPI number on all pharmacy claims. Based on this requirement, an online alert will prompt pharmacists to use a correct NPI number on all POS transactions. The message will read: "PRESCRIBING PHYSICIAN NOT ON FILE".

Prescriber NPI numbers can be obtained in a searchable database from the **CMS/ NPPES Registry** at https://nppes.cms.hhs.gov/NPPES/.

When submitting real-time (Point-of-Sale) claims transactions, the 10-digit NPI for the Prescriber ID and Provider ID must be sent with the Qualifier '01'. Please see the following link for the NCPDP Companion Guide under the EDI support tab, which will provide instructions for submitting claims with the appropriate Qualifier: www.virginiamedicaid.dmas.virginia.gov.

## PAYMENT FOR SERVICES

### General Information

Medicaid participation is limited to providers who accept, as payment in full, the amounts paid by DMAS fee-for-service (FFS) program or contracted Managed Care Organizations (MCO)plus any deductible, co-payment, or co-insurance required by the State Plan to be paid by the individual. While payments by DMAS may be less than the provider's usual and customary charge, members may not be charged for the difference. Members are only responsible for the Medicaid co-payment as applicable.

Payments for services will not exceed the amounts indicated for payment in accordance with the policy and methods described in the *State Plan for Medical Assistance Services* and described in 42 CFR § 447.331.

All NDC numbers used for billing must be recent and accurate as to manufacturer, product code, and package size. For instance, do not bill the NDC of a 100-unit package if the drug was dispensed from a bottle of 1000.  Use of the correct NDC may be audited. Payment adjustments or charges of billing fraud may occur if it is shown that excessive billings were presented as a result of incorrect NDC numbers being submitted.

### Payment Methodology for Medicaid FFS

Payment methodology for drugs dispensed by Medicaid enrolled pharmacies is defined in VAC 12VAC30-80-40 at http://leg1.state.va.us/cgi-bin/legp504.exe?000+reg+12VAC30-80-40. Drug claims shall be reimbursed using the following methodology:

(1) For brand drugs, the lessor of:
   a.  The National Average Drug Acquisition Cost Brand (NADACB) price as established by CMS
   b.  The provider's usual and customary charge to the public, as identified by the claim
   c.  The Federal Upper Limit (FUL) as established by CMS in 42 CFR § 447.332
(2) For generic drugs, the lessor of:
   a.  The National Average Drug Acquisition Cost Generic (NADACG) price as established by CMS
   b.  The provider's usual and customary charge to the public, as identified by the claim
   c.  The Federal Upper Limit (FUL as established by CMS
(3) If a National Average Drug Acquisition Cost does not exist than the drug claim shall reimburse at the lessor of:
   a.  The Wholesale Acquisition Cost (WAC)

      b.   The provider's usual and customary charge to the public, as identified by the claim

      c.   The Federal Upper Limit (FUL as established by CMS

(4)  If neither a National Average Drug Acquisition Cost (NADAC) or a Wholesale Acquisition Cost (WAC) exists, than the claim will deny and return a message "Drug Cost Not On File".

Payments for drugs include the allowed drug cost plus only one dispensing fee per month per member for each specific drug entity with the exception of 72-hour emergency prescriptions for non-PDL drugs. For the current dispensing fees, see 12 VAC 30-80-40: http://leg1.state.va.us/cgi-bin/legp504.exe?000+reg+12VAC30-80-40. This reimbursement formula applies to all prescriptions dispensed to non-institutionalized members as well as to services for nursing facilities. Co-payments will be deducted where applicable.

Payment Methodology for managed care claims will vary. Please direct any questions to the relevant MCO.

## Pharmacy Reimbursement for Drugs Purchased under the 340B Program

Pharmacies participating in the 340B program established by Section 340B of the Public Health Services Act must notify DMAS regarding their participation. Said participants must also be listed on the HRSA website, www.hrsa.gov/opa/. Drugs with discounts generated from participation in this program are not eligible for federal drug rebates and pharmacy claims from 340B providers are not submitted to manufacturers for drug rebates. Pharmacies dispensing drugs purchased under the 340B program must submit **actual acquisition cost (AAC)** on FFS claims for a drug product and will be reimbursed AAC plus a dispensing fee where applicable. 340B entities are not required to report actual acquisition cost on claims submitted to Medicaid Managed Organizations (MCOs), but must indicate that a 340B drug was dispensed. 340B entities/providers who are enrolled with DMAS as a provider type other than pharmacy shall charge DMAS no more than their actual acquisition cost for the drug. For more information, please refer to the Frequently Asked Questions – 340B document, which may be found at: https://www.virginiamedicaidpharmacyservices.com/provider/documents.

## NCPDP Prescription Claims Processing 340B Identifier

Pharmacy providers submitting FFS claims through the point-of-sale (POS) for drugs purchased through the 340B program must identify the drug as a 340B purchased drug by populating the Submission Clarification Code (42Ø-DK) field with a value of "20" **and** the Basis of Cost Determination (42Ø-DN) field with a value of "08". In addition, the pharmacy must submit their actual acquisition cost (minus any discounts) for the drug claim using NCPDP field 409-D9 Ingredient Cost Submitted. The following NCPDP denial edits and/or Virginia Medicaid edits may be posted if the claim is not submitted correctly:

- **8R = Submission Clarification Code Not Supported.** (DMAS edit = 1621) The billing provider is not enrolled with Virginia Medicaid as a 340B entity.
- **34 = M/I Submission Clarification Code**. (DMAS edit = 1620)
- **DN = M/I Basis of Cost Determination**. (DMAS edits = 85)

- **DQ** = **M/I Usual and Customary Charge**. (DMAS edit = 1623). The submitted acquisition cost is greater than the Virginia Medicaid allowed amount and Submission Clarification Code = 20 and Basis of Cost = 8, the claim will deny. NOTE: Claims will continue to deny if the acquisition cost is missing or invalid for existing DMAS edit = 0014.

Pharmacy providers submitting managed care claims through the POS system for drugs purchased through the 340B program must identify the drug as a 340B purchased drug by population the Submission Clarification Code (42Ø-DK) field with a value of "20".

For outpatient medical claims, 340B providers must indicate the use of drugs purchased through the 340B program using one of the modifiers of UD or JG or TB.

**Contract pharmacies may not submit claims to DMAS for drugs purchased through a 340B program. A 340B contract pharmacy MUST carve out Virginia Medicaid pharmacy claims from its 340B operation.**

### Nursing Facility Services

Payments for pharmacy services provided to FFS members residing in nursing facilities are described below:

- Payments are based on the lowest of the allowed amounts or the usual and customary charge as described above.
- Legend drugs

  o The allowed drug cost plus up to two dispensing fees per month per member for each specific drug. If refilled more than twice within the same calendar month, only the allowed drug cost is paid. This reimbursement formula applies to unit-dose and non-unit-dose dispensing.
  o For schedule II drug incremental fills, the dispense fee will be prorated to the equivalent of two dispensing fees, based on the percentage of the prescription dispensed.
  o CMS federal upper limits apply for unit-dose dispensing.
  o For institutional claims, the metric quantity reported on the claim is expected to reflect the quantity of the drug which has been administered to the member during the billing period.

- Non-legend drugs are paid in the same manner as Legend drugs.
- Nursing facilities may bypass the early refill edits if required to supply medication for new patients, but must be registered as an LTC facility to do so. For more information, see the Nursing Facilities Provider Manual.

For Managed Care Members, please contact the relevant managed care organizations.

## Co-payments

The following members are <u>always</u> <u>exempt</u> from co-payments:

- Children under 21 years old;
- Individuals receiving long-term care services, hospice care; and
- Home and Community-Based Waiver members.

The following services are <u>never subject to co-payments</u>:

- Services delivered in the emergency room;
- Emergency services delivered in other settings;
- Pregnancy-related services; and
- Family planning services (including family planning drugs and methods). <u>NOTE</u>: Prescribing physicians should indicate "PREGNANCY" on the prescription form for prescriptions related to the women's pregnancies.

All other members are responsible for a co-payment for each prescription in the FFS program.

Co-payment amounts for fee-for-service members are:

- One dollar ($1.00) co-pay for generic drug; and
- Three dollars ($3.00) co-pay for single-source or "Brand Medically Necessary" drugs.

Members have been notified that the inability to pay the co-payment at a particular time does not relieve them of that responsibility.

Managed Care Organizations may not charge copays for Medicaid Members, but will charge copays for FAMIS Members.

# Immunizations and Vaccines (Pharm)

### Eligibility and Coverage under Medicaid Fee-For-Service (FFS)

For Medicaid-eligible members, routine immunizations will vary depending on patient age and Medicaid program (I.e. whether Members are covered under Medicaid Expansion or traditional Medicaid).

For Members under the age of 21, immunizations are covered under Virginia Medicaid's Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program based on the Advisory Committee on Immunization Practices (ACIP) recommendations by age. The federal Vaccines for Children Program (VFC) provides free vaccines for children up through the age of 18, therefore Medicaid children under the age of 19 are not eligible for vaccination through pharmacies. For children ages 19 and 20, reimbursement for vaccines will be made to any eligible provider as defined in § 54-3408 of the Code of Virginia. For more information on immunization coverage under the EPSDT

program, see Supplement B of the Physician/Practitioner Provider Manual.  For more information on the VFC program, see Chapter IV of the Physician/Practitioner Provider Manual.All Provider Manuals may be accessed under the Provider Services dropdown menu at: https://www.virginiamedicaid.dmas.virginia.gov/wps/portal.

Individuals covered by EPSDT or Medicaid Expansion may receive the following ACIP recommended vaccines (members $\geq$ 19 years of age) through the pharmacy:

- · The pneumococcal vaccines
- · The tetanus vaccines
- · The HPV vaccines for members $\leq$ 26 years of age
- · The influenza vaccines on a yearly basis
- · The zoster vaccine for members between age 50 and 64

Pharmacy claims for immunizations for all other individuals are limited except for instances when:

- \* The immunization is necessary for the direct treatment of an injury, such as tetanus vaccinations.
- \* The immunization is a pneumococcal or influenza vaccination given as part of a plan of treatment.

Medicaid Managed Care Organizations (MCOs) may cover additional immunizations for adults not covered by the FFS program through the pharmacy POS as a value-added service. Please contact the relevant MCO for coverage information.

**Reimbursement for Vaccines for FFS claims**

Medicaid enrolled pharmacies can submit claims for the influenza vaccines using the pharmacy POS claims processing system. Influenza vaccines will be reimbursed under the payment methodology described in the "Payment for Services" section above fore FFS claims, and under the relevant plan payment methodology for MCO claims.

Please note DMAS will not cover immunizations for Members age 65 and older, as these claims should be submitted to Medicare as primary payer.  Medicaid does NOT act as secondary payer for Medicare claims.  For members with any other third party coverage, immunization claims should be submitted to these payers as primary, with any copays submitted to Medicaid as secondary if needed.

## Point-of-Sale (POS) Prescription Drug Program

The Point-of-Sale (POS) Prescription Program is available to Medicaid Pharmacy Providers for both the Fee-For-Service (FFS) program and the managed care (MCO) program. In addition to the POS system, Virginia Medicaid FFS and MCOs provide a Prospective Drug Utilization Review (ProDUR) Program. Instructions below refer to the FFS program and may vary by MCO. Please refer to the relevant MCO for any managed care claims.

Pharmacies submitting claims through POS must make necessary arrangements through their software vendors with regard to equipment, input lines, and testing. Providers will be notified when on-line access to POS is available to the provider.

## Requirements for Submission of POS Claims

Virginia Medicaid requires that a pharmacy submitting POS claims use VersionD.0, a standard format developed by the National Council for Prescription Drug Programs (NCPDP). Software capable of producing claims in this format may be obtained from a number of vendors. DMAS' fiscal agent must certify the software before claims can be accepted. Arrangements for a switching company can be made directly or through the provider's software vendor. The switch or network serves as a communication link between the pharmacy and DMAS's fiscal agent.

## How to Enroll as a FFS POS Pharmacy

The following steps must be completed prior to submitting Point-of-Sale claims: a Pharmacy Point-of-Sale Authorization Form must be completed by the provider; testing must be completed (see the "Exhibits" section at the end of this chapter for a sample form); and an authorized approval letter must be obtained from DMAS. Chain pharmacies must return their completed POS Authorization Form to their billing headquarters. All other pharmacies must return their completed POS Authorization Forms directly to:

> Virginia Medicaid Provider Enrollment Services
>
> P.O. Box 26803
>
> Richmond, VA 23261-6803

Submission of POS claims may not take place until an authorized approval letter has been sent to the pharmacy by DMAS.

To enroll as a pharmacy in the managed care program, the pharmacy provider must enroll separately with each MCO. Contact the relevant MCO for more information.

## Adjudication of FFS Claims

Since POS claims are processed online in a real-time environment, claims submitted through on-line POS will be either paid or denied. There are some claims that will be denied for PA due to high cost. These claims include the following:

- · Charges greater than $4,999.99
- · Compounds above $250 per claim or $499,99 per month (rolling)
- · Certain service authorizations

With respect to the effects of the ProDUR Program on the adjudication of claims, refer to the information in the ProDUR section below.

# THIRD PARTY LIABILITY (TPL) PROCEDURES FOR POS PHARMACY FFS CLAIMS

In order to conserve Medicaid dollars and as payer of last resort on pharmacy claims, DMAS uses a process of Coordination of Benefits (COB) for Third Party Liability (TPL) collections at the point of sale. For pharmacy claims having a service date on or after June 20, 2003, DMAS will send an online claim denial message to pharmacy providers submitting claims for which the member has other insurance coverage. The messages are shown in the table below.

| VA Code | Virginia Denial Message Text | NCPDP Code | NCPDP Reject Message Text |
|---------|------------------------------|------------|---------------------------|
| 313 | Bill Any Other Available Insurance | 41 | Submit Bill To Other Processor Or Primary Payer |
| 387 | Primary Carrier Payment Needs Explanation | 13 | Missing/Invalid Other Coverage Code |

DMAS requests that providers who receive either of these messages verify whether the member has additional coverage. If the member acknowledges such coverage, the pharmacist should submit the claim first to that third party. Once the other insurer adjudicates the claim, the claim may be resubmitted to DMAS using appropriate messages in NCPDP data element fields, "OTHER COVERAGE CODE" and "OTHER PAYER AMOUNT." These fields are included in existing payer specifications. In order to submit an override to the denial, the pharmacist must use the appropriate response in each field as shown below. In the case where a member denies having additional coverage, the responses to be used in these fields are also noted below.

The pharmacy TPL editing is based on the NCPDP "Other Coverage Code" standard values (Version 5.1). The allowed values and their definitions are as follows:

> 00 – Not specified
>
> 02 – Other coverage exists – payment collected
>
> 03 – Other coverage exists – this claim not covered
>
> 04 – Other coverage exists – payment not collected

If a member denies having other coverage, the pharmacist should call the call center at 1-800-932-6648 for FFS claims, or the relevant MCO for managed care claims. Pharmacists are requested to make every effort to capture TPL payments where possible in order to maximize the potential cost savings to the Medicaid program.

Virginia Medicaid, always the payer of last resort, will only pay claims to the maximum of the Virginia Medicaid Allowed Amount. The coordinated benefit payment of the TPL amount and any additional Medicaid payment will be equivalent to the appropriate payment allowed under DMAS payment rules. Therefore, the total payment may not appear to correspond to the submitted claim amount. The final adjudication under Medicaid will show the appropriate co-pay to be collected from the member. The member is only responsible for the applicable Medicaid co-pay.

With respect to the effects of the ProDUR Program on the adjudication of claims, refer to the information in the ProDUR section below.

## Prospective Drug Utilization Review (PRODUR) System

The ProDUR system functions in conjunction with the POS Program. As a pharmacy claim is being electronically edited for eligibility and claims adjudication, the claim may also be edited against selected drug-use criteria. Since this edit (review) occurs before the prescription is filled, it is a prospective system. In the FFS program, all ProDUR criteria have been reviewed, revised, and approved by the Virginia Drug Utilization Review (DUR) Board, a group of nurses, pharmacists, and physicians who oversee the DMAS DUR activities. Each MCO conducts a separate DUR Board, so specific criteria may differ by plan. If an exception to one or more ProDUR criteria is identified, a message will be transmitted on line to the pharmacist. The pharmacist has the opportunity to use the message as the focus of member counseling or prescriber communication. Among NCPDP-standardized messages, which the pharmacist may receive, are messages identifying drug interactions, age contraindication, drug-disease contraindication, pregnancy contraindication, excessive dose with/without an age qualifier, insufficient dose with/without an age qualifier, early refill, underutilization (late refill), and therapeutic duplication. Early refill and therapeutic duplication are denied and require intervention.

ProDUR implementation does not impact the claims adjudication edits, such as eligibility verification.

For POS transmission problems or POS set-up information for FFS claims, contact the Helpdesk at **1-800-932-6648**. For managed care claims, contact the relevant MCO Helpdesk.

### ProDur Programs (Expanded)

In July 2007, Virginia Medicaid implemented expanded ProDUR programs for dose optimization and maximum quantity limits. Claim denials are made at point-of-sale for both dose optimization and maximum quantity limits when dispensing outside of established guidelines.

### Dose Optimization

The dose optimization program identifies high cost drugs where all strengths have the same unit cost and the standard dose is one tablet per day. By providing the highest strength daily dose, the number of units dispensed is minimized. Dose optimization edits are established for a small number of drugs in the FFS program, and are available at:

http://dmasva.dmas.virginia.gov/Content_atchs/forms/DMAS-171.pdf

For Managed Care Members, please contact the relevant MCO plan.

### Maximum Quantity Limits

Maximum quantity limits involve identifying high cost products where a days supply is defined by a set number of tablets. This strategy establishes quantity limits based on commonly accepted clinical dosing practices. Maximum quantity limit edits are established for a small number of drugs.

Please see https://www.virginiamedicaidpharmacyservices.com/provider/authorizations for the FFS program. Pharmacy providers will receive a claim denial when these quantity limits are exceeded. The Clinical Call Center can be reached at **1-800-932-6648** to answer questions regarding maximum quantity limits for FFS claims. Please contact the relevant MCO for managed care claims.

## Early Refills and Therapeutic (Class) Duplication Edits on FFS claims

DMAS has an early refill denial edit and therapeutic (class) duplication edit as an enhancement of the Medicaid ProDUR activities requirement. These POS edits expand ProDUR activities to include the denial of unjustified requests for early prescription refills or therapeutic (class) duplicate products. A mechanism has been provided for override of the denial for therapeutic (class) duplicate products in unusual situations as identified below.

For legend drugs dispensed for 90 days or less, "early refill" is defined as "when a prescription refill is requested before 75% of the calculated days' supply has elapsed for the previously filled prescription." For all controlled medications and any contraceptives dispensed for greater than 90 days supply, an "early refill" is defined as "when a prescription refill is requested before 90% of the calculated days' supply has elapsed for the previously filled prescription." Providers must take extra care in verifying that a correct amount is shown for the "days' supply" entry for all prescriptions. Early Refill (ER) alerts that deny and require the pharmacist to enter an intervention code to override the denial, require a phone call for an override. The Pharmacist should call 800-932-6648 for the override for FFS claims.  Managed Care Organizations may use different criteria for early refills.  Please contact the relevant MCO for managed care claims.

The following table outlines the Early Refill (ER) Override Criteria.

Virginia Medicaid
ProDUR – Early Refill (ER) Override Criteria

**Early Refill Approval Criteria:**
- Dosage Adjustments
- Incorrect days supply
- Lost/Stolen/Destroyed
- Vacation
- Hospital kept Meds
- Member Error*
- Two meds needed
- Nursing home in/out
*Member error will only be accepted as valid reason one time per drug per lifetime.

Approval Period: When the pharmacist calls he/she will receive a SA based on the approval criteria. The criteria will not allow more than ONE SA in 30 days, except in dosage adjustment cases.

Any questions regarding the Early Refill Edit can be referred to the Clinical Call Center. The Clinical Call Center can be reached at 800-932-6648, 24 hours, 7 days a week, to answer questions and

provide SAs for Early Refill Alerts.

> A denial edit for therapeutic duplication will occur when a product in the same therapeutic drug class as a concurrently utilized product (e.g., concurrent use of two calcium channel blockers) is billed.  All covered drugs are subject to FDB ProDUR Therapeutic Duplication Edits.

An early refill claim or a therapeutic duplication within certain drug classes will be denied payment. The error code and message will appear on both the computer screen and the remittance advice.

The error codes and error message associated with the denial edits are:

| Status Error Code | NCPDP Error Code | Message |
|---|---|---|
| 418 | 88 | Early Refill/ProDUR |
| 942 | 88 | Therapeutic Duplication/ProDUR |

Although the error alert code and/or message appearing on the screen may vary in individual practice settings due to the configuration chosen by the software vendor providing POS access, the denial of payment will be shown by some combination of the error codes noted above with a message explaining the code. A payment denial code will require the provider to reverse the claim except in those cases where a valid reason can be documented for the need to override the denial. Overrides of the denial must be entered into NCPDP field 416 (PA/MC Code and Number). The provider should make sure that the software vendor verifies that this field is set up and active in the system.

Pharmacy providers are able to initiate an override in the POS system in cases where, according to specific parameters, the need for therapeutic duplication is justified. The valid reason for override must be documented in the system (NCPDP Field 416) and in the prescription records of the pharmacy. As with all documentation related to Medicaid claims, records of overrides must be maintained for a period of five years and must justify the override. The utilization of the override function by providers will be monitored.

In the following unusual circumstances, the pharmacist may override the denial. Pharmacists must exercise professional judgment before proceeding with the override function.

**DMAS ProDUR Codes**

| ProDUR Reason for Service (Conflict Code) NCPDP Field 439 | Current Claims Disposition | New Claims Disposition | Professional Service (Intervention Code) NCPDP Field 440 942 | ProDUR Result of Service (Outcome Code) NCPDP Field 441 |
|---|---|---|---|---|

| | | | | |
|---|---|---|---|---|
| DD Drug-Drug | Message only | **Provider override** | AS = Member Assessment<br>CC = Coordination of Care<br>DE = Dosing Evaluation/ Determination<br>MØ = Prescriber Consulted<br>MR = Medication Review<br>PØ = Member Consulted | 1A 1B 1C 1D 1E 1F 1G 1H 1J 1K 2A 2B 3A 3B 3C 3D 3E 3F 3G 3H 3J 3K 3M 3N |
| MC Drug-Disease | Message only | **Provider override** | AS = Member Assessment<br>CC = Coordination of Care<br>DE = Dosing Evaluation/ Determination<br>MØ = Prescriber Consulted<br>MR = Medication Review<br>PØ = Member Consulted | 1A 1B 1C 1D 1E 1F 1G 1H 1J 1K 2A 2B 3A 3B 3C 3D 3E 3F 3G 3H 3J 3K 3M 3N |
| PG Pregnancy | Message only | **Provider override** | AS = Member Assessment<br>CC = Coordination of Care<br>DE = Dosing Evaluation/ Determination<br>MØ = Prescriber Consulted<br>MR = Medication Review<br>PØ = Member Consulted | 1A 1B 1C 1D 1E 1F 1G 1H 1J 1K 2A 2B 3A 3B 3C 3D 3E 3F 3G 3H 3J 3K 3M 3N |

| TD Therapeutic Duplication | Deny for 11 drug classes - provider override allowed | **Provider override – 11 Drug Classes\* Anti-Ulcer Agents ACE Inhibitors Angiotensn II Receptor Blockers Antidepressants Benzodiazepines NSAIDs (includes salicylates and COX-2s) Calcium Channel Blockers Thiazide Diuretics Loop Diuretics Potassum-Sparing Diuretics Narcotics Cardiac Glycosides- REMOVED \*Note: some of these classes are included in the PDL** | AS = Member Assessment CC = Coordination of Care DE = Dosing Evaluation/ Determination MØ = Prescriber Consulted MR = Medication Review PØ = Member Consulted | 1A 1B 1C 1D 1E 1F 1G 1H 1J 1K 2A 2B 3A 3B 3C 3D 3E 3F 3G 3H 3J 3K 3M 3N |

**Outcome Code Definitions**

| | | | |
|---|---|---|---|
| 1A | Filled As Is, False Positive | 3A | Recommendation Accepted |
| 1B | Filled Prescription As Is | 3B | Recommendation Not Accepted |
| 1C | Filled, With Different Dose | 3C | Discontinued Drug |
| 1D | Filled, With Different Directions | 3D | Regimen Changed |
| 1E | Filled, With Different Drug | 3E | Therapy Changed |
| 1F | Filled, With Different Quantity | 3F | Therapy Changed - Cost Increase |
| 1G | Filled, With Prescriber Approval | 3G | Drug Therapy Unchanged |
| 1H | Brand to Generic Change | 3H | Follow-Up/ Report |
| 1J | Rx to OTC Change | 3J | Member Referral |
| 1K | Filled With Different Dosage Form | 3K | Instructions Understood |
| 2A | Prescription Not Filled | 3M | Compliance Aid Provided |
| 2B | Not Filled, Directions Clarified | 3N | Medication Administered |

# REIMBURSEMENT FOR MEDICATIONS SHOWING OBSOLETE NATIONAL DRUG CODE (NDC) NUMBERS

DMAS will consider current, active NDC (National Drug Code) numbers for reimbursement of drug charges. Claims for drugs bearing terminated NDC numbers will be denied. Numbers determined to be terminated are based on notification in quarterly updates from the CMS Drug Rebate Program. The Medicaid Drug Rebate Program is based on NDC-specific units billed and captures representative marketplace drug discounts based on accurate data invoiced each calendar year quarter to drug labelers. Incorrect/expired/terminated NDCs provide the basis for rebate disputes

that delay drug rebate collections by the Commonwealth.

Regardless of the use of any commercial computer data updating service, each provider is personally responsible for submissions, which are correct in all details. Failure to maintain a complete, current record of product NDCs may result in payment delays as providers must resubmit corrected claims denied for terminated products. To be assured of proper, timely reimbursement, providers should check each stock package used against the billing to be submitted. It is important to be sure that billings are made based on actual stock used.

# MEDICARE PART D DRUG COVERAGE

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) created a prescription drug benefit under the Medicare program, Medicare Part D, which began on January 1, 2006. It is a voluntary program available to all beneficiaries; however, the MMA mandates that Medicaid enrollees who are also Medicare eligible (dual eligibles) no longer have Medicaid prescription drug benefits, effective January 1, 2006.

## Medicaid Coverage for Dual Eligible Members

Members with any form of Medicare coverage (either Medicare Part A or Part B) are eligible for Medicare Part D and are excluded from most Medicaid pharmacy benefits. Virginia Medicaid maintains records that dual eligible members are Medicare eligible and/or have eligibility for third party pharmacy benefits (other supplemental coverage); however, specific plan information will not be available. Medicaid pharmacy benefits for dual eligibles may be denied for any third party coverage. When submitting claims at POS, pharmacy providers will see the Medicaid coverage denial (rejected) reasons: "Verify Part D coverage." Virginia Medicaid is not responsible for reimbursement (full or partial) of any Medicare Part D drug.

**There are specific drug classes that are excluded by law under the new Medicare Part D program. Medicaid continues to cover these medications within the currently established guidelines of its pharmacy benefit program. Coverage of these drugs is in accordance with existing Medicaid policy as described in Chapter 50 of the Virginia Administrative Code (12 VAC 30-50; "Amount, Duration, and Scope of Medical/Remedial Services").** Prescription drug claims processed for dual eligibles remain subject to Virginia Medicaid's PDL. Those drug classes that Medicaid continues to cover for dual eligibles are as follows:

- · Medications for weight loss (SA required);
- · Legend and non-legend medications for symptomatic relief of cough and colds;
- · Prescription vitamins and mineral products (except prenatal vitamins and fluoride preparations);
- · Over-the-counter medications (prescriptions are required);

Medicaid covers co-insurance and deductible for prescription drugs administered under Medicare Part B based on current coverage guidelines. Over-the-counter (OTC) drug claims processed for dual eligibles remain subject to Virginia Medicaid's PDL. Medicare Prescription Drug Plans (PDPs) cover compound drugs that include covered Part D drugs. Medicaid pays for compounded

medications for Part D members when the active ingredients include only the above referenced medications.

**Medicare Part D Prescription Drug Plan Information**

Pharmacy providers are asked to contact the beneficiary's prescription drug plans with questions regarding the plan's pharmacy benefits. For a listing and contact information for these plans, please visit the DMAS website at www.dmas.virginia.gov (under "Provider Services," then "Medicare Part D") or the CMS website through the following link: https://www.medicare.gov/plan-compare/

Pharmacies may contact the pharmacist(s) in the CMS regional office at 1-215-861-4186 with questions related to the administration of the Medicare Part D program. Pharmacy providers can also contact the DMAS Call Center at 1-804-786-6273 (available 8:30 AM to 4:30 PM, Monday through Friday) with questions specifically regarding Virginia Medicaid's pharmacy benefit policies for dual eligible members.

## REIMBURSEMENT FOR INDIAN HEALTH SERVICE TRIBAL FACILITIES

Reimbursement for tribal health clinics is detailed in 12VAC30-80-26 and applicable sections are included below:

- Services provided by or through facilities of the Indian Health Services (HIS) are paid at the applicable HIS U.S. Office of Management & Budget (OMB) rate published annually in the Federal Register of Regulations by the HIS.
- The most current published HIS OMB outpatient per visit rate, also known as the outpatient all-inclusive rate, is paid for up to five outpatient visits per beneficiary per calendar day for professional services. Included in the outpatient per visit rate are Medicaid-covered pharmaceuticals or drugs.  Each prescription dispensed is defined as a separate outpatient visit for the purpose of this calculation.
- Tribal facility prescriptions should be billed to Medicaid fee-for-service through pharmacy point of sale for both fee-for-service and managed care members to ensure correct reimbursement.
- The Virginia Medicaid Common Core Formulary does not apply to members obtaining prescriptions through tribal facilities reimbursed with the above methodology.

# Billing Procedures (Pharm)

Updated: 10/1/2017

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 for 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

Federal regulations [42 CFR § 447.45(d)] require the initial submission of all Medicaid claims (including accident cases) within 12 months from the date of service. Only claims that are

submitted within 12 months from the date of service are eligible for Federal financial participation. To request a waiver of timely filing requirements, providers billing electronically must submit a Claim Attachment Form (DMAS-3) with the appropriate attachments.

DMAS is not authorized to make payment on claims that are submitted late, 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 in which the individual makes application for benefits. All eligibility requirements must be met within that period for retroactive eligibility to be granted. In these instances, unpaid bills for that period may be submitted to DMAS as Medicaid claims.

**Delayed Eligibility** - Initial denials of an individual's Medicaid eligibility application may be overturned or other actions may cause an eligibility determination to be delayed. DMAS may make payments for dates of service more than 12 months in the past when the claims are for an individual whose determination of eligibility was delayed.

It is the provider's obligation to verify the individual's Medicaid eligibility. The individual's local department of social services will notify providers who have rendered care during a period of delayed eligibility. The notification will indicate notification of the delayed eligibility and include the Medicaid ID number, and the time span for which eligibility has been granted. The provider must submit a claim 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 13 months from the date of the initial claim denial where the initial claim was filed according to the timely filing requirements. The procedures for resubmission are:

- Complete invoice as explained in this billing chapter.
- **Attach** written documentation to justify/verify the explanation. 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 DMAS 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 DMAS within 12 months from the date of the service. If the provider waits for the settlement before billing DMAS and the wait extends beyond 12 months from the date of the service, DMAS shall make no reimbursement.

**Other Primary Insurance** - The provider must bill other insurance as primary.  However, all claims for services **must be billed to DMAS within 12 months from the date of the service.** If the provider waits for payment before billing DMAS and the wait extends beyond 12 months from the date of the service, DMAS will make no reimbursements. If payment is made from the primary insurance carrier after a payment from DMAS 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. The other insurance plan pays first. Having other health insurance does not change the co-payment amount that providers may 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 member must notify the insurance company within 90 days of the end of Medicaid coverage to reinstate the supplemental insurance.

## 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.

## 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 Reference for Services Requiring Service Authorization

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

## Billing Instructions: Billing for Pharmacy Services

To bill the Virginia Medicaid Program for pharmaceutical services provided to members, a provider may use the Daily Pharmacy Drug Claim Ledger (DMAS-173 R6/03).  For compounded prescriptions, use the Compound Prescription Pharmacy Claim Form (DMAS-174).  In the case of home I.V. services or Durable Medical Equipment (DME), which includes nutritional supplements, the CMS-1500 form must be used.  Virginia Medicaid encourages pharmacy providers to submit claims for electronic processing whenever possible.  Electronic claims must be submitted in NCPDP Version D.0 format.

**Providers shall bill the Virginia Medicaid Program their usual and customary charges for all prescriptions dispensed.**  The Medicaid claims processing system will calculate the reimbursement due according to the rules described in Chapter IV of this manual.

The National Drug Code (NDC) assigned by the manufacturer or distributor found on the package label must be used when billing the Virginia Medicaid Program.  Hyphens in an NDC are not recognized in the DMAS processing system.

For a multiple-source drug (VMAC or CMS) with maximum cost reimbursement limits where the physician indicates "Brand Necessary," the NDC identifying the brand-name product dispensed is used, and the DMAS-173 R6/03 requires entry of the number "1" in field 9 DAW.  If "Brand Necessary" is not indicated on the prescription, the NDC must identify the less expensive generic product actually dispensed, not the brand-name product.

Co-payment amounts shall be as follows:

- One dollar ($1.00) co-pay for generic drug products; and
- Three dollars ($3.00) co-pay for single source or "Brand Necessary" products.

## Billing Instructions: Third Party Liability (TPL) Collections for Point-of-Service (POS) Claims (Pharm)

In order to conserve Medicaid dollars, and as payer of last resort, DMAS is beginning a process of Coordination of Benefits (COB) for Third Party Liability (TPL) collection at the Point-of-Service.  For pharmacy claims having a service date on or after June 20, 2003, DMAS will send an online claim denial message to pharmacy providers submitting POS claims for which the patient has other insurance coverage.  The messages used in this project are shown in the table below.

| VA Code | Virginia Denial Message Text | NCPDP Code | NCPDP Reject Message Text |
|---|---|---|---|
| 313 | Bill Any Other Available Insurance | 41 | Submit Bill To Other Processor Or Primary Payer |
| 387 | Primary Carrier Payment Needs Explanation | 13 | Missing/Invalid Other Coverage Code |

DMAS requests that providers receiving either of these messages verify whether the patient has additional coverage.  If the patient acknowledges such coverage, the pharmacist should submit the claim first to that third party.  Once the other insurer adjudicates the claim, the claim may be resubmitted to DMAS using appropriate messages in NCPDP data element fields, "OTHER COVERAGE CODE" and "OTHER PAYER AMOUNT."  These fields are included in existing payer specifications.  In order to submit an override to the denial, the pharmacist must use the appropriate response in each field as shown below.  In the case where a patient denies having additional coverage, the responses to be used in these fields are also noted below.

The pharmacy TPL editing is based on the NCPDP "Other Coverage Code" standard values (Version D.0).  These values and their definitions are as follows:

> 00 - Not specified
> 01 - No other coverage identified
> 02 - Other coverage exists - payment collected
> 03 - Other coverage exists - this claim not covered
> 04 - Other coverage exists - payment not collected
> 05 - Managed care plan denied
> 06 - Other coverage denied - not a participating provider
> 07 - Other coverage exists - not in effect on date of service (DOS)

08 - Claim is being billed for co-pay

Below is a grid reflecting the combination of Other Coverage Codes, presence or absence of a third party payment amount, and whether or not the member's record indicates third party pharmacy coverage with the proposed corresponding claim disposition.

| Other Coverage Code | TPL Amt | TPL Indicated on Member's Record | Initial Claim Disposition | Override Process |
|---|---|---|---|---|
| Other Coverage Code | TPL Amt | TPL Indicated on Member's Record | Initial Claim Disposition | Override Process |
| 0 = Not Specified | 0 | Yes | Deny, Bill Other Carrier VA code 313/NCPDP code 41 | Provider can resubmit with an Other Coverage Code of 3 or 4 as appropriate. |
| 0 = Not Specified | 0 | No | Pay | |
| 0 = Not specified | >0 | Yes or No | Deny, *TPL Indicators Conflict* VA code 387/NCPDP code 13 | Provider can resubmit with corrected Other Coverage Code or zeros in TPL Amount. |
| 1 = No other coverage identified | 0 | Yes | Deny, Bill Other Carrier VA code 313/NCPDP code 41 | Provider can resubmit with an Other Coverage Code of 3 or 4 as appropriate. |
| 1 = No other coverage identified | 0 | No | Pay | |
| 1 = No other coverage identified | >0 | Yes or No | Deny, *TPL Indicators Conflict* VA code 387/NCPDP code 13 | Provider can resubmit with corrected Other Coverage Code or zeros in TPL Amount. |
| 2 = Other coverage exists, payment collected | 0 | Yes or No | Deny, *TPL Indicators Conflict* VA code 387/NCPDP code 13 | Provider can resubmit with corrected Other Coverage Code and TPL Amount. |
| 2 = Other coverage exists, payment collected | >0 | Yes or No | Pay | Payment = Calculated Amount minus Other Payer Amount |
| 3 = Other coverage exists, this claim not covered | 0 | Yes or No | Pay | This code should be used when the drug is not covered by the other carrier |

| Other Coverage Code | TPL Amt | TPL Indicated on Member's Record | Initial Claim Disposition | Override Process |
|---|---|---|---|---|
| 3 = Other coverage exists, this claim not covered | >0 | Yes or No | Deny, *TPL Indicators Conflict* VA code 387/NCPDP code 13 | Provider must resubmit with corrected Other Coverage Code if wrong code entered or enter zeros in TPL Amount if Other Coverage Code was entered correctly. |
| 4 = Other coverage exists, payment not collected | >0 | Yes or No | Deny, *TPL Indicators Conflict* VA code 387/NCPDP code 13 | Provider can resubmit with corrected Other Coverage Code or zeros in TPL Amount. |
| *Other Coverage Code* | *TPL Amt* | *TPL Indicated on Member's Record* | *Initial Claim Disposition* | *Override Process* |
| 4 = Other coverage exists, payment not collected | 0 | Yes or No | Pay | This code should be used when the drug is covered by the other carrier but the pharmacy has not been able to collect from the other resource. |
| 5 = Managed Care Plan Denial | 0 | Yes | Denial | This code should be used when the drug is not covered by other payer. |
| 6 = Other coverage denied, not participating provider | 0 | | | |
| 7 = Other coverage exists - Not in effect on date of service | 0 | | | |
| 8 = Claim is being billed for co-pay | 0 | | | |

If a patient denies having other coverage, the pharmacist should use the appropriate override codes and fill the prescription as if it were a "Pay-and-Chase" claim.  Until future notice, such claims will be handled under the "Pay-and-Chase" Waiver.  Pharmacists are requested to make every effort to capture TPL payments where possible in order to maximize the potential cost savings to the Medicaid program.

Virginia Medicaid, always the payer of last resort, will only pay claims to the maximum of the Virginia Medicaid Allowed Amount.  The coordinated benefit payment of the TPL amount and any additional Medicaid payment will be equivalent to the appropriate payment allowed under DMAS payment rules.  Therefore, the total payment may not appear to correspond to the submitted claim amount. The final adjudication under Medicaid will show the appropriate co-pay to be collected from the patient.

For claims submitted using other media, pharmacy providers are requested to attempt to determine

if such TPL coverage exists.  Using the proprietary format of the DMAS-173 (R6/03), use of fields 23 and 24 will capture the desired elements.  This information is mandatory for paper claims submission of TPL claims.  Immediate pharmacist participation in this effort will assist in the DMAS cost-savings initiatives.

## Billing Instructions: Billing Instructions (Pharm)

The Pharmacy Claim Form, DMAS-173 (R 6/03), will be used for adjustments and voids of pharmacy claims.  At the end of the chapter in the "Exhibits" section you will find an example of the Pharmacy Claim Form, DMAS-173 (R 6/03) and Compound Prescription Pharmacy Claim Form, DMAS-174 (R 6/03).  Directions for the DMAS-174 appear on the back of the claim form and may also be found in the "Exhibits" section.

The form is printed in "red drop-out" ink which allows it to be processed through a scanner, rather than having to be entered by operators into the system.  This format will speed up processing and should improve the timeliness of claims resolution.

Because the scanners operate only when the forms are printed in this special ink, it will not be possible for providers to make copies of the form to be used as substitutes for the supplied forms. Please be sure to order forms from Commonwealth-Martin in adequate time for your needs.
Virginia Department of Medical Assistance Services Pharmacy Claim Form (DMAS-173  R6/03)

Required Fields

| Field Number | Description | Required (*) |
|---|---|---|
| 1 | Medicaid Pharmacy Provider Number (9digits) | * |
| 2 | Patient's Last Name | * |
| 2a | Patient's First Name | |
| 3 | 12-digit Medicaid Patient ID | * |
| 4 | Patient's Sex  M=Male   F=Female | * |
| 5 | Patient's Birth Date  MMDDCCYY | |
| 6 | Level of Service | * - only if Emergency  **(03)** |
| 7 | Days Supply | * |
| 8 | New Prescription = **00**; Refill =  **01 to 99** | * |
| 9 | DAW Codes = 1 | *- only if brand dispensed (1) |
| 10 | Patient's location | * - only if Nursing Home (03) |
| 11 | Resubmit Code | |
| 12 | Original Reference Number | |
| 13 | Seven-digit Rx Number | * |
| 14 | Date Dispensed (MMDDCCYY) (zero fill) | * |
| 15 | 11-digit NDC of Product Dispensed | * |
| 16 | Metric Decimal Quantity -  **EG   (e.g., 000002.500)** | * |
| 17 | Unit Dose Code | * - only if Unit Dose for Nursing Home (4) |
| 18 | Service Authorization Medical Certification | |

| Field Number | Description | Required (*) |
|---|---|---|
| | Code | |
| 19 | 11-digit Service Authorization Number | |
| 20 | Valid Prescriber's Medicaid Provider ID # | * |
| 21 | ICD CM Diagnosis Code | |
| 22 | Usual & Customary Charge  (e.g., 199/09 for $199.09) | * |
| 23 | Other Coverage Codes | |
| 24 | Dollar Amount Paid by Primary Payer | |
| 25 | Dispensing Status. To be used for partial fill prescriptions only. Partial fill = P or Completion of a partial fill = C | *- if needed |
| 26 | Intended Metric Quantity to be dispensed. The quantity positions are the same as field 16 (e.g., 000002.500) | * |
| 27 | Days' supply corresponding to in-tented metric quantity (#26) | * |
| 28 | Prescription number from initial partial fill. Use for completion claim. | |
| 29 | Date dispensed from initial partial fill.  Use for completion claim. | |
| 30 | Comments | |
| 31 | Pharmacy name, address, and phone number | * |
| 31 | Certification statement, signature, and date | * |

Special information for current pharmacy claims submission:

## Billing Instructions: Pharmacy Claim Form, DMAS-173 (R06/03)

The Pharmacy Claim Form is designed to be completed for one patient only.  Each block on the form must be completed correctly with the required information to receive payment for services provided and to avoid delays in processing the claim. (See the "Exhibits" section at the end of this chapter for a sample of this form.)

The instructions for completing each block on this form are as follows:

Block 1          **Pharmacy ID Number** - Enter the nine-digit provider identification number assigned by the Virginia Medicaid Program (remember to add two leading zeroes).

Block 2 and 2A     Patient's Last Name
Patient's First Name

Block  3          **Patient ID Number** - Enter the 12-digit Virginia Medicaid identification number assigned to the member receiving the prescription.  This number must be entered exactly as it appears on the Medicaid ID card.

Block 4          Patient's sex **-** M = Male, F = Female.

Block 5          **Date of Birth -** MMDDCCYY (zero fill as necessary, e.g., 06012003)

Block 6          **Level of Service** - Enter level of service if appropriate 01 = Patient Consultation, 02 = Home Delivery, 03 = Emergency, 04 = 24- hour supply, 05 = Patient consultation regarding generic product selection, 06 = In-home Service.  At the present time only 03 = emergency is functional.  It is to be used in an emergency when a Client Medical Management (CMM) member's designated CMM pharmacy is closed or does not stock the drug.

Block 7          **Days Supply -** Maximum allowable days supply is 34

Block 8          **Refill -** If original enter 00. Refill values 01 to 99.

Block 9          **DAW -** Enter 1 for prescriptions for Brand Medically Necessary as indicated in the prescribing physician's own handwriting in accordance with Virginia law and Medicaid policy.  Fraudulent use of the DAW 1 indicator is an auditable offense.

Block 10         **Patient's Location** - NCPDP approved codes include 00 = not specified, 01 = Home, 02 = Inter-Care, 03 = Nursing Home, 04 = Long Term/Extended Care, 05 = Rest Home, 06 = Boarding Home, 07 = Skilled Care Facility, 08 = Sub Acute Care Facility, 09 = Acute Care Facility, 10 = Outpatient, 11 = Hospice.

Currently the only functioning location code is 04 = Nursing Home.

Block 11         **Resubmission Code** - use if an adjustment or void is being requested. Codes are 1033 = correcting prescriber ID, 1034 = correcting metric quantity, 1035 = correcting drug code, 1036 = allowance for Rx less than pharmacy cost, (wholesale invoice attached), 1053 = Other, 1052 = Void.  This is the only form that will be accepted for adjustments and replaces DMAS 228.

Block 12         **Original Reference Number -** Enter the 16-digit original reference number (ICN) of the claim that is to be adjusted or voided. This field must be completed if field 11 is submitted.

Block 13         **Prescription Number** – Enter nine-digit prescription number.  If the claim is a void or adjustment, the prescription number must be the original prescription number.

Block 14         **Date Dispensed -** Enter date as MMDDCCYY (zero fill as necessary - e.g., 10012003)

Block 15         **NDC Code** - Enter the 11-digit National Drug Code (NDC) for the dispensed product.

Block 16         **Metric Quantity** - Enter the metric decimal quantity. The line serves as the decimal point.  The areas allows up to six digits before the decimal point (the line on the claim form) and three digits after the decimal point  (e.g., 000002.500).

Block 17         **Unit Dose Code -** Values are 0 = Not specified,   1 =  Not unit dose, 2 = Manufacturer's unit dose, 3 = Pharmacy Unit Dose, 4 = Unit Dose for Nursing Homes.

Block 18    **Service Authorization Medical Certification Code** - Valid codes are 0 = Not specified, 1 = Service Authorization, 2 = Medical Certification, 3 = EPSDT, 4 = Exemption from Co-pay, 5 = Exemption from prescription limits, 6 = Family planning indicator, 7 = AFDC, 8 = Payer-defined exemption.

Block 19    **Service Authorization Number** - Enter 11-digit service authorization number.

Block 20    **Prescriber's Medicaid ID Number** - Enter the nine-digit Medicaid provider number.  **A valid number must be entered for payment to be approved. Use of the unknown prescriber numbers will be audited, and payment will be revoked when an unknown number is entered for a valid prescriber.**

Block 21    **Diagnosis -** Enter ICDCM diagnosis code if applicable.  Do not enter decimal point.

Block 22    **Amount Billed** - Enter usual and customary charge for prescription, including dispensing fee.  Line serves as decimal point
(eg., 199/09 for $199.09).

**Block 23**    **Other Coverage Code** - Coordination of benefits can be billed online with the appropriate NCPDP coding information.  Valid codes include: 00 = Not specified, 01 = No other coverage exists, 02 = Other coverage exists and payments have been collected, 03 = Other coverage exists - claim not covered, 04 = Other coverage exists - payment not collected, 05 = Managed Care plan denied, 06 = other coverage denied - not a participating provider, 07 = Other coverage exists - not in effect on date of service, 08 = Claim being billed for co-pay.

**Block 24**    **Payment by Primary Carrier** - Enter payment by other carrier. Line serves as decimal point (e.g., 299/09 = $299.09).

**Block 25**    **Dispense Status -** Partial and Complete fills.  This field is only required for partial prescription fills. Enter P for partial or C for complete.  This field should not be used when dispensing full prescriptions for the intended quantity.

**Block 26**    **Quantity intended to be dispensed -** Enter prescription quantity as  Prescribed by physician.  Line serves as decimal point.

**Block 27**    **Intended Days' Supply** - Enter days supply as prescribed by Physician.

Block 28    **Prescription Number from the Initial Partial Fill Claim** - When submitting a completion 'C' claim, enter in field 28 the prescription number from the initial partial fill claim.

Block 29 **Date Dispensed from the Initial Partial Fill Claim** - When submitting the completion 'C' claim, enter in field 29 the date dispensed from the initial partial fill claim.

Block 30 **Comments** - Enter comments, if any (e.g., claim #3 used for high cholesterol).

Block 31 **Pharmacy Contact Information** - Enter the Pharmacy's name, address, and telephone number.

Block 32 **Certification Statement** - Note the certification statement on the claim form, then sign and date the claim form.

## Billing Instructions: Pharmacy Claim Form, DMAS-174 (R06/03)

The Compound Prescription Pharmacy Claim Form is designed to be completed for one patient only. Each block on the form must be completed correctly with the required information to receive payment for services provided and to avoid delays in processing the claim. (See the "Exhibits" section at the end of this chapter for a sample of this form.)

The instructions for completing each block on this form are as follows:

Block 1 The Resubmission Code is only used if an adjustment or void is being requested.  Enter the appropriate code if requesting the adjustment or void.  Valid values are 1033 = Correcting prescriber ID, 1034 = Correcting metric quantity, 1035 = correcting drug code, 1036 = Allowance for Rx less than pharmacy cost, (wholesale invoice attached), 1053 = Other, 1052 = Void.

Block 2 The Original Reference Number is only used if an adjustment or void is being requested.  Enter the 16 digits of the original claim reference number (ICN) of the claim that is to be adjusted or voided.  This field must be filled if a code is in field 1.

Block 3 Leave blank.

Block 4 Enter your nine-digit Medicaid provider ID number.  Do not use zeros with slashes.

Block 5 Enter the level of service code if appropriate.  01 = Patient consultation, 02 = Home delivery, 03 = Emergency, 04 = 24-hour service, 05 = Patient consultation regarding generic product selection, 06 = In-home service.

Block 6 Enter the ICD-CM diagnosis code if appropriate.  If using a four- or five-digit code number, do not enter the decimal point.

Block 7 | Service Authorization Medical Certification code, (PAMC).  Valid codes are: 0 = Not specified, 1 = Service Authorization, 2 = Medical certification, 3 = EPSDT, 4 = Exemption from Co-pay, 5 = Exemption from prescription limits, 6 = Family planning indicator, 7 = AFDC, 8 = Payer-defined exemption.

Block 8 | Enter the 11-digit service authorization number.

Block 9 | Enter the 12-digit Medicaid Patient ID number.

Block 10 | Enter the patient's last name and first name in the appropriate boxes.

Block 11 | Enter the patient's sex - M = Male, F = Female

Block 12 | Enter the patient's birth date.  Use MMDDCCYY format.  Zero fill as appropriate (e.g., 06012003).

Block 13 | Enter the prescriber's Medicaid provider ID number.  Do not use zeros with slashes.

Block 14 | Enter the prescription's seven-digit Rx number.  If this claim is for an adjustment or void, the Rx number must be the original Rx number on the claim being adjusted or voided.

Block 15 | Enter the date dispensed in MMDDCCYY format.  Zero fill as appropriate (e.g., 10012003).

Block 16 | Enter the days' supply.

Block 17 | If this is an original prescription, enter 00.  Refill values are 01 to 99.

Block 18 | Enter the patient's location.  Valid values are 00 = Not specified, 01 = Home, 02 = Inter-Care, 03 = Nursing Home, 04 = Long Term/Extended Care, 05 = Rest Home, 06 = Boarding Home, 07 = Skilled Care Facility, 08 = Sub Acute Care Facility, 09 = Acute Care Facility, 10 = Outpatient, 11 = Hospice.

Block 19 | Enter the 11-digit National Drug Code (NDC).  Be certain all NDC's entered are current.

Block 20 | Enter the Dispense as Written, (DAW) override code of "1" for prescriptions for which "Brand Necessary" is indicated in accordance with the law and Medicaid policy.  The value should be used only when the prescribing physician certifies "Brand Necessary" in his or her own handwriting for a prescribed brand- name drug that is generically available.

Block 21 | Description or Drug Name of ingredient.

Block 22 | Indicate the metric decimal quantity (e.g., 000002.500) of product using the appropriate unit of measure (each, gram, or milliliter).

| Block 23 | Other Coverage Code (OCC).  Valid values are: 00 = Not specified, 01 = No other coverage, 02 = Other coverage exists - payment collected, 03 = Other coverage exists - claim not covered, 04 = Other coverage exists - payment not collected, 05 = Managed Care plan denial, 06 = other coverage denied - not a participating provider, 07 = Other coverage exists - not in effect on date of service (DOS), 08 = Claim is being billed for co-pay. |
|---|---|
| Block 24 | Enter the dollar amount paid by the primary payer if other coverage applies (e.g., 2199/09 = $2,199.09). |
| Block 25 | Enter the usual and customary charge for the prescription.  This field should include the dispensing fee.  The last two positions of the field are for cents only (e.g., 199/09 = $199.99). |
| Block 26 | Enter comments, if any (i.e., "For high cholesterol"). |
| Block 27 | Enter the pharmacy's name, address, and telephone number. |
| Block 28 | Note the certification statement on the claim form, then sign and date the claim form. |

## 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: Group Practice Billing Functionality

Providers defined in this manual are not eligible to submit claims as a Group Practice with the Virginia Medicaid Program. Group Practice claim submissions are reserved for independently enrolled fee-for-service healthcare practitioners (physicians, podiatrists, psychologists, etc.) that share the same Federal Employer Identification Number. Facility based organizations (NPI Type 2) and providers assigned an Atypical Provider Identifier (API) may not utilize group billing functionality.

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

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

## Billing Instructions: Negative Balance Information

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

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

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

and it may also show "the negative balance to be carried forward".

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

## Billing Instructions: 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.

## Billing Instructions: EDI Billing (Electronic Claims)

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

## Special Billing Instructions: Health Departments (Drugs, Family Planning and Nutritional Supplements)

Tuberculosis Oral Drugs
Health Department clinics should bill for all drugs using the unlisted HCPCS code J8499.  Modifier U2 must be used in Block 24-D of the CMS-1500 (02-12) claim form.  Clinics bill Medicaid with their actual cost for the drugs.  If no modifier is billed, the claim may be denied. The qualifier 'N4' should be in locator 24 red shaded line followed by the NDC of the J code listed in 24D.

Family Planning Drugs and Devices
Birth control pills must be billed using code J8499 along with modifiers FP and U2 in Block 24-D of the CMS-1500 (02-12) claim form.  The qualifier 'N4' should be in locator 24 red shaded line followed by the NDC of the J code listed in 24D.

Family planning supplies (such as condoms, Intrauterine Devices, etc.) should be billed using unlisted supply code 99070 with the FP and U2 modifiers.  Actual costs for the drugs and supplies should be reflected in the charges.  Claims submitted without the modifiers may be denied.

Nutritional Supplements
Nutritional Supplements should be billed using the national HCPCS codes for Enteral and Parenteral Therapy (B4000-B9999) with the U2 modifier in Block 24-D of the CMS-1500 (02-12) claim form. Actual cost for the supplements should be billed. If no modifier is billed, the claim may be denied.

## 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.<br>a. Employment?<br>b. Auto accident<br>c. Other Accident? (This includes schools, stores, assaults, etc.) NOTE: The state should be entered if known. |
| 10d | Conditional | **Claim Codes (Designated by NUCC)**<br>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**<br>Enter the word '**CROSSOVER**'<br>**IMPORTANT: <u>DO NOT</u>** enter 'HMO COPAY' when billing for Medicare/Medicare Advantage Plan copays! Only enter the word '**CROSSOVER**' |
| 11d | REQUIRED<br>If Applicable | **Is There Another Health Benefit Plan?**<br>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<br>Enter date MM DD YY format<br>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<br>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.<br>**Note: ICD Ind. Not required at this time.** |
| 22 | REQUIRED<br>If Applicable | **Resubmission Code** – Original Reference Number. Required for adjustment or void. Enter one of the following resubmission codes for an adjustment:<br><br>(see tables below)<br><br>**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).**<br>**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:<br>• A cover letter on the provider's letterhead which includes the current address, contact name and phone number.<br>• An explanation about the refund.<br>• A copy of the remittance page(s) as it relates to the refund check amount.<br>• Mail all information to:<br>Department of Medical Assistance Services<br>Attn: Fiscal & Procurement Division, Cashier<br>600 East Broad St, Suite 1300<br>Richmond, VA 23219 |
| 23 | REQUIRED<br>If Applicable | **Prior Authorization (PA) Number** – Enter the PA number for approved services that require a service authorization.<br>**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). |

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 |

| | | |
|---|---|---|
| 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:**<br>• **A1 = Deductible (Example: A120.00) = $20.00 ded**<br>• **A2 = Coinsurance (Example: A240.00) = $40.00 coins**<br>• **A7= Copay (Example: A735.00) = $35.00 copay**<br>• **AB= Allowed by Medicare/Medicare Advantage Plan (Example AB145.10) = $145.10 Allowed Amount**<br>• **MA= Amount Paid by Medicare/Medicare Advantage Plan (Example MA27.08) see details below**<br>• **CM= Other insurance payment (not Medicare/Medicare Advantage Plan) if applicable (Example CM27.08) see details below**<br>• **N4 = National Drug Code (NDC)+Unit of Measurement**<br>'**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<br>Example: Payment by Medicare/Medicare Advantage Plan is $27.08; enter **MA27.08** in the red shaded area<br>'**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.<br>Example: Payment by the other insurance plan is $27.08; enter **CM27.08** in the red shaded area<br>NOTE: No spaces are allowed between the qualifier and dollars. No $ symbol is allowed. The decimal between dollars and cents is required.<br>**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<br>**Any spaces unused for the quantity should be left blank.**<br>**Unit of Measurement Qualifier Codes:**<br>• **F2 – International Units**<br>• **GR – Gram**<br>• **ML – Milliliter**<br>• **UN – Unit**<br>**Examples of NDC quantities for various dosage forms as follows:**<br>**a. Tablets/Capsules – bill per UN**<br>**b. Oral Liquids – bill per ML**<br>**c. Reconstituted (or liquids) injections – bill per ML**<br>**d. Non-reconstituted injections (I.E. vial of Rocephin powder) – bill as UN (1 vial = 1 unit)**<br>**e. Creams, ointments, topical powders – bill per GR**<br>**f. Inhalers – bill per GR**<br>**Note: All supplemental information entered in locator 24A thru 24H is to be left justified.**<br>**Examples:**<br>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.**<br>   **- Enter:A110.00 AB20.00 MA16.00 A24.00**<br>2. **Copay is $35.00, Medicare/Medicare Advantage Plan Paid Amt is $0.00 Medicare/Medicare Advantage Plan Allowed Amt is $100.00**<br>   **- Enter: A735.00 MA0.00 AB100.00**<br>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**<br>   **- Enter: MA10.00 CM10.00 AB10.00 A25.00 N412345678911GR2**<br>**\*\*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.<br>**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.<br>1 - Early and Periodic, Screening, Diagnosis and Treatment Program Services<br>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**

# Utilization Review and Control (Pharm)

Updated: 12/16/2015

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

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

## Financial Review and Verification

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

## Compliance Reviews (Pharm)

DMAS routinely conducts compliance reviews to ensure that the services provided to Medicaid recipients are medically necessary and appropriate and are provided by the appropriate provider.  These reviews are mandated by Title 42 C.F.R., Part 455.  Providers and recipients are identified for review by systems-generated exception reporting using various sampling methodologies or by

referrals and complaints from agencies or individuals.  Exception reports developed for providers compare an individual provider's billing activities with those of the provider peer group.  An exception profile report is generated for each provider that exceeds the peer group averages by at least two standard deviations.

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

Statistical sampling and extrapolation may be used in a review.   DMAS may use a random sample of paid claims for the audit period to calculate any excess payment.  When a statistical sample is used, the amount of invalid payments in the audit sample are compared to the total invalid payments for the same time period, and the total amount of the overpayment is estimated from this sample.  Overpayments may also be calculated based upon review of all claims submitted during a specified time period.

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

# Fraudulent Claims

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

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

**Provider Fraud**

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

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

Supervisor, Provider Review Unit

Program Integrity Section

Division of Cost Settlement and Audit

Department of Medical Assistance Services

600 East Broad Street, Suite 1300

Richmond, Virginia 23219

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

Director, Medicaid Fraud Control Unit

Office of the Attorney General

900 E. Main Street, 5th Floor

Richmond, Virginia 23219

**Recipient Fraud**

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

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

Referrals should be made to:

Supervisor, Recipient Audit Unit

Program Integrity Section

Division of Cost Settlement and Audit

Department of Medical Assistance Services

600 East Broad Street, Suite 1300

Richmond, Virginia 23219

## Referrals To the Client Medical Management (CMM) 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 recipients 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 the "Exhibits" section at the end of Chapter I for detailed information on the CMM Program. If CMM enrollment is not indicated, RMU staff may educate recipients on the appropriate use of medical services, particularly emergency room services.

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

Supervisor, Recipient Monitoring Unit

Program Integrity Section

Division of Cost Settlement and Audit

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 recipient and a brief statement about the nature of the utilization problems. Hospitals continue to have the option of using the "Non-Emergency Use of the Emergency Room" Referral Form when reporting emergency room abuse. 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.

# Drug Utilization Review (Pharm)

Updated: 3/14/2017

Purpose and Scope of the DUR Program

State and federal legislation created the directive for the Virginia Medicaid Drug Utilization Review (DUR) Program.  The purpose of the DMAS OBRA '90 DUR Program is to ensure that prescriptions for outpatient drugs are appropriate, medically necessary, and are not likely to cause adverse medical conditions.  OBRA '90 further requires that the DUR Program educate physicians and pharmacists to reduce the frequency of patterns of fraud, abuse, gross overuse, or inappropriate or medically unnecessary care.  DMAS established a DUR Board to:

1.  review and approve drug use criteria and standards for both retrospective and prospective DUR;

2.  apply these criteria and standards in the performance of DUR activities;

3.  review and report the results of DURs; and,

4.  recommend and evaluate educational intervention programs.

Retrospective DUR (RetroDUR) is required only for outpatients by OBRA '90.  However, because of the previous state legislative mandate for nursing facility retrospective DUR, nursing facility patients are also included in the retrospective component of the DUR Program.  Certain criteria used for the nursing facility population are tailored to the needs of the elderly; the data for the outpatient and nursing facility populations are analyzed and reported separately.

Prospective DUR (ProDUR), which includes prospective review, patient counseling, and patient profiling, is required only for outpatients.  Patient counseling is not required for inpatients of a hospital or institution where a nurse or other caregiver authorized by the state is administering medications.

The impact of the DUR Program on Medicaid providers varies.  The retrospective component primarily is focused on prescribing patterns and is likely to have more of an effect on physicians and other prescribing providers.  The pharmacist is responsible for performing the activities required for the prospective component.  As a result, ProDUR will affect pharmacy providers to a greater degree than prescribing providers.

## Retrospective DUR Component

### OVERVIEW

The retrospective component of the DUR Program consists of two parts:

- Retrospective claim review
- Provider education

### Retrospective DUR Computerized Claims Analysis

OBRA '90 mandates that the following problems be addressed in the retrospective component of the DUR Program:

- Therapeutic appropriateness;
- Overutilization and underutilization;
- Appropriate use of generic products;
- Therapeutic duplication;
- Drug-disease contraindications;
- Drug-drug interactions;
- Incorrect drug dosage or duration of drug treatment; and
- Clinical abuse/misuse.

The DUR Board uses selected retrospective DUR criteria that are representative of clinically important issues.  The focus of these criteria is on high-risk, high-volume, and high-cost drugs.  In addition, certain criteria have been tailored to specific populations; different criteria are used for ambulatory outpatient members than for elderly nursing facility members.  The criteria are updated periodically to include new products and reflect changing needs as well as patterns identified through the DUR analyses and follow-up.

The retrospective component of the DUR Program is performed at the direction of DMAS through the computer applications available from the DMAS retrospective DUR computer analysis contractor.  The provider education functions are also the responsibility of DMAS, with input and guidance from the DUR Board.

After the claims data are analyzed, profiles containing complete claims information (pharmacy, hospital, prescriber, and laboratory claims data) are generated for the members who do not meet the DUR criteria.  These exception profiles are produced in such a way that the identity of the member and providers is not apparent.  The profiles are reviewed by members of the DUR Review Team to determine whether or not to send an intervention letter to the provider.  The DUR Board determines the content of the intervention letters.

## Retrospective DUR Criteria - Nursing Facility Members

Certain criteria for the retrospective DUR analysis of pharmacy claims data for nursing facility members are based on criteria developed specifically for the geriatric population.  These age specific criteria were developed by the University of Maryland's Center for Drug Policy and the Philadelphia College of Pharmacy and Science's Geriatric Pharmacy Institute through a grant from the Centers for Medicare and Medicaid Services (CMS). The criteria are edited as needed to make them consistent with the current edition of *Drug Regimen Review: A Process Guide for Pharmacists* (American Society of Consultant Pharmacists, Alexandria, VA) and CMS' interpretive guidelines for nursing facility regulations on "unnecessary drugs" and "antipsychotic drugs." The criteria set includes the following areas:

- Angiotensin converting enzyme inhibitors;
- Antipsychotics;
- Benzodiazepines;
- Calcium channel blockers;
- Digoxin;
- Histamine H2 receptor antagonists; and,
- Nonsteroidal anti-inflammatory drugs.

The problem areas covered by the criteria noted above include:

- Dosage;
- Duration of therapy;
- Drug interactions; and,
- Therapeutic duplication.

## Retrospective DUR Criteria - General Outpatient Members

The criteria for the DUR analysis of pharmacy claims data for general outpatient members are based on the criteria developed by the DMAS retrospective DUR computer analysis contractor. The DMAS DUR Board has selected general classes of retrospective DUR criteria that are representative of clinically important issues; the focus of these criteria is on high-risk, high-volume, and high-cost drugs. The criteria cover the areas listed in Exhibit VII.1.

## Educational Program

Several educational approaches are used in the retrospective component of the DUR Program, including letters to individual providers outlining specific or potential therapeutic problem. The purpose of these general communications is to provide information on the findings and to solicit feedback on the issues and outcomes related to the DUR Program.

Letters to individual providers outlining specific or potential therapeutic problems determined through the application of the DUR criteria are also used. In those cases where a patient's drug therapy falls outside of the criteria approved by the DUR Board, a letter citing authority for the generally accepted therapeutic recommendations is sent to the prescribing provider. The providers may also be requested to provide clarifying information and justification. While it is hoped that these efforts promote judicious and cost-conscious use of drugs, the thrust of the DUR Program interventions is educational and informative, not punitive. Finally, DMAS works with the various state pharmacy and medical associations to provide suggestions, and, when requested, expertise for DUR-related seminar topics for continuing education purposes.

# Prospective DUR Component

## Overview

The prospective component of the DUR Program consists of three parts:

- ProDUR screening through DMAS' MMIS computer programming;
- On-line, real-time notice to the pharmacist; and,
- Patient counseling.

Since it is possible to perform the ProDUR screening function via a computer, DMAS has chosen to use this approach to facilitate the process. The pharmacist performs all ProDUR activities at the time a prescription is dispensed, applying the following general precepts:

- ProDUR screening shall be performed **before** all prescriptions for outpatient Virginia

Medicaid members are filled; and,
- The pharmacist may use his or her professional judgement as to the depth of counseling required for prescription refills.

Since pharmacy providers perform the ProDUR screenings, it is important that pharmacists discuss questions resulting from the prospective screening directly with the prescriber and/or member. Specific concerns may also be communicated to the DMAS' DUR pharmacist at dmasinfo@dmas.virginia.gov. Clarification on existing criteria and the need to develop new criteria or replace existing criteria are examples of such concerns.

## Prospective DUR Screening Criteria

OBRA '90 requires that the following types of problems be addressed in the prospective component of the DUR Program:

- Therapeutic duplication;
- Drug-disease contraindications;
- Drug-drug interactions;
- Incorrect drug dosage or duration of drug treatment;
- Drug-allergy interactions; and,
- Clinical abuse/misuse.

ProDUR activities are being carried out in Virginia's fee-for-service Medicaid Program as proposed by CMS. Implementation of the mandated prospective component of the OBRA '90 DUR Program is an evolutionary process. That is, the requirements for the DUR Program are likely to change over time. The approach used in the Virginia Medicaid DUR Program is to start with requirements that can be reasonably accomplished by the majority of pharmacy providers.

While the following information on prospective screening is meant to serve as a guide for ProDUR activities for Virginia Medicaid providers, it should not be construed to be an all-encompassing document. Pharmacists, and other Medicaid providers, are expected to exert their clinical judgement in dealing with the types of problems outlined below.

## Therapeutic Duplication

Therapeutic duplication is defined as the concomitant use of two or more drugs having the same or very similar pharmacologic properties. In some circumstances, therapeutic duplication may be appropriate (e.g., the use of more than one antihypertensive to treat difficult-to-control hypertension). However, in many situations, therapeutic duplication has the potential to cause the patient harm as a result of drug interactions, additive toxicity, and/or enhanced pharmacologic effects and represents unnecessary health care expenditures.

## Drug-Disease Contraindications

Drug-disease contraindications are identified by reference to medical claims data in the system. Alerts are sent when appropriate.

## Drug-Drug Interactions

Drug-drug interactions may involve both prescription and non-prescription drugs.

## Incorrect Drug Dosage or Duration of Drug Treatment

Incorrect drug dosage or duration of drug treatment is a problem that may be difficult to screen for because of lack of information about diagnoses, patient response to therapy, and hepatic and/or renal function.  Where possible, the MMIS system identifies problems based on data submitted through the claims process.

## Drug-Allergy Interactions

It is the responsibility of the dispensing pharmacist to detect drug-allergy interactions since Medicaid does not collect allergy data.  It is important to remember that what may be called an allergy by a patient is often an adverse reaction or a side effect (e.g., most codeine/morphine allergies are really reports of adverse GI effects of the drug). When requesting allergy information, be sure to also ask, "what happened?" Reports of shortness of breath or skin rashes are usually indicative of true allergic reactions.  Reports of GI upset (nausea, vomiting, diarrhea, etc.) and CNS disturbances (feeling "funny" or feeling sleepy) are generally the results of side effects.  This does not mean that side effects are to be trivialized and ignored.  Rather, the patient should be educated as to the true nature of these undesirable results of drug therapy and encouraged to discuss them with the prescriber.  More often than not, other therapeutic alternatives are available.  Pharmacists should be vigilant for potential cross-sensitivity concerns when therapeutic alternatives are considered within classes of drugs (e.g., NSAIDs) and across classes of drugs (e.g., penicillins and cephalosporins).

## Clinical Abuse/Misuse

Clinical abuse/misuse is the occurrence of any of the situations referred to in the definitions of abuse, gross overuse, overutilization, and underutilization, and incorrect dosage and duration:

**Abuse** means practices that are inconsistent with sound fiscal, business, or medical practices and result in unnecessary costs to the Virginia Medicaid Program or reimbursement for services that are not medically necessary or fail to meet professionally recognized standards for health care.

**Gross overuse** means repetitive overutilization without therapeutic benefit.

**Overutilization** means use of a drug in quantities or duration that put the member at risk of an adverse medical condition.

**Underutilization** means use of a drug by a member in insufficient quantity to achieve a desired therapeutic goal.

**Incorrect drug dosage** means the dosage lies outside the daily dosage range (i.e., under dosage and excessive dosage) specified in predetermined standards (i.e., the manufacturer's dosage information) as necessary to achieve therapeutic benefit.  Dosage range is the strength multiplied by the quantity dispensed divided by the days' supply.

**Incorrect duration of drug treatment** means the number of days of prescribed therapy exceeds or falls short of the recommendations contained in the predetermined standards.

### Summary of the Drugs and Drug Classes to be Covered by ProDUR

The criteria for the retrospective and prospective components of the DUR Program should be consistent if maximum benefit is to be derived from the Program.  As previously noted, the retrospective DUR criteria are representative of clinically important issues with a focus on high-risk, high-volume, and high-cost drugs.  Thus, criteria very similar to those developed for retrospective DUR will be used for ProDUR.

## Patient Counseling Activities (Pharm)

The state statute regarding patient counseling allows for a broader interpretation of what constitutes an "offer to counsel" than OBRA '90. The original intent of the OBRA '90 patient counseling mandate was for the pharmacist to make a verbal offer to discuss the medication to be dispensed with the Medicaid member or his or her agent.

Please note that:

- The pharmacist may delegate the responsibility of offering the counseling to a non-pharmacist; however, the actual responsibility for patient counseling may not be delegated to anyone except a pharmacy intern working under the supervision of a pharmacist.
- Printed materials may be used to **supplement** patient counseling, but **may not** be used **in place of** verbal counseling.

 Both state statute and OBRA '90 also require that the information provided to members include, but not be limited to, the following:

- Name and description of medication;
- Dosage form, dosage, route of administration, and duration of therapy;
- Special directions and precautions for preparation, administration, and use by the patient;
- Common adverse or severe side effects or interactions and therapeutic contraindications that may be encountered, including their        avoidance, and the action required if they occur;
- Techniques for self-monitoring drug therapy;
- Proper storage;
- Prescription refill information; and,
- Action to be taken in the event of a missed dose.

The pharmacist should use his or her professional judgement as to the amount of information to provide in each area.  The pharmacist must provide complete and thorough counseling before dispensing **all new** prescriptions.  The degree of counseling to be provided before dispensing **refills** is subject to the pharmacist's discretion.  The member or his or her agent may refuse counseling;

however, the offer to counsel should not be presented in such a way as to encourage refusal of counseling.  The acceptance or refusal of the offer to counsel should be documented, preferably in the patient's profile (see below).

**Patient Profile Activities**

Both OBRA '90 and state ProDUR/patient counseling/patient profiling statute require that the following information be included in the patient's profile:

- Patient's name, address, telephone number, date of birth (or current age), and gender;
- Medical history, including:

  -- Disease state(s)

  -- Known allergies and drug reactions

  -- A comprehensive list of medications and relevant devices

- Pharmacist's comments relevant to the patient's drug use, including any failure to accept the pharmacist's offer to counsel.

**Provider Profiling**

Evaluation of claims-based data is also used to determine the presence of providers who receive a high number of alerts for unusual prescription use. Using the RetroDUR process, the system is programmed to collate the alerts generated for each prescriber or pharmacy.  The DUR Board then determines which types of alerts are to be focused upon and sets the point for exceptions to trigger the system generation of a provider letter.  Information conveyed to providers in this program reinforces the norms established for prescribing/dispensing of the classes or products in question.

Providers are asked to respond to a questionnaire regarding reasons for the documented pattern of care.  Provider profiling is a useful tool in identifying prescribers and dispensers who may need educational intervention(s) related to potentially harmful therapeutic decisions.


# Appendix D: Preferred Drug List / Common Core Formulary Changes, and Drug Utilization Review Board Service Authorization Changes

Updated: 6/10/2022

PREFERRED DRUG LIST / COMMON CORE FORMULARY CHANGES, 90 DAY SUPPLY LIST CHANGES, AND DRUG UTILIZATION REVIEW BOARD SERVICE AUTHORIZATION CHANGES

The following updates were recently recommended and approved by the Drug Utilization Review Board and the DMAS Pharmacy and Therapeutics (P&T) Committee.  These changes, along with a complete listing of preferred drugs and service authorization requirements, are posted on the Virginia Medicaid Pharmacy Services Portal at: https://www.virginiamedicaidpharmacyservices.com/provider

**Effective immediately**, the following drugs require a service authorization (SA). SA forms can be found at: https://www.virginiamedicaidpharmacyservices.com/provider/authorizations

- Besremi[R] (ropeginterferon alfa-2b-njft)
- Livtencity[TM] (maribavir)
- Scemblix[R] (asciminib)
- Tavneos[TM] (avacopan)
- Voxzogo[TM] (vosoritide)
- Exkivity[TM] (mobocertinib)
- Kerendia[R] (finerenone)
- Welireg[TM] (belzutifan
- Fotivda[R] (tivozanib)
- Lumakras[TM] (sotorasib)
- Myfembree[R] (relugolix, estradiol, and norethindrone acetate)
- Truseltiq[TM] (infigratinib)
- Wegovy[TM] (semaglutide)

The DMAS P&T Committee conducted its annual review of the following PDL Phase II drug classes and reviewed new drugs in PDL Phase I on March 17, 2022. **On July 1, 2022,** the following changes, and additions to the Preferred Drug List (PDL) will be effective.

| Virginia Preferred Drug List Changes Effective July 1, 2022 | | |
| --- | --- | --- |
| **Drug Class** | **Preferred** | **Non-Preferred (requires SA)** |
| Antivirals, Topical | -acyclovir ointment (topical) -docosanol OTC (topical) | -Abreva OTC (topical) -Zovirax (topical) |
| Antimigraine, Other (NEW CLOSED CLASS) | -Nurtec ODT | -Ubrelvy |
| Antipsychotics | quetiapine ER | -quetiapine ER **(AG)** |
| COPD Agents | -Spiriva Respimat | NA |
| Cytokine and CAM Antagonists | -Inflectra (IV) | -Renflexis (IV) |

| | | |
|---|---|---|
| Hypoglycemics, Insulins | -insulin aspart cartridge/pen/vial<br>-insulin aspart/insulin aspart protamine insulin pen/vial<br>-insulin lispro Junior pen<br>-insulin lispro pen<br>-insulin lispro protamine mix pen | -Novolog Mix Pen/Vial |
| Hypoglycemics, Incretin Mimetics | | -Glyxambi |
| Multiple Sclerosis (NEW CLOSED CLASS) | -dimethyl fumarate DR<br>-dimethyl fumarate DR starter pack | -Tecfidera<br>-Tecfidera Starter Pack |
| Progestational agents (NEW CLOSED CLASS) | NA | NA |
| Stimulants | -dexmethylphenidate | -Focalin |

Classes in red designate Common Core Formulary "closed classes"

NEW CLOSED CLASSES

AG = authorized generic

**SA criteria can be found on the updated Preferred Drugs List (PDL/Common Core Formulary) at:**
https://www.virginiamedicaidpharmacyservices.com/provider/preferred-drug-list.

**SA forms for specific drugs or drug classes can be found at:**
https://www.virginiamedicaidpharmacyservices.com/provider/authorizations

| Virginia 90 day list changes Effective July 1, 2022 | | |
|---|---|---|
| **Drug Class** | **Added** | **Removed** |
| COPD Agents | -Spiriva Respimat | NA |

| Hypoglycemics, Insulins | -insulin aspart cartridge/pen/vial<br>-insulin aspart/insulin aspart protamine insulin pen/vial<br>-insulin lispro junior pen<br>-insulin lispro pen<br>-insulin lispro protamine mix pen | -Novolog Mix Pen/Vial |

# Pharmacy Appendix E: DMAS 90 DAY SUPPLY LIST

Updated: 6/10/2022

## ADHD AGENTS

Atomoxetine

Clonidine ER

Guanfacine ER

## ANTIBIOTICS-ANTI-INFECTIVES

Sulfonamide-Antibiotics

Sulfamethoxazole- trimethoprim susp

Sulfamethoxazole/trimethoprim SS tab

Sulfamethoxazole- trimethoprim DS tab

Azole-Antifungals

Fluconazole 50, 100, 150, 200 mg tab

Fluconazole 10 mg/ml 40 mg/ml susp

Griseofulvin 125 mg/5 ml susp

Nystatin 100,000 unit/ml susp

Nystatin 500,000-unit oral tab

Terbinafine 250 mg tab

# ANTIVIRALS

Herpes Oral

Acyclovir 200 mg cap

Acyclovir 200 mg/5 ml susp

Acyclovir 400, 800 mg tab

Famciclovir 125, 250, 500 mg tab

Valacyclovir 500 mg, 1 gram tab

HIV Oral

All Preferred Agents

# BLOOD MODIFIERS

Bile Salts

Ursodiol

Phosphate Binders

Calcium Acetate 667mg cap

Sevelamer carbonate tab

# BONE RESORPTION SUPPRESSION

Bisphosphonates

Alendronate 5, 10, 35, 70 mg tab

Ibandronate

Calcitonins

Calcitonin-salmon nasal spray

Others

Raloxifene

## CARDIAC AGENTS

ACE Inhibitors

Benazepril 5, 10,20, 40 mg

Enalapril 2.5, 5, 10, 20 mg

Lisinopril 2.5, 5, 10, 20, 30, 40 mg

Ramipril 1.25, 2.5, 5, 10 mg

Quinapril 5, 10, 20, 40 mg

ACE Combinations

Benazepril-HCTZ 5-6.25, 10-12.5, 20-12.5, 20-25 mg

Lisinopril- HCTZ 20-12.5, 20-25, 10-12.5 mg

Enalapril- HCTZ 5-12.5, 10-25 mg

Amlodipine-Benazepril 2.5-10, 5-10, 5-20, 5-40,10-20, 10-40mg

Anticoagulants and Antiplatelets

Brilinta 60, 90 mg tab

Eliquis (dose pack excluded)

Jantoven

Pradaxa

Warfarin Sodium 1, 2, 2.5, 3, 4, 5, 6, 7.5, 10 mg tab

Xarelto (dose pack excluded)

ARBs

Losartan Potassium 25, 50, 100 mg

Irbesartan 75, 150, 300 mg

Olmesartan Medoxomil 5, 20, 40 mg

Valsartan 40, 80, 160, 320 mg

ARB Combinations

Amlodipine-Valsartan 5-160, 5-320, 10-160, 10-320 mg

Amlodipine-Olmesartan 5-20, 10-20, 5-40, 10-40 mg

Irbesartan-HCTZ 150-12.5, 300-12.5 mg tab

Losartan-HCTZ 50-12.5, 100-12.5, 100-25 mg tab

Olmesartan-HCTZ 20-12.5, 40-12.5, 40-25 mg tab

Valsartan-HCTZ 80-12.5, 160-12.5, 160-25,320-12.5,320-25mg

Beta Blockers

Atenolol 25, 50, 100 mg

Bisoprolol Fumarate 5, 10 mg

Carvedilol 3.125, 6.25, 12.5, 25 mg tab

Carvedilol ER 10, 20, 40, 80 mg cap

Labetalol 100, 200, 300 mg tab

Metoprolol Tartrate 25, 37.5, 50, 75, 100 mg

Metoprolol Succinate ER 25, 50, 100, 200 mg

Propranolol 10, 20, 40, 60, 80 mg tab

Propranolol 20 Mg/5, 40 Mg/5 ml soln

Propranolol ER 60, 80, 120, 160 mg cap

Sotalol AF 80, 160 mg tab

Sotalol 120,160, 240 mg tab

Sorine 80, 120, 160, 240 mg tab

Calcium Channel Blockers

Amlodipine Besylate 2.5, 5, 10 mg tab

Nifedipine 10, 20 Mg Capsule

Nifedipine ER 30, 60, 90 mg tab

Cartia XT 120, 180, 240, 300 mg cap

Diltiazem 30, 60, 90, 120 mg tab

Diltiazem 12HR ER 60, 90,120 mg cap

Diltiazem 24HR ER 120, 180, 240, 300, 360, 420 mg cap

Diltiazem 24h ER(XR) 120, 180, 240 mg cap

Diltiazem 24HR CD 360 MG CAP

Taztia XT 120, 180, 240, 300, 360 MG cap

Verapamil 40, 80, 120 Mg Tab

Verapamil ER 120, 180, 240 Mg Tab

Cardiac Glycosides

Digoxin 0.05 mg/ml, 0.125 mg/2.5 ml solution

Digoxin 125, 250 mcg tab

Loop Diuretics

Bumetanide tab 0.5, 1, 2mg tab

Furosemide 20, 40, 80 mg tab

Torsemide 5, 10, 20, 100 mg tab

Nitrates and Nitrites

Isosorbide Dinitrate 5, 10, 20, 30, 40 mg tab

Isosorbide Dinitrate ER 40 mg tab

Isosorbide Mononitrate 10, 20 mg tab

Isosorbide Mononitrate ER 30, 60, 120 mg tab

Nitroglycerin 400 mcg Spray

Nitroglycerin 2.5, 6.5, 9 mg cap SA

Nitroglycerin 2% ointment

Nitroglycerin 0.1, 0.2, 0.3, 0.4, 0.6, mg/hr. patch Nitroglycerin 0.3, 0.4, 0.6 mg sl tab

Nitroglycerin Lingual 0.4 mg

Platelet Inhibitors

Clopidogrel 75, 300 mg tab

Dipyridamole 25, 50, 75 mg tab

Prasugrel 5, 10 mg tab

Potassium Sparing Diuretics

Eplerenone 25, 50 mg tab

Spironolactone 25, 50, 100 mg tab

Triamterene-Hctz 37.5/25, 75-50 mg tab & cap

Selective Cholesterol Absorption Inhibitors

Ezetimibe 10 mg tab

Fibrates

Fenofibrate 48, 145 mg tab

Gemfibrozil 600 mg tab

Statins

Atorvastatin 10, 20. 40. 80 mg tab

Rosuvastatin Calcium 5, 10, 20, 40 mg tab

Simvastatin 5, 10, 20, 40, 80 mg tab

Lovastatin 10, 20, 40 mg tab

Pravastatin 10, 20, 40, 80 mg tab

Sympatholtic Antihypertensives

Catapres-TTS 1, 2, 3 Patch

Clonidine HCL 0.1, 0.2, 0.3 mg tab

Guanfacine 1, 2 mg tab

Methyldopa 250, 500 mg tab

Thiazide Diuretics

Chlorthalidone 25, 50 mg tab

Hydrochlorothiazide 12.5, 25, 50,100 mg

Potassium Supplements

Potassium Chloride 8, 10 Meq cap SA

Potassium Chloride 10% liq S-F

Potassium Chloride 15%, 20% liq

Potassium Chloride 10, 20 meq tab

Potassium Chloride ER 10, 15, 20 meq tab

Vasodilators

Hydralazine HCL 10, 25, 50, 100 mg tab

## CNS AGENTS

Alzheimer's Disease Agents

Donepezil 5, 10, 23 mg tab

Donepezil ODT 5 mg, 10 mg tab

Exelon 4.6 mg/24hr, 9.5, 13.3 mg/24hr patch

Memantine 5, 10 mg tab

Memantine 5-10 mg titration pack

Memantine ER 14, 21, 28 mg cap

Memantine 2 mg/ml, 10 mg/5 ml soln

Memantine ER 7 mg cap

## Antidepressants

Bupropion 75, 100 mg tab

Bupropion SR 100, 150, 200 mg tab

Bupropion XL 150, 300 mg tab

Bupropion SR 150 mg tab

Citalopram 20 mg/10 ml sol

Citalopram 10, 20, 40 mg tab

Desvenlafaxine ER 50, 100 mg tab

Desvenlafaxine SUC ER 25 mg tab

Escitalopram 5, 10, 20 mg tab

Fluoxetine 10, 20, 40 mg cap

Fluoxetine 20 mg/5 ml soln

Fluvoxamine maleate 25, 50, 100 mg tab

Mirtazapine 15, 30, 45 mg tab

Mirtazapine 15, 30, 45 mg ODT

Mirtazapine 7.5 mg tab

Paroxetine 10 mg, 20, 30, 40 mg tab

Sertraline 25, 50, 100 mg tab

Sertraline 20 mg/ml oral conc

Sertraline 20 mg/ml oral soln

Trazodone 50, 100, 150, 300 mg tab

Venlafaxine 25, 37.5, 50, 75, 100 mg tab

Venlafaxine ER 37.5, 75, 150 mg cap

Anticonvulsants

Carbamazepine 100 mg tab

Carbamazepine 100 mg tab chew

Carbamazepine 100 mg/5 ml susp

Carbamazepine ER 100, 200, 300 mg cap

Carbamazepine ER 100, 300, 400 mg tab

Divalproex DR 125 mg cap sprinkle

Divalproex DR 125, 250, 500 mg tab

Divalproex ER 250, 500 mg tab

Ethosuximide 250 mg capsule

Ethosuximide 250 mg/5 ml sol

Lamotrigine 150, 200 mg tab

Lamotrigine 25, 100 mg tab

Lamotrigine 5, 25 mg ODT

Lamotrigine ER 25, 50, 100, 200, 250, 300 mg tab

Levetiracetam 100 mg/ml, 500 mg/5 ml sol

Levetiracetam 250, 500, 750, 1000 mg tab

Levetiracetam ER 500, 750 mg tab

Oxcarbazepine 150, 300, 600 mg tab

Oxcarbazepine 300 mg/5 ml susp

Phenytoin 100 mg/4ml, 125 mg/5 ml susp

Phenytoin 50 mg tab chew

Phenytoin sod ext 100, 200, 300 mg cap

Primidone 50, 250 mg tab

Roweepra 500, 750, 1,000 mg tab

Topiramate 15, 25 mg sprinkle cap

Topiramate 25, 50, 100, 200, mg tab

Valproic acid 250 mg cap

Valproic acid 250 mg capsule

Valproic acid 250 mg/5 ml sol

Valproic acid 250 mg/5, 500 mg/10 ml sol

Zonisamide 25, 50, 100 mg cap

Antimanic Agents

Lithium carbonate 150, 300, 600 mg cap

Lithium carbonate 300 mg tab

Lithium carbonate er 300, 450 mg tab

Lithium citrate 8 meq/5 ml sol & syrup

Atypical Antipsychotics

Aripiprazole 2, 5, 10, 15, 20, 30 mg tab

Latuda 20, 40, 60, 80,120 mg tab

Olanzapine 2.5, 5, 7.5, 10, 15, 20 mg tab

Olanzapine ODT 5, 10, 15, 20 mg tab

Olanzapine 10 mg vial

Quetiapine 25, 50, 100, 200, 300, 400 mg tab

Quetiapine er 50, 150, 200,300, 400 mg tab

Risperidone 0.25, 0.5, 1, 2,3, 4 mg tab

Risperidone 1 mg/ml solution

Risperidone 0.25, 0.50 1, 2, 3, 4 mg ODT

Ziprasidone 20, 40, 60, 80 mg cap

<u>Parkinson's Disease Agents</u>

Benztropine 0.5, 1, 2, 2.5, 5 mg tab

Pramipexole 0.125, 0.25, 5.0, 0.75, 1, 1.5 mg tab

Pramipexole er 0.375, 0.75, 1.5, 2.25, 3, 3.75, 4.5 mg tab

Ropinirole 0.25, 0.5, 1, 2, 3, 4, 5 mg tab

Ropinirole ER 2, 4, 6, 8, 12 mg tab

<u>Typical Antipsychotics</u>

Chlorpromazine 10, 25, 50, 100. 200 mg tab

Fluphenazine 1, 2.5, 5, 10 mg tab

Fluphenazine 2.5 mg/5 ml elixir

Fluphenazine 5 mg/ml conc

Fluphenazine dec 125 mg/5 ml

Haloperidol 0.5, 1, 2. 5, 10, 20 mg tab

Haloperidol decanoate 50 mg/ml, 100 mg/mg vial

Haloperidol decanoate 250 mg/5 ml, 500 mg/5 ml vial

Haloperidol decanoate 50 mg/ml, 100 mg/ml amp

Haloperidol lactate 2 mg/ml conc

Loxapine 5, 10, 25, 50 mg cap

Perphenazine-amitriptyline 2-10, 2-25, 4-10, 4-25, 4-50 mg tab

Perphenazine 2, 4, 8, 16 mg tab

Thioridazine 10, 25, 50, 100 mg tab

Thiothixene 1, 2, 5, 10 mg caps

Trifluoperazine 1, 2, 5, 10 mg tab

## CORTICOSTEROIDS

Prednisone 5 mg/5 ml solution

Prednisone 1, 2.5, 5, 10. 20, 50 mg tab

Prednisone 50 mg tab

Prednisone 5, 10 mg tab dose pack

## DIABETES AGENTS

Orals

Acarbose25, 50, 100 mg tab

Farxiga 5, 10 mg tab

Glimepiride 1,2,4 mg tab

Glipizide 5, 10 mg tab

Glipizide ER 2,5, 5, 10 mg tab

Glyburide 1.25, 2.5, 5 mg tab

Glyburide Micro 1.5, 3, 6 mg tab

Glyburide-metformin 2.5-500

Invokamet XR 50-500, 50-1000,150-500, 150-1000 mg

Invokana 100, 300 mg tab

Janumet 50- 500, 50-1000 mg tab

Janumet XR 50-500, 50-1000, 100-1000 mg tab

Januvia 25, 50, 100 mg tab

Jardiance 10, 25 mg tab

Jentadueto 2.5-500, 2,50850, 2.5-1000 mg tab

Metformin 500, 850, 1,000 mg tab

Metformin ER 500, 750 mg tab

Nateglinide 60, 120 mg tab

Repaglinide 0,5, 1, 2 mg tab

Synjardy 12.5-500, 12.5-1000, 5-500, 5-1000mg tab

Tradjenta 5 mg tab

Xigduo 2.5-1000, 5-500, 10-500, 5-1000, 10-1,000 mg tab

Injectables

Bydureon 2 mg pen

Byetta 5, 10 mcg pen

Humalog 100 Units/ml vial & cartridge

Humalog Mix 50-50, 75-25 vial

Humulin 70-30 Vial & Kwikpen

Humulin N 100 u/ml vial & Kwikpen

Humulin R 100 Units/ml vial

Humulin R 500 Units/ml vial & Kwikpen

Insulin Aspart Cartridge Pen and Vial SQ

Insulin Aspart/Insulin Aspart Protamine Insulin Pen SQ

Insulin Aspart/Insulin Aspart Protamine Vial SQ

Insulin Lispro 100 Unit/ml vial

Insulin Lispro Junior Kwikpen SQ

Insulin Lispro Pen SQ

Insulin Lispro Protamine Mix Kwikpen SQ

Lantus 100 Unit/ml vial

Levemir Flextouch 100 Units/ml & Vial

Novolog 100 Unit/ml Cartridge & Vial

Novolog 100 Units/ml Flexpen

Trulicity 0.75mg/0.5ml, 1.5mg/0.5ml, 3mg-0.5ml, 4mg/0.5ml pen

Victoza 2-Pak 18 Mg/3 ml pen

Diabetic Supplies

Diabetic Needles

Diabetic Pen Needles

Diabetic Syringes

## ESTROGENS

Estradiol 0.5, 1, 2 mg tab

## GASTROINTESTINAL AGENTS

Chronic Motility Agents

Amitiza

Linzess

Movantik

H2 Receptor Antagonists

Famotidine 10, 20, 40 mg tab

Famotidine 40 mg/5 ml susp

Proton Pump Inhibitors

Omeprazole DR 10, 20, 40 mg cap

Pantoprazole sod DR 20, 40 mg tab

Pantoprazole 40 mg susp

Ulcerative Colitis Agents

Apriso

Balsalazide disodium

Pentasa

Sulfasalazine DR & IR

## GENITOURINARY

Benign Prostatic HyperplasiaAgents

Alfuzosin ER 10 mg tab

Doxazosin mesylate 1, 2, 4, 8 mg tab

Dutasteride 0.5 mg cap

Finasteride 5 mg tab

Tamsulosin 0.4 mg cap

Terazosin 1, 2, 5, 10 mg cap

Terazosin 1, 2, 5, 10 mg tab

Urinary Antispasmodics

Oxybutynin tab/syr

Oxybutynin ER

Solifenacin

Toviaz

## GOUT AGENTS

Allopurinol 100, 300 mg tab

Colchicine 0.6 mg tab

Probenecid 500 mg tab

Probenecid-Colchicine tab

## HYPOTHYROIDISM AGENTS

Levothyroxine 25, 50, 75, 88, 100, 112, 125, 137, 150, 175, 200, 300 mcg tab

Levothyroxine 13, 25, 50, 75, 88, 100, 112, 125, 137, 150, 175, 200 mcg cap

## IMMUNOLOGICAL AGENTS

Azathioprine 50 mg tab

Methotrexate 2.5 mg tab

Methotrexate 1 gm vial

Methotrexate 1 gram/40 ml vial

Methotrexate 25 mg/ml vial

Methotrexate 250 mg/10 ml vial

Methotrexate 50 mg/2 ml vial

## NSAIDS

Children's Motrin® susp (OTC)

Diclofenac sodium 1% (RX & OTC)

Ibuprofen cap

Ibuprofen tab (OTC & Rx)

Infant's ibuprofen drops

Meloxicam tab

Naproxen tab

Naproxen sodium (OTC)

Naproxen EC (Rx)

Sulindac

## PANCREATIC ENZYMES

Creon DR 3,000, 6,000, 1200, 24000, 36000 u cap

Zenpep DR 3,000, 5,000, 10,000, 15,000, 20,000, 25,000, 40,000 u cap

## RESPIRATORY AGENTS

Antihistamines

Cetirizine liquid 1mg/1mL (RX & OTC)

Cetirizine tab OTC

Levocetirizine tab (OTC)

Loratadine syr (OTC)

Loratadine tab (OTC)

Inhalers

Advair HFA 45-21, 115-21, 230-21 mcg

Anoro Ellipta 62.5-25 mcg

Asmanex twisthaler 110 mcg, 220 mcg

Atrovent HFA

Bevespi Aerosphere

Combivent Respimat

Dulera 50, 100, 200 mcg/5 mcg

Flovent Diskus 50, 100, 250 mcg

Flovent HFA 44, 90, 110, 180, 220 mcg

Proair HFA 90 mcg

Serevent Diskus 50 Mcg

Spiriva Handihaler 18 mcg

Spiriva Respimat

Stiolto Respimat inhaler Spray

Symbicort 80-4.5, 160-4.5 mcg

Ventolin HFA 90 mcg

Leukotriene Receptor Antagonists

Montelukast tab

Montelukast chewable tab

Nebulizer Solutions

Ipratropium bromide 0.02%

Ipratropium/albuterol 0.5-3(2.5) mg/3 ml