Pre-Admission Screening

Last Updated: 09/22/2022

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General Information

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

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

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

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

Program Background

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

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 Originally enacted by the Social Security amendments of 1965 (Public Law 89-97), Title XIX was approved on July 30, 1965.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

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

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

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

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

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

General Scope of the Program

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

Covered Services

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

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

- Blood glucose monitors and test strips for pregnant women

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

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

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

    - Health education

- Home health services

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

- Hearing services

- Inpatient psychiatric services for members under age 21

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

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

- Skilled nursing facilities for persons under 21 years of age

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

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

criteria for non-State Plan services under EPSDT.

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

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

- Emergency hospital services

- Emergency services for aliens

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

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

- Eye refractions

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

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

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

- Laboratory and radiograph services

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

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

- Mental Health:

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

- Substance Use Disorder:

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

- Outpatient Treatment

- Community Living Waiver:

- Nurse-midwife services
- Nursing facility services

- Occupational therapy

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

- Optometry services

- Outpatient hospital services

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

- Papanicolaou smear (Pap) test

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

- Podiatry services

- Prostate specific antigen (PSA) test (1998)

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

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

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

- Reconstructive surgery - post-mastectomy (1998)

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

- Renal dialysis clinic services

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

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

Adult (Medicaid Expansion) covered group.

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

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

- Transportation services related to medical care

- Treatment Foster Care Case Management

General Exclusions

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

Examples of such non-covered services are as follows:

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

- Acupuncture

- Artificial insemination or in vitro fertilization

- Autopsy examinations

- Cosmetic surgery

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

services which are unrelated to patient care

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

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

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

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

- Unkept or broken appointments

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

- Weight loss programs

MEMBER COPAYS

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

Managed Care Programs

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

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

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

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

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

Managed Care Enrollment Broker (Maximus)

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

- **Medallion 4.0**

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

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

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

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

- **CCC Plus**

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

MCO Provider Reimbursement

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

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

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

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

Eligibility and MCO Enrollment Verification

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

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

Continuity of Care

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

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

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

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

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

Family Access to Medical Insurance Security (FAMIS) Plan

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

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

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

FAMIS Covered Services

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

The following services are covered for FAMIS enrollees:

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

  - Assistive technology

  - Blood lead testing

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

  - Intensive in-home services

  - Therapeutic day treatment

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

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

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

Member Copays

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

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

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

*Other co-payments may apply to other services.

EMERGENCY MEDICAID SERVICES FOR ALIENS

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

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

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

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

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

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

Client Medical Management (CMM)

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

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

Providers may refer Medicaid patients suspected of inappropriately using or abusing

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

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

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

Written referrals should be mailed to:

Lead Analyst, Recipient Monitoring Unit

Division of Program Integrity

Department of Medical Assistance Services

600 East Broad Street, Suite 1300

Richmond, Virginia 23219

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

Sources of Information

MediCall Automated Voice Response System

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

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

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

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

Automated Response System (ARS)

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

HELPLINE

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

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

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

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

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

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

ELECTRONIC FILING REQUIREMENTS

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

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

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

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

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

Provider Manual Updates

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

Notice of Provider Responsibility

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

THE VIRGINIA MEDICAL ASSISTANCE MEDICALL SYSTEM

GENERAL INFORMATION

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

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

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

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

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

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

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

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

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

The telephone numbers are:

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

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

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

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

HOW TO USE THE SYSTEM

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

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

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

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

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

- Press “1” for member eligibility verification.

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

MEMBER ELIGIBILITY VERIFICATION

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

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

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

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

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

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

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

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

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

PROVIDER CHECK LOG

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

CLAIMS STATUS

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

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

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

SERVICE AUTHORIZATION INFORMATION

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

SERVICE LIMITS INFORMATION

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

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

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

PRESCRIBING PROVIDER ID

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

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

The Automated Response System (ARS)

GENERAL INFORMATION

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

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

CITY/COUNTY CODES

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

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

COUNTIES

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

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

CITIES

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

976 Central Processing Unit for FAMIS

STATE MENTAL HEALTH FACILITIES

983 Southern Virginia Mental Health Institute

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

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

996. Hiram Davis Hospital
997. Catawba State Hospital

CLIENT MEDICAL MANAGEMENT INTRODUCTION

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

MEMBER RESTRICTION

Utilization Review and Case Management

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

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

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

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

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

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

Member Enrollment Procedures

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

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

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

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

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

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

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

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

Designated Primary Care Physicians (PCP)

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

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

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

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

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

Designated Pharmacies

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

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

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

Changing Designated CMM Providers

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

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

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

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

A PCP No Longer in Practice

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

Covered Services and Limitations

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

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

Physician Services

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

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

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

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

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

Services Excluded from PCP Referral

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

Covered services that do not need a referral include:

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

- Immunizations (member under age 21);

- Family planning services;

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

- Dental services (members under age 21);

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

- School-based services.

CMM Provider Affiliation Groups

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

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

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

Emergency Room Services

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

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

CMM also requires a PCP referral form for:

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

Emergency Pharmacy Services

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

Provider Reimbursement and Billing Instructions

Management Fees

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

PCP and Designated Pharmacy Providers

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

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

Affiliated Providers

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

Referral Providers

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

Physicians Billing Emergency Room Services

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

Facilities Billing Emergency Room Services with a Referral

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

Non-designated Pharmacy Providers

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

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

REFERRALS TO THE CLIENT MEDICAL MANAGEMENT PROGRAM

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

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

Lead Analyst, Recipient Monitoring Unit

Division of Program Integrity

Department of Medical Assistance Services

600 East Broad Street, Suite 1300

Richmond, Virginia 23219

Telephone: (804) 786-6548

CMM Helpline: 1-888-323-0589

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

PROVIDER RESTRICTION

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

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

Provider Participation Requirements (PAS)

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 (PAS)

A participating provider must have a current, signed participation agreement with the Department of Medical Assistance Services (DMAS). Individuals must have a current and valid license from either the Virginia Department of Social Services (VDSS) or the Virginia Department of Health (VDH), as appropriate.

Provider Enrollment (PAS)

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

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

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

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

Requests for Enrollment

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

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

Please note: If you are planning to enroll via the paper enrollment process, DMAS will only accept the provider enrollment applications that have the provider screening questions listed. Previous versions of the provider enrollment applications that do not have the provider screening regulation questions will not be accepted and will be rejected

with a request to submit the version that is currently posted on the Virginia Medicaid Web Portal at www.virginiamedicaid.dmas.virginia.gov.

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

Provider Screening Requirements

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

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

Limited Risk Screening Requirements

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

Moderate Risk Screening Requirements

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

High Risk Screening Requirements

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

Application Fees

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

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

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

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

Out-of-State Provider Enrollment Requests

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

Revalidation Requirements

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

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

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

Ordering, Referring, and Prescribing (ORP) Providers

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

The ACA requires ordering, referring, and prescribing providers to enroll only to meet new ACA program integrity requirements designed to ensure all orders, prescriptions or referrals for items or services for Medicaid beneficiaries originate from appropriately licensed practitioners who have not been excluded from Medicare or Medicaid. The only exception to this requirement is if a physician is

ordering or referring services for a Medicaid beneficiary in a risk-based managed care plan, the provider enrollment requirements are not applicable to that ordering or referring physician.

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

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

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

Participation Requirements (PAS)

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

- Immediately notify the Department of Medical Assistance Services, in writing, of any change in the information which the provider previously submitted to the Department;
- Assure freedom of choice to recipients in seeking medical care from any institution, pharmacy, or practitioner qualified to perform the service(s) required and participating in the Medicaid Program at the time the service was performed;
- Assure the recipient's freedom to reject medical care and treatment;
- Comply with Title VI of the Civil Rights Act of 1964, as amended (42 U.S.C.

  §§ 2000d through 2000d-4a), which requires that no person be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance on the ground of race, color, or national origin.

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

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

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

- Not require, as a precondition for admission or continued stay, any period of private pay or a deposit from the patient or any other party;

- Accept Medicaid payment from the first day of eligibility if the provider was aware that an application for Medicaid eligibility was pending at the time of admission;
- Accept assignment of Medicare benefits for eligible Medicaid recipients;
- Use program-designated billing forms for submission of charges;
- Maintain and retain business and professional records sufficient to document fully and accurately the nature, scope, and details of the health care provided. Such records must be retained for a period of not less than five years from the date of service or as provided by applicable state laws, whichever period is longer. 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 in this chapter regarding documentation.);

- Accept as payment in full the amount established by DMAS. 42 CFR § 447.15 provides that a "State Plan must provide that the Medicaid agency must limit participation in the Medicaid Program to providers who accept, as payment in full, the amount paid by the agency." A provider may not bill a recipient for a covered service regardless of whether the provider received payment from the State. A provider may not seek to collect from a Medicaid recipient, or any financially responsible relative or representative of that recipient, any amount that exceeds the established Medicaid allowance for the service rendered. The provider may not bill DMAS or recipients for broken or missed appointments.

Example: If a third party payer reimburses $5 out of an $8 charge, and Medicaid's allowance is $5, then payment in full of the Medicaid allowance has been made. The provider may not attempt to collect the $3 difference from Medicaid, the recipient, a spouse, or a responsible relative;

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

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

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

PROVIDER RESPONSIBILITIES TO IDENFIFY EXCLUDED INDIVIDUAL AND ENTITIES

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

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

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

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

2. Search the HHS-OIG List of Excluded Individuals and Entities (LEIE) website monthly by name for employees, contractors and/or entities to validate their eligibility for Federal programs. See below for information on how to search the LEIE database.
3. Immediately report to DMAS any exclusion information discovered. Such information should be sent in writing and should include the individual or business name, provider identification number (if applicable), and what, if any, action has been taken to date. The information should be sent to:

DMAS

Attn: Program Integrity/Exclusions

600 E. Broad St, Ste 1300

Richmond, VA 23219

-or-

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

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.

Participation Conditions (PAS)

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

participation outlined in their individual provider agreements. The following paragraphs outline special participation conditions for pre-admission screening providers.

Pre-admission screening shall be performed by local committees, and acute care and rehabilitation committees.

Local Committees

Local committees, to be organized by the local health director, are composed, at a minimum, of a physician, registered nurse, and social worker. The registered nurse and physician are required to be licensed or eligible to be licensed by the Commonwealth of Virginia to practice in the Commonwealth and must be employees of the local Health Department.

The social worker must be from the local department of social services. The committee, at the discretion of the local health director, may include representatives of other agencies providing community services to aged and disabled individuals. Experience in geriatrics or adult services is desired for all committee members. Screening committees may have additional members with other pertinent knowledge and expertise who do not meet these requirements.

In all instances, the assessment process, including the home visit, must be completed jointly by both the registered nurse and social worker. The physician must fully sign and date the authorization to receive services form (DMAS-96). No individual may sign or date for the physician. DMAS does not accept the use of electronic signatures or rubber stamps for any of the signatures that appear on the DMAS-96 form.

Acute Care Committees and Rehabilitation Committees

Acute Care committees and rehabilitation committees are composed of a social worker or discharge planner and physician in general acute-care hospitals, licensed private psychiatric hospitals, and free-standing rehabilitation hospitals. The social worker or discharge planner, if not a nurse, must collaborate with a registered nurse licensed or eligible to be licensed by the Commonwealth of Virginia to practice in the Commonwealth and knowledgeable about the individual's medical needs prior to completion of the screening process. Hospitals must seek prior approval from the DMAS if an exemption from social work involvement in the screening process is desired.

Requirements of the Section 504 of the Rehabilitation Act

Section 504 of the Rehabilitation Act of 1973, as amended (29 U. S. C. §794), provides that no

disabled individual shall, solely by reason of the disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal assistance. As a condition of participation, all Medicaid providers are responsible for making provision for disabled individuals in their program activities.

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

Records Retention (PAS)

All pre-admission screening forms must be retained for a period of not less than five years from the date of the screening. This requirement is for all screening teams such as local health department, department of social services, and acute care hospitals.

Documentation of Records (PAS)

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

- The record must identify the patient on each page; and
- The responsible licensed participating provider must sign and date the entries. (The responsible licensed participating provider must countersign care rendered by personnel under the supervision of the provider, which is in accordance with Medicaid policy.)

Termination of Provider Participation

The provider participation agreement is time-limited with periodic renewals required. DMAS will request a renewal of the Participation Agreement prior to its expiration.

A participating provider may terminate participation in Medicaid at any time; however, written notification must be provided to DMAS 30 days prior to the effective date. The address is:

DMAS Provider Enrollment Services

PO Box 26803

Richmond, Virginia 23261-6803

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

1.325(D." DMAS

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

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

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

Termination of a Provider Contract Upon Conviction of a Felony

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

Appeals of Adverse Actions

Definitions:

Administrative Dismissal – means:

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

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

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

Adverse Benefit Determination – Pursuant to 42 C.F. R. § 438.400, means, in the case of an MCO, any of the following: (i) The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit; (ii) The reduction, suspension, or termination of a previously authorized service; (iii) The denial, in whole or in part, of payment for a

service; (iv) The failure to provide services in a timely manner, as defined by the State; (v) The failure of an MCO to act within the timeframes provided in §438.408(b)(1) and (2) regarding the standard resolution of grievances an appeals; (vi) For a resident of a rural area with only one MCO, the denial of a member's request to exercise his or her right, under §438.52(b)(2)(ii), to obtain services outside the network; (vii) The denial of a member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other member financial liabilities. The denial, in whole or in part, of payment for a service solely because the claim does not meet the definition of a "clean claim" at § 447.45(b) is not an adverse benefit determination.

Appeal – means:

1) A member appeal is:

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

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

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

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

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

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

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

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

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

MEMBER APPEALS

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

PROVIDER APPEALS

Non-State Operated Provider

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

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

Program Operations Division

Department of Medical Assistance Services

600 East Broad Street,

Richmond, Virginia 23219

DMAS will review the documentation submitted and issue a written response to the provider's request for reconsideration. If the adverse decision is upheld, in whole or part, as a result of the

reconsideration process, the provider may then appeal that decision to the DMAS Appeals Division, as set forth below.

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

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

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

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

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

- Through the Appeals Information Management System ("AIMS") at https://www.dmas.virginia.gov/appeals/. From there you can fill out an informal appeal request, submit documentation, and follow the process of your appeal.
- Through mail, email, or fax. You can download a Medicaid Provider Appeal Request form at https://www.dmas.virginia.gov/appeals/. You can use that form or a letter to file the informal appeal. The appeal request must identify the issues being appealed. The request can be submitted by:
    - Mail or delivery to: Appeals Division, Department of Medical Assistance Services, 600 E. Broad Street, Richmond, VA 23219;
    - Email to appeals@dmas.virginia.gov; or
    - Fax to (804) 452-5454.

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

Any provider appealing a DMAS informal appeal decision must file a written notice of formal appeal with the DMAS Appeals Division **within 30 calendar days** of the provider's receipt of the DMAS informal appeal decision. The notice of formal appeal must identify each adjustment, patient, service date, or other disputed matter that the provider is appealing. Failure to file a written notice of formal

appeal within 30 calendar days of receipt of the informal appeal decision will result in dismissal of the appeal. The notice of appeal must be transmitted through the same methods listed above for informal appeals.

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

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

Repayment of Identified Overpayments

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

State-Operated Provider

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

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

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

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

The second step permits a state-operated provider to request, within 30 days after receipt of the Division Director's decision, that the DMAS Agency Director or his/her designee review the Decision of

the Division Director. The DMAS Agency Director has the authority to take whatever measures he/she deems appropriate to resolve the dispute.

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

Client Appeals

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

Medicaid Program Information (PAS)

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. Providers enrolled at multiple locations or who are members of a group using one central office may receive multiple copies of manuals, updates, and other publications sent by DMAS. Individual providers may request that publications not be mailed to them by completing a written request to the Xerox - Provider Enrollment Services Unit at the address given under "Requests for Participation" earlier in this chapter.

Provider Risk Category Table

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

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

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

Member Eligibility

Updated: 2/22/2019

Determining Eligibility

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

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

Groups Covered by Medical Assistance

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

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

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

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

Medically Needy Covered Groups and Spenddown

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

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

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

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

Emergency Medicaid Services for Aliens

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

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

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

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

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

Medicaid Eligibility for Institutionalized Individuals

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

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

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

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

Family Access to Medical Insurance Security (FAMIS) Plan

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

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

FAMIS Covered Services

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

The following services are covered for FAMIS enrollees:

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

  - Assistive technology

  - Blood lead testing

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

  - Intensive in-home services

  - Therapeutic day treatment

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

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

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

Member Copays

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

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

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

*Other co-payments may apply to other services.

Member Eligibility Card

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

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

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

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

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

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

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

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

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

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

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

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

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

Verification of Member Eligibility

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

Program/Benefit Package Information

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

Limited Benefit Programs for Which Members Receive Eligibility Cards

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

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

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

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

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

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

Special Indicator Code (Copayment Code)

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

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

The following copay exemptions apply:

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

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

The FAMIS member co-pays are:

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

*Other co-payments may apply to other services.

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

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

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

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

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

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

Managed Care Programs

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

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

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

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

Member Without an Eligibility Card

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

Assistance to Patients Possibly Eligible for Benefits

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

Medicaid Applications -- Authorized Representative Policy

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

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

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

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

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

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

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

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

Non-Medicaid Patient Relationship

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

Newborn Infant Eligibility

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

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

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

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

Medicaid Eligibility for Hospice Services

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

Guidelines on Institutional Status

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

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

Inmates of a Public Institution

Inmates of public institutions fall into three groups:

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

- juveniles in detention.

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

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

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

Incarcerated Individuals

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

Incarcerated individuals include:

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

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

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

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

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

Juveniles

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

a. Prior to Court Disposition

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

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

b. After Court Disposition

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

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

c. Type of Facility

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

Who is Not an Inmate of a Public Institution

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

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

Member Appeals

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

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

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

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

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

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

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

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

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

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

HCBS Waivers, PACE and Nursing Facilities

Updated: 10/25/2021

GENERAL SCOPE OF THE SCREENING PROCESS FOR MEDICAID-FUNDED LONG-TERM SERVICES AND SUPPORTS (LTSS)

The *State Code of Virginia.* ***§ 32.1-330. Long-term services and supports screening (LTSS) required,*** states that every individual who applies for or requests community or institutional long-term services and supports as defined in the state plan for medical assistance services: may choose to receive services in a community or institutional setting; shall be afforded the opportunity to choose the setting and provider of long-term services and supports; and shall be screened prior to admission to such community or institutional long-term services and supports to determine the need for long-term services and supports, including nursing facility services as defined in the state plan for medical assistance services. The type of long-term services and supports screening performed shall not limit the long-term services and supports settings or providers for which the individual is eligible.

Entities authorized to conduct Screenings are local Departments of Social Services (LDSS), local Departments of Health (LDH), hospitals and nursing facilities. DMAS contracts with the Virginia Department of Health (VDH) and Department for Aging and Rehabilitation Services (DARS), and hospitals to conduct Screenings for individuals. Community-based Screening teams (CBTs) shall consist of members who are employees of, or contracted with, VDH and/or the local department of social services (LDSS). All hospitals, which includes acute care hospitals, rehabilitation hospitals, and rehabilitation units in acute care hospital, are to assign staff who are responsible for conducting and submitting the completed Screening. Nursing facilities shall appoint qualified staff for NF Screening teams.

The Screening for Medicaid LTSS is a process to:

- Evaluate the functional, medical or nursing, and social needs of each individual believed to be in need of *or* at risk of NF admission (42 CRF 441.302 State Assurances), and needing services within 1 month or less;

- Analyze specific services and supports that the individual needs (42 CFR 441.302);

- Evaluate whether a service or a combination of existing home and community-based services (HCBS) is available to meet the individual's needs by applying existing criteria for NF and HCBS, including the Commonwealth Coordinated Care Plus (CCC

Plus) Waiver and the Program of All-Inclusive Care for the Elderly (PACE);

- Provide the individual with the choice of home and community-based or NF services for which the individual qualifies; and

- Conduct an additional Screening for individuals who have selected NF services to identify individuals with any *suspected or known* diagnosis of mental illness (MI), intellectual disability (ID) or a related condition (RC) who should be evaluated through the "Preadmission Screening and Resident Review" (PASRR) process. A RC is a condition that is similar to a disability (e.g., Cerebral Palsy, Down Syndrome, anoxia at birth, Multiple Sclerosis, paraplegia, intractable seizures, BSpina Bifida, congenital blindness or deafness, Muscular Dystrophy etc.). Federal regulations require anyone being admitted to a Medicaid certified NF with any *suspected or known* MI, ID, or RC be evaluated through the PASRR process.

The Virginia Uniform Assessment Instrument (UAI) is the standardized multidimensional assessment instrument used in Virginia for assessing an individual's physical health, mental health, psycho/social and functional abilities, and medical or nursing needs. This instrument is used by many agencies across the Commonwealth for a variety of purposes. It is also used in the Medicaid LTSS Screening and is one of several forms in the Screening packet, which must be completed for individuals to determine eligibility for the following LTSS:

(NOTE: The Medicaid LTSS Screening encompasses more documents than the UAI.)

The following requires a LTSS Screening to determine level of care needs for program enrollees:

- NF (to include specialized care NF, long-stay hospital, and LTSS offered in a NF, often referred to as custodial care),

- CCC Plus Waiver and CCC Plus Waiver with Private Duty Nursing (PDN), or

- PACE.

DMAS Resource Website for Screening for LTSS:
https://www.dmas.virginia.gov/for-providers/long-term-care/programs-and-initiatives/screening/, including FAQs, and training requirements for LTSS Screeners.

Definitions (PAS)

"Activities of daily living" or "ADLs" means personal care tasks such as bathing, dressing, toileting, transferring, and eating or feeding. An individual's degree of independence in performing these activities is a part of determining appropriate level of care and service needs.

“Acute care hospital” or “Hospital” means an acute care hospital, a rehabilitation hospital, a rehabilitation unit in an acute care hospital, or a psychiatric unit in an acute care hospital.

"Adult" means a person age 18 years or older who may need Medicaid-funded long-term services and supports (LTSS) or who becomes eligible to receive Medicaid-funded LTSS. (Private Duty Nursing services begin at age 21 for adults in the CCC Plus Waiver.)

"Appeal" means the processes used to challenge actions regarding services, benefits, and reimbursement provided by Medicaid pursuant to 12VAC30-110-10 et seq. and 12VAC30-20-500 et seq.

"At risk" means the need for the level of care provided in a hospital or nursing facility when there is reasonable indication that the individual is expected to need the services within the next 30 days in the absence of home or community-based services.

"Child" means a person up to the age of 18 years who may need Medicaid-funded LTSS or who becomes functionally eligible to receive Medicaid-funded LTSS. (Private Duty Nursing services begin at age 21 for adults in the CCC Plus Waiver.)

"Choice" means the individual is provided the option of either the Commonwealth Coordinated Care Plus Waiver , the Program of All-inclusive Care for the Elderly (PACE), if available or appropriate, or institutional services and supports, after the individual has been determined likely to need LTSS.

“Commonwealth Coordinated Care Plus Program” or “CCC Plus Program” is a

Medicaid program that provides LTSS through a managed care approach. The program

addresses medical, behavioral, and substance use disorder conditions. Services may be provided in the community or in institutional settings. Eligible Medicaid members who have long-term service and support needs are required to participate in the CCC Plus program.

“Commonwealth Coordinated Care Plus Waiver” or “CCC Plus Waiver” [1915 (c)] provides long-term services and supports in the home and community rather than in a nursing facility (NF) or other specialized care medical facility.

"Communication" means all forms of sharing information and includes oral speech and augmented or alternative communication used to express thoughts, needs, wants, and ideas, such as the use of a communication device, interpreter, gestures, and picture/symbol communication boards.

"Community-based team" or "CBT" means (i) a registered nurse, nurse practitioner (ii) a social worker or other assessors designated by DMAS; and (iii) a physician. The CBT members are employees of, or contracted with, the Virginia Department of Health or the local department of social services. The authorization or denial for Medicaid LTSS (DMAS-96 form) must be signed and attested to by the screener(s) and a physician (or the nurse practitioner or physician’s assistant working with the physician).

“CSB” means a local Community Services Board

"DARS" means the Virginia Department for Aging and Rehabilitative Services.

"Day" means calendar day unless specified otherwise.

"DBHDS" means the Virginia Department of Behavioral Health and Developmental Services.

"DMAS" means the Department of Medical Assistance Services.

"DMAS designee" means the public or private entity with a contract with the Department of Medical Assistance Services to complete Medicaid LTSS screenings pursuant to § 32.1-330 of the Code of Virginia when a community-based, hospital or nursing facility LTSS Screening team cannot complete LTSS Screenings within the required 30 days of the LTSS Screening request date.

"Electronic Medicaid LTSS Screening" or " eMLS" means the DMAS electronic record system used by LTSS screening entities to record results from LTSS screenings pursuant to § 32.1-330 of the Code of Virginia.

"Face-to-face" means an in-person meeting with the individual seeking Medicaid-funded

LTSS.

"Feasible alternative" means a range of services that can be provided in the community via waiver or PACE, for less than the cost of comparable institutional care, in order to enable an individual to continue living in the community.

“Functional capacity” means the degree of independence that an individual has in performing ADLs, mobility, joint motion, medication administration, and in relation to behavior and orientation as measured on the UAI and as used as a basis for differentiating levels of LTSS.

“Functional eligibility” means. the individual met criteria used for determining whether an individual needs nursing facility level of care. Functional eligibility is separately assessed from Medicaid financial eligibility.

“Home and community-based services (HCBS)” means community-based waiver services i.e. the Commonwealth Coordinated Care Plus (CCC Plus) waiver or the Program of All-Inclusive Care for the Elderly (PACE).

"Home and community-based services provider" means a provider or agency enrolled with Virginia Medicaid to offer services to individuals eligible for the CCC Plus Waiver or PACE.

"Home and community-based services waiver," “HCBS”, or "waiver services" means the range of community services and supports, approved by the Centers for Medicare and Medicaid Services (CMS) pursuant to § 1915(c) of the Social Security Act to be offered to individuals as an alternative to institutionalization.

"Hospital team" means persons designated by the hospital who are responsible for conducting and submitting the Medicaid LTSS Screening documents for inpatients to eMLS. The authorization or denial for Medicaid LTSS (DMAS-96 form) must be signed and attested to by the screener(s) and a physician.

"Inpatient" means an individual who has a physician's order for admission to an acute care hospital, rehabilitation hospital, or a rehabilitation unit in an acute care hospital and shall not apply to outpatients, patients in observation beds, and patients of the hospital's emergency department.

“Level of Care” or “LOC” means the formal designation used when describing a person’s eligibility for Medicaid-funded, nursing facility care. It is also used when describing someone’s eligibility to receive long-term services and supports at-home from providers paid by Medicaid. Documentation of needed level of care must include: a summary of the screener’s direct observations, summary of the screener’s professional judgments and conclusions that provide the basis for the judgments and conclusions that substantiate the Level of Care determination and whether the individual qualifies for Medicaid LTSS.

"Local department of social services" or "LDSS" means the entity established under § 63.2-324 of the Code of Virginia by the governing city or county in the Commonwealth.

"Local health department" or "LHD" means the entity established under § 32.1-31 of the Code of Virginia.

"Long-term services and supports" or "LTSS" means a variety of services that help individuals with health or personal care needs and ADLs over a period of time that can be provided in the home, the community, or nursing facilities.

“Long-Term Services and Supports (LTSS) Screening” or “LTSS Screening” means the face-to-face process to (i) evaluate the functional, medical or nursing, and social support needs and at-risk status of individuals referred for certain long-term services requiring nursing eligibility; (ii) assist individuals in determining what specific services the individual needs; (iii) evaluate whether a service or a combination of existing community services are available to meet the individual’s needs; and (iv) provide a list to individuals of appropriate providers for Medicaid-funded nursing facilities, PACE plan services or the Commonwealth Coordinated Care Plus waiver for those individuals who meet nursing facility level of care. Individuals enrolled in the CCC Plus managed care program will have the list provided by the MCO in which they are enrolled.

“Long-Term Services and Supports (LTSS) Screening Team” means the staff assigned to the hospital screening team, community-based team (CBT), or nursing facility LTSS team, to perform and submit screenings pursuant to § 32.1-330 of the Code of Virginia.

“Managed Care Organization,” or "MCO" means those health plans participating in the CCC Plus program and that are a party to a contract with DMAS.

"Medicaid" means the program set out in the 42 USC § 1396 and administered by the Department of Medical Assistance Services consistent with Chapter 10 (§ 32.1-323 et seq.) of Title 32.1 of the Code of Virginia.

“Medical or nursing need” means (i) the individual’s condition requires observation and assessment to ensure evaluation of needs due to an individual’s inability for self-observation or evaluation; (ii) the individual has complex medical conditions that may be unstable or have the potential of instability, or (iii) the individual requires at least one ongoing medical or nursing service.

"Medicare" means the Health Insurance for the Aged and Disabled program as administered by the Centers for Medicare and Medicaid Services pursuant to 42 USC 1395ggg.

“Minimum Data Set” or “MDS” means the assessment form used by nursing facilities, as federally required, for the purpose of documenting ongoing level of care required for all of the NF’s residents.

"Nursing facility" or "NF" means any nursing home as defined in § 32.1-123 of the Code of Virginia.

“Nursing facility LTSS screening team” means nursing facility staff trained and certified in the use of the LTSS screening tools who are responsible for performing and submitting LTSS screenings for individuals who apply for or request LTSS while receiving skilled nursing services in a setting not covered by Medicaid and after discharge from a hospital. Nursing facility LTSS screening staff must include at least one registered nurse and a certifying physician. The authorization or denial for Medicaid LTSS (DMAS-96 form) must be signed and attested to by the screener(s) and a physician.

"Ongoing" means continuous medical or nursing needs that shall not be temporary.

"Other assessor designated by DMAS" means an employee of the local department of social services holding the occupational title of family services specialist or an employee of a DMAS designee.

"Private pay individual" means individuals who are not eligible for Medicaid or not expected to become financially eligible for Medicaid and have alternate payment sources that will pay 100 percent for care or services (this can include private insurance, Tricare, Medicare, etc.).

"Program of All-Inclusive Care for the Elderly" or "PACE" means the community-based service pursuant to CFR 42 §460.2 through 210 and § 32.1-330.3 of the Code of Virginia. PACE is an array of services available to individuals 55 or older, eligible for Medicaid, Medicare or are private-pay status individuals living in a PACE service area. The program provides all-inclusive care, including medical and supportive care that enable the individual to live independently while meeting nursing home criteria. All-inclusive services include coverage for prescription drugs, physician and dental care, transportation, home care, checkups, hospital visits, and NF stays when necessary.

"Referral for LTSS screening" means information obtained from an interested person or other third party having knowledge of an individual who may need Medicaid-funded LTSS and may include, for example, a physician, PACE provider, service provider, family member, or neighbor who is able to provide sufficient information to enable contact with the individual.

"Representative" means a person who is legally authorized to make decisions on behalf of the individual.

"Request date for LTSS screening" or "request date" means the date (i) that an individual,

the individual's representative, an Adult Protective Services (APS) worker, Child Protective Services (CPS) worker, physician, or the managed care organization (MCO) (health plan) contacts the LTSS screening entity in the jurisdiction where the individual resides asking for assistance with LTSS or, (ii) for hospital inpatients, that a physician orders case management consultation or a hospital's case management service determines the need for LTSS upon discharge from the hospital.

"Request for LTSS screening" means (i) communication from an individual, an emancipated child, individual's representative, Adult Protective Services (APS) worker, Child Protective Services (CPS) worker, physician, managed care organization (MCO) or CSB support coordinator, expressing the need for LTSS, or (ii) for hospital inpatients, a physician order for determination of the need for LTSS upon discharge from a hospital.

"Residence" means the location in which an individual is living, e.g., an individual's private home, apartment, assisted living facility, nursing facility, jail/correctional facility.

"Screening entity" or "Screening organization means the employer of the hospital LTSS screening team, community-based LTSS Screening team (CBT), or nursing facility LTSS Screening team responsible for performing screenings pursuant to § 32.1-330 of the Code of Virginia.

"Services facilitator" means a DMAS-enrolled provider, a DMAS-designated entity, or a person who is employed or contracted by a DMAS-enrolled services facilitator that is responsible for supporting the individual and the individual's family/caregiver or employer of record (EOR), as appropriate, by ensuring the development and monitoring of the consumer-directed (CD) services plans of care, providing employee management training, and completing ongoing review activities as required by DMAS for consumer-directed (CD) personal care and respite services. "Services facilitator" shall be deemed to mean the same thing as "consumer-directed services facilitator".

"Significant change in condition" means a change in an individual's condition that is expected to last longer than 30 days and shall not include (i) short-term changes that resolve with or without intervention; (ii) a short-term illness or episodic event; or (iii) a well-established, predictive, cyclic pattern of clinical signs and symptoms associated with a previously diagnosed condition where an appropriate course of treatment is in progress.

"Skilled Care" means care provided by a registered nurse over a limited period of time resulting in the potential that the individual is able to function independently. Skilled care includes rehabilitation services, observation during periods of acute or unstable illness; administration of intravenous fluids, enteral feedings, and intravenous or intramuscular medications; short-term bowel and bladder retraining; and changing of sterile dressings.

"Submission" means the transmission of the screening findings via the electronic portal for LTSS screenings (commonly called eMLS).

"Uniform Assessment Instrument" or "UAI" means the standardized multidimensional assessment instrument that is completed by the LTSS screening team that assesses an individual's physical health, mental health, psycho/social and functional abilities, and medical or nursing needs used to determine if the individual meets the nursing facility level of care.

"VDH" means the Virginia Department of Health.

Populations to be Screened for Medicaid-Funded LTSS (PAS)

A face-to-face Screening and observation must be performed for individuals who are Medicaid members or are applying for Medicaid, and may need LTSS. In addition, any individual who requests to receive a LTSS Screening and is not already receiving Medicaid LTSS, must be screened. LTSS Screenings may occur in the community, for inpatients in a hospital, or for individuals admitted to a NF for skilled care directly from a hospital, when Medicaid is not a payment or potential payment source at admission, but who may have a change in Medicaid financial status AND need LTSS. The LTSS Screening is used to determine if the individual meets the LOC necessary for the CCC Plus Waiver, PACE or NF placement.

All requests for LTSS Screening shall be honored regardless of the financial or functional capacity of the individual to be screened. Being a Medicaid member or application for Medicaid is not a requirement to receive a LTSS Screening. No individual shall be denied a Screening if it is requested, even if a previous Screening indicated that they did not meet the LOC criteria.

POPULATION EXCLUSIONS AND SPECIAL CIRCUMSTANCES FOR MEDICAID-FUNDED LTSS SCREENING

Private Pay Individuals

- LTSS Screeners are not required to screen private pay individuals being admitted to NFs who are not expected to apply for Medicaid and need LTSS. .

- Hospitals are required to conduct a screening for all individuals who are Medicaid members, pending Medicaid members or persons likely to become financially eligible for Medicaid after admission to a NF. Hospitals shall **not be required** to initiate a Screening for inpatients who are determined by the hospital team to be private pay individuals and are not anticipated to be financially eligible for Medicaid. However, **anytime an inpatient or authorized representative requests a Screening, a Screening must be conducted**.

- CBTs are **not required** to perform a Screening for individuals who are private pay or are not anticipated to be financially eligible for Medicaid. However, **anytime** an individual living in the community who is not already receiving Medicaid LTSS requests a Screening, a Screening must be conducted.

- If a private pay individual (or person with 100% alternate forms of payment excluding Medicaid) is admitted for SNF services but later becomes Medicaid eligible AND needs LTSS, the NF will complete the Medicaid LTSS Screening per state guidelines. The NF LTSS Screeners (including a registered nurse) and a NF physician must attest to their signature on the Medicaid LTSS authorization form regarding authorization or non-authorization for LTSS.

- If a private pay individual (or person with 100% alternate forms of payment excluding Medicaid) chooses a NF for services and is admitted directly to an NF for LTSS but later becomes Medicaid eligible, the NF will complete the Minimum Data Set (MDS) assessment per federal guidelines and a NF physician will certify whether the individual meets the NF LOC criteria.

- All individuals, private pay or not, entering the PACE program must be Screened.

Hospice

- Individuals enrolled in hospice care or who are being admitted to a NF for hospice care are exempt from the Screening for Medicaid LTSS. For example: if an individual enrolled in hospice enters a NF and remains under the hospice benefit, a Screening for Medicaid LTSS is not required for the individual to be enrolled for NF services. If an individual converts from hospice status to NF LTSS (custodial care) status, the MDS is completed by the NF and a NF physician must certify that the individual meets NF LOC criteria.

- Individuals enrolled in hospice care who also seek CCC Plus Waiver services (personal care, private duty nursing, etc.) will need to meet eligibility requirements

for those services, i.e. CCC Plus Waiver requires the completion of a Medicaid LTSS Screening. This LTSS Screening is conducted by the CBT.

Out-of-State Residents

- For individuals who reside out-of-state and wish direct admission to a NF in Virginia, a LTSS Screening is not required. The admitting NF is responsible for ensuring that the individual meets the established criteria for NF placement and meets federal requirements for MI, ID or RC screening and if needed, evaluation and determination of specialty services (PASRR: See Level I and Level II section of this Chapter.) Note: Virginia cannot impose the state's LTSSLTSS Screening requirements on other states.

- If a person from out of state is admitted for SNF services but later becomes Virginia Medicaid eligible AND needs LTSS (or is already a Virginia Medicaid member admitted for SNF but later needs LTSS), the NF will complete the Medicaid LTSS Screening per state guidelines. The NF LTSS Screeners and a NF physician must attest to their signature on the Medicaid LTSS authorization form regarding authorization or non-authorization for LTSS.

- For individuals who reside out-of-state and wish to enroll into the CCC Plus Waiver or PACE, the CBT in the Virginia locality in which the individual will reside must complete a LTSSLTSS Screening once the individual relocates to Virginia.

- Out-of-state hospitals and NFs shall not be required to perform a LTSS Screening for residents of the Commonwealth who are inpatients. For Virginia residents who receive Virginia Medicaid and who may receive out-of-state acute care hospitalization, from a "border" state hospital close to their homes (i.e., NC, TN, WV, DC, or MD), and who returns to Virginia for care either to their home or to a NF, the following procedure applies:
    - Medicaid LTSS Screening shall not be required for individuals who transfer directly into a NF in the Commonwealth from an out-of-state hospital or NF.
    - If the individual chooses to apply for CCC Plus Waiver or PACE or requests a LTSS Screening (either the individual, the individual's representative or others

as defined and allowed), then the individual shall be screened upon discharge from the out-of-state hospital or NF by the CBT serving the locality in which the individual resides or relocates (once the individual relocates to Virginia).

Veterans Administration Medical Center or Other Military Hospital Facility

- LTSS Screenings shall not be required for individuals who transfer directly to a NF in the Commonwealth from a veterans' or military hospital or Veterans' Administration Medical Center.
- If a person from a veterans' or military hospital or medical center is admitted for SNF services but later becomes Virginia Medicaid eligible AND needs LTSS (or is already a Virginia Medicaid member admitted for SNF but later needs LTSS), the NF will administer the Medicaid LTSS Screening per state guidelines. The NF LTSS Screeners and a NF physician must attest to their signature on the Medicaid LTSS authorization form regarding authorization or non-authorization for LTSS.
- Individuals seeking CCC Plus Waiver or PACE may, upon discharge from a Veterans' Administration Medical Center or military hospital, receive a referral to the CBT serving the locality in which the individual resides, and be Screened by the CBT once the individual has relocated.

DBHDS Facilities

- Individuals residing in state owned/operated facilities by the Department of Behavioral Health and Developmental Services (DBHDS) who seek direct admission to a Virginia NF shall not be required to have a LTSS Screening.
- If a person transitioned from a DBHDS facility is admitted for SNF services but later becomes Virginia Medicaid eligible AND needs LTSS (or is already a Virginia Medicaid member admitted for SNF but later needs LTSS), the NF will administer the Medicaid LTSS Screening per state guidelines. The NF LTSS Screeners and a NF physician must attest to their signature on the Medicaid LTSS authorization form regarding authorization or non-authorization for LTSS.

- Individuals residing in state owned/operated facilities by DBHDS that need or request a LTSS Screening for a CCC Plus Waiver or PACE shall be referred, upon discharge from the DBHDS facility, to the CBT serving the locality in which the individual resides and be screened by the CBT once the individual has relocated.

Requirements for Performing a Screening for Medicaid-Funded LTSS (PAS)

DMAS, in partnership with VDH, Virginia Department of Social Services (VDSS), DARS, hospitals, and NFs within the Commonwealth, are providing the following guidance to assist LTSS Screeners in understanding their roles and responsibilities in the LTSS Screening process.

- **Who May Request or Refer an Individual for a Screening**:
    - **Request for an adult LTSS Screening in the community**: means communication from an individual, the individual's representative, an Adult Protective Services (APS) worker, the individual's physician, a health plan, or CSB support coordinator expressing the need for LTSS. For individuals residing in NF LTSS who do not have a LTSS Screening, the person(s) planning discharge for the individual may request a CBT to conduct a LTSS Screening to enable the individual to enroll in CCC Plus Waiver or PACE.
    - **Request for children's LTSS Screening in the community**: the request for a LTSS Screening of a child residing in the community shall initiate from either the parent, legal guardian, the entity having legal custody of that child, an emancipated child, a child's physician, the child's health plan , a Child Protective Services (CPS) worker or CSB support coordinator having an interest in the child.
    - **Request for a hospital inpatient LTSS Screening (adult or child)**: means a physician's order for case management consultation or determination of the need for LTSS upon discharge from the hospital. In addition, if a direct request for a LTSS Screening is made by the individual, the individual's representative, parent or legal guardian, entity having legal custody, the health plan, CSB support coordinator, APS/CPS worker, or emancipated child, a LTSS Screening shall be conducted.
    - **Request for a NF LTSS Screening (adult or child)**: means a physician's order for case management consultation or determination of the need for LTSS upon level of care change from skilled (including rehabilitation services) to HCBS or LTSS (custodial care) within the nursing facility. In addition, if a

direct request for a LTSS Screening is made by an individual receiving skilled (including rehab) care or by the individual's representative, parent or legal guardian, entity having legal custody, the health plan care coordinator, CSB support coordinator, or APS/CPS worker, a LTSS Screening shall be conducted.

- **Referral for a LTSS Screening** means information obtained from an interested person or other third-party having knowledge of an individual who may need Medicaid-funded LTSS and may include a consulting physician, PACE provider, service provider, family member, neighbor or other person who is able to provide sufficient information to enable contact with the individual. A referral results in a LTSS Screening, when the individual (or individual's authorized representative) is contacted by the LTSS Screening Team and agrees to participate in the LTSS Screening process.

- An individual shall have the right to refuse to participate in the LTSS Screening process except for situations when a court has issued an order for a LTSS Screening. Any individual refusing to participate must be informed that Medicaid support for services cannot be considered if the LTSS Screening is not completed.

- The individual shall be permitted to have another person or persons present at the time of the LTSS Screening. The LTSS Screening team shall determine the appropriate degree of participation and assistance given by the other person to the individual during the LTSS Screening and will accommodate the individual's preferences to the extent feasible.

- Observe "face-to-face" the individual's ability to perform ADLs, as appropriate, according to 12VAC30-60-303, consider the individual's (or his representative's) communication or responses to questions, and document the person's functional capacity.

- Consider services and settings that may be needed by the individual in order for the individual to safely perform ADLs.

- Observe "face-to-face," assess, identify, and report the individual's medical, nursing, and functional abilities. This information shall be used to ensure accurate and comprehensive evaluation of the individual's need for modification of treatment or

additional medical procedures or services to prevent destabilization even when an individual has demonstrated an inability to self-observe or evaluate the need to contact skilled medical professionals.

- Determine if the individual is "at-risk for institutionalization." "At-risk for institutionalization" means that without HCBS the individual would be at-risk of admission to a NF or hospital, within 30 days; however, it *does not mean* that an individual must be placed in one of these settings. Results are documented in the case summary box (found on the DMAS-P98 UAI B in eMLS) and on the DMAS-97 when <u>one</u> of the following conditions are met:

    - The individual has been cared for in the home prior to the LTSS Screening and written evidence is available demonstrating: a deterioration in the individual's health care condition, a significant change in condition, or a change in available supports preventing former care arrangements from meeting the individual's needs; or

    - There has been no significant change in the individual's condition or available support, but evidence is available that demonstrates that the individual's functional and medical or nursing needs are <u>not</u> being met.

  Examples of evidence for the items above may be, but shall not be limited to, recent hospitalizations, attending physician documentation, and/or reported findings from medical or social services programs such as APS, CPS, and CSBs.

    - Assess the community resources available to meet the needs of the individual (i.e. immediate family, other relatives, neighbors, community services, and other supports in the continuum of LTSS) and document the findings. Screeners can enter this information into eMLS, UAI-A and B.

- Assist individuals and authorized representatives in determining the most appropriate means of meeting the needs of the individual. Use a person-centered approach when obtaining information from the individual being screened. The individual's needs,

wants and desires must be considered when planning for LTSS. The LTSS Screener must:

- Honor the individual's desire to live a meaningful life.
- Communicate in a manner that is comfortable for the individual.
- Be sensitive regarding any trauma the individual discloses.
- Be quality-of-life centered.
- Listen and ensure that the individual has an active role in the LTSS screening process.
- Collaborate with the individual regarding his or her health care choices and decisions.

- ***Provide the individual with LTSS choices and document the individual's choice*** on the DMAS-97, Individual Choice, Institutional Care or Waiver Services form. Note that the option of HCBS program alternatives (CCC Plus Waiver or PACE) has been explained. The LTSS Screener must have this document signed by the individual or the individual's authorized representative and retain it in the individual's record.

- Community service options must be considered first. Consider NF placement only when services in the community are either not a feasible alternative or the individual or the individual's authorized representative declines HCBS.

- The LTSS Screening team shall notify all individuals or individual's authorized representative in writing of the LTSS Screening determination as well as provide a copy of the LTSS Screening packet

  - For each LTSS screening conducted, ***provide approval or denial letters.*** The approval or denial letter is sent to the individual or individual's authorized representative. Sample approval and denial letters are located on the Medicaid Web Portal under Provider Services/Provider Forms Search at: https://www.virginiamedicaid.dmas.virginia.gov/wps/portal

    *[Under Category, use the drop down menu and click on Pre-Admission Screening to access the sample letters.]

- Denial letters shall include the individual's right to appeal consistent with DMAS client appeals regulations.

- Referrals for LTSS: Upon completion of the LTSS Screening, if the individual meets the NF LOC criteria for one of the Medicaid LTSS listed below, aa referral is made by the LTSS Screening Team based on the individual's choice:

  - CCC Plus Waiver:

    CCC Plus program member: a copy of the completed LTSS Screening packet is provided to the health plan via the listed FAX number(s) provided later in this Chapter.

    - Should the individual need Private Duty Nursing (PDN), a copy of the LTSS Screening Packet including the DMAS-108 (adult) or DMAS-109 (child) form will also be sent to the health plan.

    Fee-for-Service (FFS) member: a copy of the LTSS Screening packet is sent to the provider selected by the individual.

    - Should the individual need Private Duty Nursing (PDN), a copy of the LTSS Screening Packet including the DMAS-108 (adult) or DMAS-109 (child) form will go to appropriate DMAS staff for final authorization, please see FFS-PDN section.

  - PACE

    A copy of the LTSS Screening packet is sent to the appropriate PACE provider.

  - NF services

    A copy of the LTSS Screening packet is provided to the chosen nursing facility. For CCC Plus members a copy of the completed LTSS Screening packet is also provided to the health plan via the listed FAX number(s) provided later in this Chapter.

Prior to the individual's admission, the NF shall review the completed LTSS Screening packet to ensure that appropriate NF admission criteria have been met and documented (12VAC30-60-308) unless the individual meets any of the special circumstances as set out in 12VAC30-60-302.

- For **every** LTSS screening, a copy of the DMAS-96, Medicaid LTSS Authorization Form shall be faxed to the appropriate local DSS Benefits Program (local DSS eligibility unit) where the individual resides.

- LTSS Screening Teams **shall not refuse a request** for a LTSS Screening or bill an individual for performing a LTSS Screening required for Medicaid-funded services. This includes the responsibility of administering a LTSS Screening even if the individual is in process of appealing a former screening. If the new LTSS Screening determines an individual meets the required level of care criteria for services, parties are responsible for notifying the DMAS appeals unit.

- Individuals refusing the LTSS Screening must be informed that the LTSS Screening determines eligibility for Medicaid LTSS and if the screening is not conducted eligibility cannot be determined and Medicaid cannot be used for service payments if needed.

- Individuals, families or advocates shall be instructed that only individuals admitted as an inpatient (not outpatients, patients under observational status or in the emergency department of a hospital) are required to be screened for LTSS by a hospital screener. If outpatients or patients under observational status request a LTSS Screening, the individual should be referred to the CBT in their locality of residence for a LTSS Screening typically conducted after discharge. Hospitals and CBTs may negotiate who will conduct the LTSS Screening in APS or other emergency situations where the individual cannot safely return home without services.

- Individuals, families, or advocates shall not be required to apply for Medicaid in order to receive a LTSS Screening; and, individuals are not required to have Medicaid financial coverage determined prior to the LTSS Screening being initiated or

completed.

- LTSS Screening teams do not update LTSS Screening documents if an individual needs an increase in CCC Plus Waiver personal care hours. It is the responsibility of the health plan care coordinator or FFS agency/Services Facilitator provider to update the plan of care and other documents.

- All LTSS screening information must be submitted and successfully processed via eMLS.

Hospital Teams – Additional LTSS Screening Requirements

The following information clarifies areas related to individuals admitted as an inpatient and receiving a LTSS Screening in a hospital:

1. Individuals admitted to a hospital as an inpatient shall receive a LTSS Screening from the hospital when:

   a. The individual is eligible for Medicaid or is anticipated to become eligible for Medicaid reimbursement and may need LTSS provided through the CCC Plus Waiver, PACE or is being admitted to a NF for skilled care (including rehabilitation services) or LTSS (known as custodial or unskilled care).).; **OR**

   b) There is a request or referral for a LTSS Screening and regardless if the LTSS Screening entity has reason to believe that the individual is eligible or ineligible for Medicaid or is anticipated to become eligible for Medicaid reimbursement for LTSS (NF, CCC Plus Waiver, or PACE) ; **and**

   c) The appropriate individuals consent to the LTSS Screening.

If the above conditions are not met or if the individual is being treated only in the emergency department, or is under outpatient or observational status and requests a LTSS Screening or is likely to need nursing facility or hospital care within the next 30

days, the individual should be referred to the CBT for a LTSS Screening that is scheduled for completion after discharge. If the situation is an emergency or the individual's life is endangered upon return to a community home, or the case involves APS, LTSS teams (hospital and community) should confer as to which can most expediently conduct the LTSS Screening.

2. LTSS Screenings performed in hospitals *must be completed and* ***successfully processed*** *in eMLS prior to hospital discharge of the individual to CCC Plus Waiver, PACE or NF*. DMAS will not approve Medicaid reimbursement for an individual's LTSS NF placement or waiver services without a successfully processed and authorized LTSS Screening prior to NF admission or the initiation of waiver services. This includes all required LTSS screening forms as reflected on thetheDMAS-P98 (inclusive of the UAI, DMAS-96, DMAS-97 and the DMAS-95 MI/ID/RC when an individual selects NF placement).

3. .

Hospital teams must be aware that prior to a NF receiving Medicaid reimbursement for LTSS for an individual, a Medicaid LTSS Screening must be completed which authorizes LTSS and is successfully processed in eMLS.

NFs will not be reimbursed for services until a LTSS Screening has been completed for individuals being admitted for Medicaid LTSS or who have a change in the level of care from skilled care (including rehabilitation services) to LTSS. The individual must be found to meet NF level of care criteria and the screening is successfully processed in eMLS.

4. When an individual transfers from a NF to a hospital and then back to the NF, a new LTSS Screening is not needed, unless the individual has been **terminated** from NF services.

Nursing Facility Teams – Additional LTSS Screening Requirements

The following information clarifies areas related to individuals admitted for skilled nursing facility care (including rehabilitation services) not covered by Medicaid after discharge from a hospital who may need LTSS and are screened in a NF.

1. Private pay individuals admitted to a NF for skilled care (including rehab) who experience a change in the level of care potentially resulting in the need for Medicaid LTSS SHALL be screened by the NF for LTSS PRIOR to enrollment in LTSS (also known as custodial care). The individual must be found to meet Virginia Medicaid NF level of care criteria to be enrolled and receive Medicaid paid LTSS.

2. Functional capacity, medical or nursing need and risk for institutionalization shall be determined by the NF LTSS screening team via face-to-face assessment and after completion of a LTSS screening of the individual's medical/nursing, functional needs, risk status, and available supports. The NF LTSS screening team shall consider all the supports available for that individual in the community (e.g., the immediate family, other relatives, other community resources), and other services in the continuum of LTSS. The LTSS screening shall be documented on the DMAS-designated forms identified in 12VA30-60-306 and entered into the eMLS portal.

3. The individual shall be permitted to have another person present at the time of the LTSS screening. Except when a court has issued an order for a LTSS screening, the individual shall also be afforded the right to refuse to participate. The NF LTSS screening team shall determine the appropriate degree of participation and assistance given by other persons to the individual during the LTSS screening and accommodate the individual's preferences to the extent feasible.

   Individuals refusing the LTSS Screening must be informed that the LTSS Screening determines eligibility for Medicaid LTSS and if the screening is not conducted eligibility cannot be determined and Medicaid cannot be used for service payments if needed.

4. The NF LTSS screening team shall:

   a. Observe the individual's ability to perform appropriate ADLs according to 12VAC30-60-303**, excluding** all institutionally induced dependencies, and

consider the individual's communication or responses to questions or his representative's communication or responses;

b. Observe, assess, and report the individual's medical or nursing and functional condition.
c. Consider services and settings that may be needed by the individual in order for the individual to safely perform ADLs.

5. Upon completion of the LTSS screening and in consideration of the communication from the individual or his representative, if appropriate, and observations obtained during the LTSS screening, the NF LTSS screening team shall determine whether the individual meets the criteria set out in 12VAC30-60-303. If the individual meets the criteria for Medicaid-funded LTSS, the NF LTSS screening team shall inform the individual or his representative, if appropriate, of this determination in writing and provide choice of the setting (community or NF) and provider of LTSS. Community options such as PACE or home and community-based waiver services (CCC Plus Waiver) shall be discussed prior to placement in NF LTSS.

6. If CCC Plus Waiver services or PACE, where available, are declined, the reason for declining shall be recorded on the DMAS-97, Individual Choice - Institutional Care or Waiver Services Form. The NF LTSS screening team shall have this document signed by either the individual or his representative, if appropriate. In addition to the electronic document, a paper copy of the DMAS-97 form with the individual's or his representative's signature shall be retained in the individual's record.

7. If the individual meets criteria and selects home and community-based services, the NF LTSS screening team shall also document that the individual is at risk of NF placement in the absence of home and community-based services by finding that at least one of the following conditions exists:

   a. Prior to the admission to the hospital, the individual was cared for in the home and evidence is available demonstrating a deterioration in the individual's health care condition, a significant change in condition, or a change in available supports. Examples of such evidence may include (i) recent hospitalizations, (ii) attending physician documentation, or (iii) reported findings from medical or social service agencies.
   b. There has been no significant change in condition or available support but evidence is available that demonstrates the individual's functional, medical, or nursing needs are not being met. Examples of such evidence may include (i)

recent hospitalizations, (ii) attending physician documentation, or (iii) reported findings from medical or social services agencies.

c. If the individual selects NF placement, the NF LTSS screening team shall assure that the individual is referred for Level II evaluation and determination (PASRR process) as outlined in 12VAC30-130-160 through 12VAC30-130-260 as needed and appropriate and that resident reviews of the individuals condition occur periodically.

8. All individuals SHALL have a PASRR Level I Screening and if needed, Level II Evaluation and Determination PRIOR to an NF admission to a Medicaid-certified facility. NF Screeners will need to obtain a copy of the Level I Screening, and if applicable Level II results, and transcribe that information onto the DMAS-95, DMAS-95 supplement, and Medicaid LTSS Authorization form (DMAS-96) as appropriate.

9. If the NF LTSS screening team determines that the individual does not meet the criteria set out in 12VAC30-60-303, the NF LTSS screening team shall notify the individual or the individual's representative, as may be appropriate, in writing that LTSS are being denied for the individual. The denial notice shall include the individual's right to appeal consistent with DMAS client appeals regulations (12VAC30-110).

The following chart is provided to clarify roles and responsibilities for Medicaid LTSS Screenings related to NF admissions.

The following chart summarizes LTSS Screening responsibilities.

SCREENING RESPONSIBILITIES CHART FOR NFs

Funding Source	Is a LTSS Screening Required?	When is the LTSS screening completed?	Who completes the Medicaid LTSS Screening?
Private Pay*	NO	Not Applicable (NA)	NA
Medicare Only*	NO	NA	NA

Dual Medicare & Medicaid	YES	Prior to admission to SNF or ICF (LTSS)	Hospital (if inpatient) Community-based Team (community resident)**
Medicaid (partial or full) or Medicaid pending (*having applied for Medicaid or planning on applying for Medicaid*)	YES	Prior to admission to SNF or ICF (LTSS)	Hospital (if inpatient) Community-based Team (community resident)
Private Pay or Medicare applying for Medicaid while in SNF	YES	Change of Level of Care from SNF to LTSS	Nursing Facility
REQUESTS: Any time a person requests a LTSS Screening one shall be conducted, regardless of payment source.	YES	When requested	Community-based Team, Hospital or Nursing Facility
Use of the MDS and Physician's Signature Certifying NF LOC			
Special Circumstances with Direct Admissions to SNF or LTSS NF (i.e. from veterans' facility, DBHDS facility, or out-of-state)	NO LTSS Screening	MDS and Physician signature certifies NF LOC	Handled by NF

Private Pay individual becomes financially eligible for Medicaid while in NF LTSS	NO LTSS Screening	MDS and Physician signature certifies NF LOC	Handled by NF

*

For the purposes of this chart, Private Pay refers to ANY payment source other than Medicaid or partial Medicaid payment.

** *Community-Based Teams are continuing to conduct ALL screenings as requested and referred.*

****** ALL individuals, regardless of payment source, who are being considered for admission to a Medicaid-certified NF (SNF or LTSS NF) SHALL be screened for mental illness, intellectual disability or related conditions, PRIOR to NF admission. This is referred to as the PreAdmission and Resident Review (PASRR) process.*** **Community-Based Teams – Additional LTSS Screening Requirements**

The following information clarifies issues related to individuals Screened by the CBTs.

CBTs are responsible for all requests and referrals for individuals residing within the jurisdiction of the CBT (who are not inpatients in a hospital) unless there is a special circumstance as previously outlined.

For adults, a CBT shall consist of both a public health nurse from the local health department, and a social worker or a family services specialist from the local department of social services.

For children, the local health department is considered the DMAS community designee for LTSS Screenings. A CBT shall consist of the public health nurse from the local health department, and **may** include a social worker or a family services specialist from the local department of social services. For children, it is the locality that decides the final members of the CBT.

For both adult and child community LTSS Screenings, a physician (or the nurse practitioner or physician's assistant working with the physician) working in the local health district must review the screening information, confirm the LTSS Screening determination and sign the Medicaid LTSS Authorization form.

For the LTSS Screening to be scheduled by the CBT, the individual or his representative must agree to participate and consent to allow the CBT to collect and share information necessary for the completion of the LTSS Screening. If an individual refuses to participate in the LTSS Screening, the LTSS Screening shall proceed only under order of a court in the appropriate jurisdiction. Individuals refusing the LTSS Screening must be informed that the LTSS Screening determines eligibility for Medicaid LTSS and if the screening is not conducted eligibility cannot be determined and Medicaid cannot be used for service payments if needed.

1. Determine if the individual is currently enrolled for Medicaid LTSS. If the individual is currently enrolled for Medicaid LTSS and is not receiving services, the screening

team may refer the individual back to the identified provider or care coordinator to assist with establishing services or addressing issues involving, specific services or number of hours for authorized services.

2. Individuals in the community shall be screened by the CBT when:
    - Individuals who are Medicaid members or likely to become eligible for Medicaid shall be screened for LTSS, OR
    - There is a **request** for a LTSS Screening. All requests for a LTSS Screening must be honored. LTSSLTSS Screenings shall be conducted regardless of whether the person has applied for Virginia Medicaid. This includes the responsibility of completing a LTSS Screening even if the individual is in process of appealing a former screening. If the new LTSS Screening determines an individual meets the required level of care criteria for services, parties are responsible for notifying the DMAS appeals unit.

    a.

3. Each CBT shall contact the individual or his representative within seven (7) calendar days of the **request date for a LTSS Screening** to schedule the LTSS Screening with the individual. It is the responsibility of the CBT to coordinate contacts and scheduling between the LDSS and LHD using the most efficient method agreed to between the two agencies.
    - The "request date for a LTSS Screening" means "the date that an individual, an emancipated child, the individual's representative, an Adult or Child Protective Services Worker, physician, CSB Support Coordinator, or the individual's health plan health plan contacts the LTSS Screening entity in the jurisdiction where the individual resides asking for assistance with LTSS."

4. When the LDSS or LHD receives a **referral for a LTSS Screening**, the LDSS or LHD shall obtain sufficient information from the referral source to initiate contact with the individual or his representative to discuss the LTSS Screening process.
    - Within seven (7) days of the referral date for a LTSS Screening, the LDSS or LHD shall contact the individual or his representative to determine if the individual is interested in receiving LTSS and would participate in the LTSS Screening.
    - If the LDSS or LHD is unable to contact the individual or his representative,

the attempts shall be documented using the method adopted by the CBT.

- After contact with the individual (or his representative) or if the LDSS or LHD is unable to contact the individual or his representative, the LDSS or LHD shall advise the referring person that contact or attempt to contact has been made in response to the referral for LTSS Screening.
- With either the individual's written consent or the written consent of his legal representative information about the results of the contact (not the actual LTSS Screening or the LTSS Screening determination) may be shared with the interested person who made the referral. .

5. CBTs shall complete and submit all LTSS Screenings to eMLS as soon as possible but within 30 calendar days of the request date for the Screening to assure delivery of services to individuals seeking LTSS and to document efforts to achieve timely and appropriate LTSS Screenings.

6. A LTSS Screening shall be completed in the individual's residence unless the residence presents a safety risk for the individual or the CBT, or unless the individual or the representative requests that the LTSS Screening be performed in an alternate location within the same jurisdiction (alternate location may include a hospital emergency department or someone in observation status when there is an urgent need). The CBT shall accommodate the individual's preferences to the extent feasible.

Residence means the location in which the individual is living, for example, an individual's private home, apartment, assisted living facility, children's residential facility, NF or jail/correctional facility.

CBTs are allowed to conduct LTSS Screenings for individuals who are residing in a NF when a copy of the original LTSS Screening cannot be documented or located and the individual chooses to leave the NF and receive HCBS. This action would be considered conducting a LTSS Screening for a significant change in condition.

Note: Individuals Who Are Inmates

Inmates in local jails or correctional facilities who are ready for release back into the community may require a LTSS Screening if they need HCBS (CCC Plus Waiver or PACE) NF services or NF services. The CBT in the jurisdiction where the correctional facility is located is responsible for conducting the LTSS Screening.

7. In order to be consistent with 42CFR § 441.302 which states that individuals are to be reevaluated at least annually, **enrollment** in home and community-based services (CCC Plus Waiver and PACE) must occur within one year of the date of authorization for LTSS. If an enrollment has not occurred within one year of the LTSS Screening, a new LTSS Screening shall be conducted to document the level of care and assure need for services.

8. VDH and DARS are the state agencies responsible for the oversight of the LHD and LDSS LTSS Screening activities, respectively. Both VDH and DARS have staff identified to provide technical assistance to the CBT upon notification that a LTSS Screening has not been scheduled within 21 days of the request date for a LTSS Screening or when the CBT anticipates that a LTSS Screening will not be completed within 30 days of the request date for a LTSS Screening.

For Technical Assistance for the LHD:

PAS Program Manager

Department of Health

109 Governor Street

Richmond, VA 23219

Grace.Hughes@vdh.virginia.gov

For Technical Assistance for LDSS Adult Services/ Screeners:

Auxiliary Grant Program Manager

Adult Protective Services Division

Department for Aging and Rehabilitative Services (DARS)

8004 Franklin Farms Drive

Richmond, VA 23229

Phone: 804-662-7531

Tishaun.HarrisUgworji@dars.virginia.gov

Federal Preadmission Screening and Review (PASRR) Process

The following process applies to all Medicaid-certified nursing facility admissions regardless of payer source or reason for admission.

Level I Screening and Level II Evaluation and Determination for Individuals Entering Nursing Facilities

Mental Illness (MI), Intellectual Disability (ID), and/or Related Condition (RC) Evaluations and Determinations

Federal law requires that ALLALL individuals **(regardless of payer source)** who apply as a new admission to a Medicaid-certified NF be evaluated for evidence of possible MI, ID, or RC. This evaluation and determination is conducted to ensure that individuals are placed appropriately, in the least restrictive setting possible and that individuals receive needed services, wherever they are living**.** The process involves two steps, known as Level I screening and Level II and determination. The use of a Level I screening and Level II evaluation and determination is federally known as the **Preadmission Screening and Resident Review (PASRR) process**. By federal law, an individual **shall not be admitted to a NF** unless a Level I screening has been completed, and, if it is determined that the individual may have a condition of MI/ID or RC, then the individual shall not be admitted until the Level II evaluation and determination has been completed.

The Omnibus Budget Reconciliation Act (OBRA) of 1987, Part 2, Subtitle C of Title IV, added §1919 to the Social Security Act prohibits Medicaid-certified NFs from admitting ANY new resident who may have MI, ID, or a RC unless that individual has been determined by the

State Mental Health Authority (MHA) or State Intellectual Disability Agency (IDA) to require the level of services provided by a NF and/or the individual receives Specialized Services if needed.

The PASRR Level I Screening and Level II evaluation and determination (DMAS-95 MI/ID/RC Form) are not completed for individuals choosing the CCC Plus Waiver or PACE.

Medicaid-certified NFs must have a policy on file describing how the MI/ID/RC screening (Level I) and referral for evaluation and determination (Level II), when needed, will be handled for non-Medicaid-eligible individuals, or when the information is not part of the Medicaid LTSS Screening packet. This means each NF should have a written policy for how private pay, Medicare, persons admitted under special circumstances and those transferred from CCC Plus Waiver or PACE to NF, receive Level I Screening and, as needed, Level II evaluations and determinations. NFs may use the Level I form developed by DMAS, entitled, Level I Screening for Mental Illness, Intellectual Disability and Related Conditions, found at http://www.dmas.virginia.gov/#/longtermprograms

A PASRR Level I screening must be completed for all persons applying for admission to a Medicaid-certified nursing facility for all short-term and long-term services. This includes private pay, skilled or rehabilitation admissions regardless of payer source. NFs shall have procedures in place to ensure Level I screenings are conducted which could include use of qualified NF staff for Level I screenings, and, when needed, assure Level II evaluations are sent to the designated Level II contractor. Any individual who is seeking admission to a NF and has not been screened for Medicaid LTSS must receive a Level I screening following the NFs procedures and when a Level II evaluation and determination is needed the NF will ensure that necessary documentation and information is submitted to the designated Level II contractor.

PASRR Level I Screening

When it is determined that an individual chooses or requires NF services, a DMAS-95 MI/ID/RC or MI/ID/RC Level I Screening form is completed by the Medicaid LTSS Screener

or party responsible for the PASRR process. A Level I screening, and a Level II evaluation and determination, if indicated, must be completed before a resident can be admitted into a nursing facility. When it is *unsuspected or unknown* that an individual has MI, ID, or RC *findings must be documented on the Level I Screening form or DMAS-95*. If the individual requires a Level II evaluation and determination, the responsible party forwards the completed Level I Screening form or DMAS-95to the DBHDS contractor (contact information follows) for further evaluation.

PASRR Level II Evaluation and Determination

Level II is an in-depth evaluation. Virginia's Level II process includes the participation of a representative from the DBHDS and the contractor performing the reviews.

The Level II evaluation determines if the individual may benefit from additional specialized services and does not preclude an individual from receiving NF services. The following documents SHALL be provided to the Level II contractor:

- Completed UAI or equivalent assessment of ability to complete ADLs and IADLs,

  Level I Screening form or DMAS-95 and Guardianship documentation (if applicable).

- Medical History and physical, signed by a physician and performed within 1 year of the screening date.
- Psychiatric Evaluation for individuals already diagnosed with severe mental illness (SMI), signed by a psychiatrist and performed within one (1) year of the screening date.
- Intelligence testing for ID. - If not available the Level II evaluator will perform this test if an ID or RC is suspected.

DBHDS and contractor completes the Level II evaluation and determination prior to NF admission. The Level II results must be returned to the responsible party and if it a Medicaid LTSS Screener, the Level II Screening and determination is to be entered into the eMLS.

NFs cannot admit an individual without a Level I screening and, if needed, a Level II

evaluation and determination. The results from DBHDS and the contractor are documented on the DMAS-96 Authorization Form. The Level II evaluation and determination must be made in writing within an annual average of 7 to 9 working days of referral of the individual with MI/ID or RC by whatever agent performs the Level I identification. The DBHDS contractor contact information is:

Ascend, A Maximus Company

Phone: 877-431-1388, Extension 3205

Fax: 877-431-9568

Website: www.ascendami.com

Screening for Medicaid-Funded LTSS Level of Care (LOC) Authorization Criteria (PAS)

Attachment B of this chapter provides a worksheet to assist in determining if an individual meets NF LOC criteria. Results from the Screening can be entered on the two-page worksheet (Attachment B) that assists with summarizing the information gathered and considers the NF LOC criteria.

Adult Screening Criteria for Medicaid-Funded LTSS (PAS)

The LTSS Screening criteria for assessing an adult's eligibility for Medicaid reimbursement of LTSS consists of several components as follows:

1. **Functional capacity**: evaluates an individual's ability to independently perform activities of daily living (ADLs),demonstrate mobility, joint motion, and medication administration and assess behavior and orientation status as measured on the UAI. This capacity assessment should be conducted face-to-face and to the extent possible observed by the Screener. The assessment considers how an individual functions in a community environment and excludes all institutionally induced dependencies. IADLs may also be assessed to assist in determining needs for community (non-Medicaid) resources.

2. **Medical or nursing needs:** determines if the individual meets the medical or nursing need criteria for NF level of care.

3. In order to qualify and be authorized for Medicaid reimbursement for LTSS, an individual must also be **at risk for NF placement within 30 days in the absence of the CCC Plus Waiver or PACE** (42CFR441.302(c)(1)). "At Risk" also includes the need for the level of care provided in a hospital.

Individuals may be screened for the CCC Plus Waiver or PACE while they are on the waiting list for the Building Independence (BI); Family & Individual Services (FIS); or Community Living (CL) Waivers. However, the individual must meet the criteria for the services for which they seek enrollment in order to be authorized. Please note that eligibility for CCC Plus Waiver, PACE or NF services does not indicate eligibility for one of the Developmental Disability (DD) Waivers nor is someone who is a participant in a DD waiver automatically eligible for CCC Plus Waiver, PACE or NF services.

It should be noted that the authorization for Medicaid-funded LTSS may be rescinded by the LTSS provider (including CCC Plus health plan or PACE) at any point in time that the individual is determined to no longer meet the criteria for Medicaid-funded LTSS.

Functional Capacity

Functional capacity is the degree of independence that an individual can perform ADLs, demonstrate mobility, joint motion, and medication administration, and the individual's behavior and orientation status as measured on the UAIUAI. These can be measured and are commonly used as a basis for differentiating levels of long-term services and supports. This capacity assessment should be conducted face-to-face and to the extent possible observed by the Screener.

An individual may meet the functional capacity requirements for NF care when one of the following applies:

1. Rated dependent in two or more ADLs, *and* also rated semi-dependent *or* dependent in Behavior Pattern *and* Orientation, *and* semi-dependent or dependent in Joint Motion *or* dependent in Medication Administration; *or*

2. Rated dependent in five to seven ADLs *and* also rated dependent in Mobility; *or*

3. Rated semi-dependent or dependent in two or more of the ADLs *and* also rated dependent in Mobility *and* Behavior Pattern *and* Orientation.

The following abbreviations are used on the UAI and mean:

I = independent	**d= semi-dependent**	**D= dependent**

Activities of Daily Living (ADLs)

Without help	I
Mechanical Help (MH) only	d
Human Help only (HH)	D
MH & HH	D
Performed by others	D
Is not performed	D

Continent	I
Incontinent less than weekly	d
External/In-dwelling device/Ostomy self-care	d
Incontinent weekly or more	D
Ostomy - not self-care	D

Continent	I
Incontinent less than weekly	d
External/In-dwelling device/ Ostomy-self-care	d
Incontinent weekly or more	D
External device - not self-care	D
Indwelling catheter - not self-care	D
Ostomy - not self-care	D

Without help	I
Mechanical help (MH) only	d
Human help only (HH)	D
MH & HH	D
Spoon Fed	D
Syringe or Tube Fed	D
Tube fed by IV or clysis	D

Within normal limits or instability corrected	I

Limited motion	d
Instability - uncorrected or immobile	D
Goes outside without help	I
Goes outside with Mechanical help (MH) only	d
Goes outside with Human help only (HH)	D
Goes outside with MH & HH	D
Confined - moves about	D
Confined – does not move about	D
No medications	I
Self-administered – monitored less than weekly	I
By lay persons administered/monitored	D
By licensed/ professional nurse administered/ monitored	D
Oriented	I
Disoriented – Some spheres, some of the time	d
Disoriented – Some spheres, all the time	d
Disoriented – All spheres, some of the time	D
Disoriented – All spheres, all of the time	D
Comatose	D
Appropriate	I
Wandering/Passive-Less than Weekly	I
Wandering/Passive - Weekly or More	d
Abusive/Aggressive/Disruptive - Less than Weekly	D
Abusive/Aggressive/Disruptive - Weekly or More	D
Comatose	D

Medical or Nursing Needs

An individual with medical or nursing needs is an individual whose health needs **require medical or nursing supervision** or care above the level, which could be provided through assistance with ADLs, medication administration, and general supervision and is not primarily for the care and treatment of mental diseases (12VAC30-60-303. D.). **Medical or nursing supervision or care beyond this level is required when any one of the following describes the individual's need for medical or nursing supervision:**

1. The individual's medical condition requires observation and assessment to ensure evaluation of the individual's need for modification of treatment *or* additional medical procedures to prevent destabilization, *and* the individual has demonstrated an inability to self-observe *or* evaluate the need to contact skilled medical professionals; *or*

2. Due to the complexity created by the individual's multiple, inter-related medical conditions, the potential for the individual's medical instability is high or medical instability exists; *or*

3. The individual requires *at least one ongoing* medical or nursing service. Ongoing means that the medical/nursing needs are continuing, not temporary, or where the individual is expected to undergo or develop changes with increasing severity in status. "Ongoing" refers to the need for daily direct care and/or supervision by a licensed nurse that cannot be managed on an outpatient basis.

If applicable, specify the ongoing medical/nursing need in eMLS. An individual who is receiving rehabilitation services and/or special medical procedures does not automatically have ongoing medical or nursing needs as there should be documentation to support the rehabilitation services and/or ongoing special medical procedures such as physician orders or progress notes.

Note: NF LOC for an individual is not determined by an individual's age, nor a specific diagnosis or therapy.

The following is a non-exclusive list of medical *or* nursing services that MAY indicate a need for medical *or* nursing supervision or care:

a. Application of aseptic dressings;

b. Routine catheter care;

c. Respiratory therapy;

d. Supervision for adequate nutrition and hydration for individuals who show clinical evidence of malnourishment or dehydration or have a recent history of weight loss or inadequate hydration

which, if not supervised, would be expected to result in malnourishment or dehydration (this also includes observation and supervision of special diets, e.g. diabetic, renal, cardiac, etc.);

e. Therapeutic exercise and positioning;

f. Routine care of colostomy or ileostomy or management of neurogenic bowel and bladder;

g. Use of physical (e.g., side rails, Posey vests, geri-chairs, locked units) or chemical restraints (e.g. overuse of sedatives), or both;

h. Routine skin care to prevent pressure ulcers for individuals who are immobile or whose medical condition increased the risk of skin breakdown;

i. Care of small uncomplicated pressure ulcers and local skin rashes;

j. Management of those with sensory, metabolic, or circulatory impairment with demonstrated clinical evidence of medical instability;

k. Chemotherapy;

l. Radiation;

m. Dialysis including observation of and care of the access port;

n. Suctioning;

- Tracheostomy care;

p. Infusion therapy;

q. Oxygen;

Examples of Medical or Nursing Needs:

- Drainage Tubes
- End-Stage Disease
- Naso-gastric Tube Feeding
- Total Parenteral Nutrition management and care as directed
- Severe Daily Pain Management as directed by physician
- Transplant management and care as directed
- Uncontrolled Seizures management and observation
- Use of Ventilator

A medical situation that requires complex medical care or equipment to sustain life may be a reason for an individual to need PDN services. In these circumstances the individual may not meet functional criteria but would be considered in need of NF LOC. The DMAS-108 (for adults) or a DMAS-109 (for children) is completed for these cases.

PDN exception note: If the individual is rated dependent in some functional limitations, but does not meet the functional capacity requirements, it should be determined if the individual requires the daily direct services or supervision of a licensed nurse for PDN services that cannot be managed on an outpatient basis (e.g. clinic, physician visits, home health services).

Rating Criteria for Adult Assessments

It is mandatory, when assessing an adult, to use the rating criteria below that indicates the individual's functional capacity and medical need. When reviewing for dependencies, LTSS Screening teams should rate at the individual's highest level of need, which allows the person to perform the activity safely, reliably and completely from beginning to end.

Rating Criteria for Bathing:

Bathing entails getting in and out of the tub, preparing the bath (e.g., turning on the water), actually washing oneself, and towel drying. Some individuals may report various methods of bathing that constitute their usual pattern. For example, they may bathe themselves at a sink or basin five days a week, but take a tub bath two days of the week when an aide assists them. The questions refer to the method used **most or all of the time** to bathe the entire body.

- **Does Not Need Help (I):** Individual gets in and out of the tub or shower, turns on the water, bathes entire body, or takes a full sponge bath at the sink and does not require immersion bathing, without using equipment or the assistance of any other person.

- **Mechanical Help Only (d):** Individual usually needs equipment or a device such as a shower/tub chair/stool, grab bars, pedal/knee-controlled faucet, long-handled brush, and/or a

mechanical lift to complete the bathing process.

- **Human Help Only (D):**

Supervision (Verbal Cues, Prompting): Individual needs prompting and/or verbal cues to safely complete washing the entire body. This includes individuals who need someone to teach them how to bathe.

Physical Assistance (Set-up, Hands-On Care): Someone fills the tub or brings water to the individual, washes part of the body, helps the individual get in and out of the tub or shower, and/or helps the individual towel dry. Individuals who only need human help to wash their backs or feet would not be included in this category. Such individuals would be rated as "Does Not Need Help".

- **Mechanical and Human Help (D):** Individual usually needs equipment or a device *and* requires assistance of other(s) to bathe.

- **Performed by Others (D):** Individual is completely bathed by other(s) and does not take part in the activity at all.

Rating Criteria for Dressing:

Dressing is the process of getting clothes from closets and/or drawers, putting them on, fastening, and taking them off. Clothing refers to clothes, braces and artificial limbs worn daily. Individuals who wear pajamas or gown with robe and slippers as their usual attire are considered dressed.

- **Does Not Need Help (I):** Individual usually completes the dressing process without help from others. If the only help someone gets is tying shoes, do not count as needing help.

- **Mechanical Help Only (d):** Individual usually needs equipment or a device such as a long-handled shoehorn, zipper pulls, specially designed clothing or a walker with an attached basket to complete the dressing process.

- **Human Help Only (D):**

Supervision (Verbal Cues, Prompting): Individual usually requires prompting and/or verbal cues to complete the dressing process. This category also includes individuals who are being taught to dress.

Physical Assistance (Set-up, Hands-On Care**):** Individual usually requires assistance from another person who helps in obtaining clothing, fastening hooks, putting on clothes or artificial limbs, etc.

- **Mechanical and Human Help (D):** Individual usually needs equipment or a device and requires assistance of other(s) to dress.

- **Performed by Others (D):** Individual is completely dressed by another individual and does not take part in the activity at all.

- **Is Not Performed (D):** Refers only to individuals confined to bed who are considered not dressed.

Rating Criteria for Toileting:

Toileting is the ability to get to and from the bathroom, get on/off the toilet, clean oneself, manage clothes and flush. A commode at any site may be considered the "bathroom" only if in addition to meeting the criteria for "toileting" the individual empties, cleanses, and replaces the receptacle, such as the bed pan, urinal or commode, without assistance from other(s).

- **Does Not Need Help (I):** Individual uses the bathroom, cleans self, and arranges clothes without help. This includes appropriate use and disposal of incontinent supplies or pads by the individual.

- **Mechanical Help Only (d):** Individual needs grab bars, raised toilet seat or transfer board and manages these devices without the aid of other(s). Includes individuals who use handrails, walkers, wheelchairs, or canes for support to complete the toileting process. Also includes individuals who use the bathroom without help during the day, use a bedpan, urinal, or bedside commode without help during the night, and can empty this receptacle without assistance. This category includes appropriate use and disposal of incontinent supplies or pads by the individual.

- **Human Help Only (D):**

Supervision (Verbal Cues, Prompting): Individual requires verbal cues and/or prompting to complete the toileting process.

Physical Assistance (Set-up, Hands-On Care): Individual usually requires assistance from another person who helps in getting to/from the bathroom, adjusting clothes, transferring on and off the toilet, or cleansing after elimination. The individual participates in the activity. This includes supervision and/or physical assistance with incontinent supplies or pads.

- **Mechanical and Human Help (D):** Individual usually needs equipment or a device and requires assistance of other(s) to toilet.

- **Performed by Others (D):** Individual does use the bathroom, but is totally dependent on another's assistance. Individual does not participate in the activity at all. This includes total assistance by others with incontinent supplies or pads.

- **Is Not Performed (D):** Individual does not use the bathroom.

Rating Criteria for Transferring:

Transferring means the individual's ability to move between the bed, chair, and/or wheelchair. If a person needs help with some transfers but not all, rate assistance at the highest level.

- **Does Not Need Help (I):** Individual usually completes the transferring process without human assistance or use of equipment.

- **Mechanical Help Only (d):** Individual usually needs equipment or a device, such as lifts, hospital beds, sliding boards, pulleys, trapezes, railings, walkers or the arm of a chair, to safely transfer, and individual manages these devices without the aid of another person.

- **Human Help Only (D):**

Supervision (Verbal Cues, Prompting): Individual usually needs verbal cues or guarding to safely transfer.

Physical Assistance (Set-up, Hands-On Care): Individual usually requires the assistance of another person who lifts some of the individual's body weight and provides physical support in order for the individual to safely transfer.

- **Mechanical and Human Help (D):** Individual usually needs equipment or a device and requires the assistance of other(s) to transfer.

- **Performed By Others (D):** Individual is usually lifted out of the bed and/or chair by another person and does not participate in the process. If the individual does not bear weight on any body part in the transferring process; he/she is not participating in the transfer. Individuals who are transferred with a mechanical or Hoyer lift are included in this category.

- **Is Not Performed (D):** The individual is confined to the bed.

Rating Criteria for Eating/Feeding:

Eating/Feeding is the process of getting food/fluid by any means into the body. This activity includes cutting food, transferring food from a plate or bowl into the individual's mouth, opening a carton and pouring liquids, and holding a glass to drink. This activity is the process of eating food after it is placed in front of the individual.

- **Does Not Need Help (I):** Individual is able to perform all of the activities without using equipment or the supervision or assistance of another.

- **Mechanical Help Only (d):** Individual usually needs equipment or a device, such as hand splints, adapted utensils, and/or nonskid plates, in order to complete the eating process. Individuals needing mechanically adjusted diets (pureed food) and/or food chopped are included in this category.

- **Human Help Only (D):**

Supervision (Verbal Cues, Prompting): Individual feeds self, but needs verbal cues and/or prompting to initiate and/or complete the eating process.

Physical Assistance (Set-up, Hands-On Care): Individual needs assistance to bring food to the mouth, cut meat, butter bread, open cartons and/or pour liquid due to an actual physical or mental disability (e.g., severe arthritis, Alzheimer's). This category must not be checked if the individual is able to feed himself but it is more convenient for the caregiver to complete the activity.

- **Mechanical and Human Help (D):** Individual usually needs equipment or a device and requires assistance of other(s) to eat.

- **Performed By Others (D):** Includes individuals who are spoon fed; fed by syringe or tube, or individuals who are fed intravenously (IV). *Spoon fed* means the individual does not bring any food to his mouth and is fed completely by others. *Fed by syringe or tube* means the individual usually is fed a prescribed liquid diet via a feeding syringe, NG-tube (tube from the nose to the stomach) or G-tube (opening into the stomach). *Fed by I.V.* means the individual usually is fed a prescribed sterile solution intravenously. Total parenteral nutrition (TPN) is the administration of a nutritionally adequate solution through an indwelling catheter into the superior vena cava.

Rating Criteria for Bowel:

Bowel continence is the physiological process of elimination of feces.

Continence is the ability to control bowel elimination. Incontinence may have one of several different causes, including specific disease processes and side effects of medications. Helpful questions include, Do you get to the bathroom on time?; "How often do you have accidents?", and "Do you use pads or adult diapers?"

- **Does Not Need Help (I):** This category includes: 1**)** the individual voluntarily controls the elimination of feces. **OR** 2) If the individual on a bowel program never empties his or her bowel without stimulation or a specified bowel regimen, he or she is rated as "Does not need help," and the bowel/bladder training is noted under medical/nursing needs because in this case, there is no voluntary elimination; evacuation is planned. If an individual on a bowel regimen also has occasions of bowel incontinence, then he or she would be rated as incontinent, either less than weekly or weekly or more. **OR** 3) If an individual uses incontinent supplies such as briefs, pads or diapers and can independently change and dispose of items appropriately, then the individual is rated "Does not need help."

- **Incontinent Less than Weekly [does not occur every week] (d):** The individual has involuntary elimination of feces but it does not occur every week (e.g., every other week). Includes individuals who use incontinence supplies such as briefs, pads, or diapers for involuntary elimination of feces and the individual is unable to properly dispose of the items but it does not occur every week. In these cases, the individual is rated as "incontinent less than weekly."

- **Ostomy - Self-Care (d):** The individual has an artificial anus established by an opening into

the colon (colostomy) or ileum (ileostomy) and can independently care for the ostomy, stoma, skin cleansing, dressing, application of appliance, irrigation, etc., and if needed with ostomy, can appropriately change and dispose of incontinence supplies used.

- **Incontinent Weekly or More [Occurring at least once a week or more] (D):** The individual has involuntary elimination of feces at least once a week or more. Includes individuals who use incontinence supplies such as briefs, pads, or diapers for involuntary elimination of feces occurring at least once a week or more and does not correctly dispose of incontinence supplies.

- **Ostomy - Not Self-Care (D):** The individual has an artificial anus established by an opening into the colon (colostomy) or ileum (ileostomy) and another person cares for the ostomy, stoma, skin cleansing, dressing, application of appliance, irrigations, etc., and may also need assistance with the changing and appropriate disposal of incontinence supplies.

Rating Criteria for Bladder:

Bladder continence is the physiological process of elimination of urine.

Continence is the ability to control urination (bladder). Incontinence may have one of several different causes, including specific disease processes and side effects of medications. Helpful questions include, "Do you get to the bathroom on time?"; "How often do you have accidents?, and "Do you use pads or adult diapers?"

- **Does Not Need Help (I):** This category includes:

1) The individual voluntarily empties his or her bladder. **OR**

2) Individuals on dialysis who have no urine output would be rated “Does not need help” as he or she does not perform this process. Dialysis will be noted under medical/nursing needs. **OR**

3) Similarly, individuals who perform the Crede method for himself or herself for bladder elimination would also be rated “Does not need help.” **OR**

4) If an individual uses incontinent supplies such as briefs, pads or diapers and can independently

change and dispose of them appropriately, then the individual is rated "Does not need help".

- **Incontinent Less than Weekly [does not occur every week] (d):** The individual has involuntary emptying or loss of urine but it does not occur every week. Includes individuals who use incontinence supplies such as briefs, pads, or diapers for involuntary emptying or loss of urine and the individual is unable to properly dispose of the items but it does not occur every week. In these cases, the individual is rated as "incontinent less than weekly."

- **External Device, Indwelling Catheter, or Ostomy - Self Care (d):** The individual has an urosheath or condom with a receptacle attached to collect urine (external catheter); a hollow cylinder passed through the urethra into the bladder (internal catheter); a surgical procedure that establishes an external opening into the ureter(s) (ostomy)or may include in and out catheterizations occurring multiple times a day (not indwelling). The individual completely cares for urinary devices (changes the catheter or external device, irrigates as needed, empties and replaces the receptacle) and the skin surrounding the ostomy This includes individuals who use any of these devices and may also need to use incontinence supplies such as briefs, pads, or diapers but can correctly dispose of them.

- **Incontinent Weekly or More [Occurring at least once a week or more] (D):** The individual has involuntary emptying or loss of urine at least once a week or more. Includes individuals who use incontinence supplies such as briefs, pads, or diapers for involuntary emptying or loss of urine occurring at least once a week or more and does not correctly dispose of them.

- **External Device - Not Self-Care (D):** Individual has an urosheath or condom with a receptacle attached to collect urine. Another person cares for the individual's external device. This includes individuals who use these devices and may need to use incontinence supplies such as briefs, pads, or diapers but cannot correctly dispose of them.

- **Indwelling Catheter - Not Self-Care (D):** Individual has a hollow cylinder passed through the urethra into the bladder. Another person cares for the individual's indwelling catheter or must perform in and out catheterizations multiple times a day. This category includes individuals who self-catheterize, but who need assistance to set-up, clean up, etc. This includes individuals who use these devices and may need to use incontinence supplies such as briefs, pads, or diapers but cannot correctly dispose of them.

- **Ostomy - Not Self-Care (D):** Individual has a surgical procedure that establishes an external opening into the ureter(s). Another person cares for the individual's ostomy and may assist with the use, changing, and appropriate disposal of incontinence supplies.

Rating Criteria for Mobility:

Mobility is the extent of the individual's movement **outside** his or her usual living quarters. Evaluate the individual's ability to walk steadily and his or her level of endurance.

Ambulation is the ability to get around indoors (walking) and outdoors (mobility), climb stairs and wheel. Individuals who are confined to a bed or chair must be shown as needing help for all ambulation activities. This is necessary in order to show their level of functioning/dependence in ambulation accurately. Individuals who are confined to a bed or a chair are rated Is Not Performed for all ambulation activities.

Walking is the process of moving about indoors on foot or on artificial limbs.

Wheeling is the process of moving about by a wheelchair. The wheelchair itself is not considered a mechanical device for this assessment section.

Stair Climbing is the process of climbing up and down a flight of stairs from one floor to another. If the individual does not live in a dwelling unit with stairs, ask whether he can climb stairs if necessary.

- **Does Not Need Help (I):** Individual usually goes outside of his or her residence on a routine basis. If the only time the individual goes outside is for trips to medical appointments or treatments by ambulance, car, or van, do not rate the individual here because this is not considered going outside. These individuals would be rated either in the "confined - moves about" or "confined - does not move about" categories.

- **Mechanical Help Only (d):** Individual usually needs equipment or a device to go outside. Equipment or device includes splint, special shoes, leg braces, crutches, walkers, wheelchairs, canes, handrails, chairlifts, and special ramps.

- **Human Help Only (D):**

Supervision (Verbal Cues, Prompting): Individual usually requires assistance from another person who provides supervision, cues, or coaxing to go outside.

Physical Assistance (Set-up, Hands-On Care): Individual usually receives assistance from another person who physically supports or steadies the individual to go outside.

- **Mechanical and Human Help (D):** Individual usually needs equipment or a device and requires assistance of other(s) to go outside.

- **Confined - Moves About (D):** Individual does not customarily go outside of his or her residence, but does go outside of his or her room.

- **Confined - Does Not Move About (D):** The individual usually stays in his or her room.

Rating Criteria for Joint Motion:

This is the individual's ability to move his or her fingers, arms, and legs (active range of movement or ROM) or, if applicable, the ability of someone else to move the individual's fingers, arms, and legs (passive ROM).

- **Within normal limits or instability corrected (I):** means the joints can be moved to functional motion without restriction, or a joint does not maintain functional motion and/or position when pressure or stress is applied, but has been corrected by the use of an appliance

or by surgical procedure.

- **Limited motion (d):** means partial restriction in the movement of a joint including any inflammatory process in the joint causing redness, pain, and/or swelling that limits the motion of the joint.

- **Instability uncorrected or immobile (D):** means a joint does not maintain functional motion and/or position when pressure or stress is applied and the disorder has not been surgically corrected or an appliance is not used, or there is total restriction in the movement of a joint (e.g., contractures, which are common in individuals who have had strokes).

Rating Criteria for Medication Administration:

Medication Administration refers to the person(s) who administer medications or if the individual is being referred elsewhere, the person(s) who will administer medications following referral.

- **Without Assistance or No Medications (I):** No Medications means the individual takes medication without any assistance from another person or is monitored by another individual less than weekly or does not take any medications.

- **Administered/Monitored by Lay Person(s) (D):** The individual needs assistance of a person without pharmacology training to either administer or monitor medications. This includes medication aides in assisted living facilities (certified but not licensed) and programmed medication dispensers.

- **Administered/Monitored by Professional Nursing Staff (D):** The individual needs licensed or professional health personnel to administer or monitor some or all of the medications.

Rating Criteria for Behavior Pattern and Orientation: Behavior and Orientation are considered

in combination for service authorization. To accurately rate Behavior and Orientation please use the crosswalk included as Attachment A in this manual.

Behavior Pattern is the manner of conducting oneself within one's environment.

Orientation is the awareness of an individual within his or her environment in relation to time, place, and person.

Behavior Pattern (PAS)

- **Appropriate (I):** The individual's behavior pattern is suitable or fitting to the environment. Appropriate behavior is of the type that adjusts to accommodate expectations in different environments and social circumstances. Behavior pattern does not refer to personality characteristics such as "selfish," "impatient," or "demanding," but is based on direct observations of the individual's actions.

- **Inappropriate Wandering, Passive, or Other:**

Wandering/Passive < weekly = (I);

Wandering/Passive Weekly or More = (d):

The individual's usual behavior is manifested in a way that does not present major management problems. Wandering is characterized by physically moving about aimlessly or mentally being non-focused. Passive behavior is characterized by a lack of awareness or interest in personal matters and/or in activities taking place in close proximity. Other characterizations of behavior such as impaired judgment, regressive behavior, agitation, or hallucinations that is not disruptive are included in this category.

- **Inappropriate Abusive, Aggressive, or Disruptive:**

Abusive/Aggressive/Disruptive < Weekly = (D);

Abusive/Aggressive/Disruptive Weekly or More = (D):

The individual’s behavior is manifested by acts detrimental to the life, comfort, safety, and/or property of the individual and/or others. Agitations, hallucinations, or assaultive

behavior that is detrimental are included in this category and specified in the space provided.

- **Comatose (D):** refers to the semi-conscious or comatose (unconscious) state.

Orientation (PAS)

- **Oriented (I):** The individual has no apparent problems with orientation and is aware of who he or she is, where he or she, the day of the week, the month, and people around him or her.
- **Disoriented-Some Spheres, Some of the Time (d):** The individual sometimes has problems with one or two of the three cognitive spheres of person, place, or time. Some of the Time means there are alternating periods of awareness-unawareness.
- **Disoriented-Some Spheres, All of the Time (d):** The individual is disoriented in one or two of the three cognitive spheres of person, place, and time. All of the time means this is the individual's usual state.
- **Disoriented-All Spheres, Some of the Time (D):** The individual is disoriented to person, place, and time periodically, but not always.
- **Disoriented-All Spheres, All of the Time (D):** The individual is always disoriented to person, place, and time.
- **Comatose (D):** The individual is in a semi-comatose or unconscious state or is otherwise non-communicative.

Crosswalk for combination determination: Behavior and Orientation are considered as a combination for service authorization. Please see the chart below that provides the combinations that determine whether or not an individual is independent (I), semi-dependent (d), or dependent (D) in both behavior and orientation for the purposes of Screening for Medicaid-funded LTSS. This crosswalk has been provided as a quick pull reference sheet, Attachment A, for face to face assessments.

ORIENTATION PATTERN	BEHAVIOR PATTERN	Appropriate	Wandering/ Passive Less Than Weekly	Wandering/ Passive Weekly or More	Abusive/Aggressive/ Disruptive Less Than Weekly	Abusive/ Aggressive /Disruptive Weekly or More
	Oriented	**I**	**I**	**I**	**d**	**d**
	Disoriented: **Some** spheres S**ome** of the time	**I**	**I**	**d**	**d**	**D**
	Disoriented: **Some** spheres **All** of the time	**I**	**I**	**d**	**d**	**D**
	Disoriented: **All** spheres **Some** of the time	**d**	**d**	**d**	**D**	**D**
	Disoriented: **All** spheres **All** of the time	**d**	**d**	**d**	**D**	**D**
	Comatose	**D**	**D**	**D**	**D**	**D**

Reminder: An individual must meet all criteria to meet NF LOC, i.e. the individual has limited functional capacity, medical or nursing needs, and is at imminent risk of NF placement within 30 days without services

Attachment B of this manual provides a worksheet for summarizing the results of the LTSS Screening and determining functional, medical or nursing need, and at-risk status of the individual.

CHILDREN'S SCREENING CRITERIA FOR MEDICAID-FUNDED LTSS

The Screening criteria for assessing a child's eligibility for Medicaid reimbursement of LTSS consists of several components as follows:

1. **Functional capacity**: evaluates a child's ability to independently perform activities of daily living (ADLs), demonstrate mobility, joint motion, and medication administration, and assess behavior and orientation status as measured on the UAI. The assessment considers how a child functions in a community environment and excludes all institutionally induced dependencies. IADLs may also be assessed to assist in determining needs for community (non-Medicaid) resources.

2. **Medical or nursing needs:** determines if the child meets the medical criteria for nursing facility level of care and/or admission.

3. In order to qualify and be authorized for Medicaid reimbursement for LTSS, the child **must also be at risk for NF placement, or equivalent facility for children, within 30 days in the absence of the CCC Plus Waiver.** "At Risk" also includes the need for the level of care provided in a hospital.

The CCC Plus Waiver may be an appropriate choice for children. Prior to a NF placement or admission (or equivalent for children), the LTSS Screening team must also ensure that provision of services in a HCBS setting is considered before a NF placement is sought.

Children may be screened for the CCC Plus Waiver while they are on the waiting list for the Building Independence (BI); Family & Individual Services (FIS); or Community Living (CL) Waivers. However, the child must meet the criteria for the waivers for which they seek enrollment in order to be authorized for services. Please note that eligibility for CCC Plus Waiver or NF services does not indicate eligibility for one of the Developmental Disability (DD) Waivers nor is someone who is a participant in a DD waiver automatically eligible for CCC Plus Waiver or NF services.

Children are considered a household of one for the purposes of the CCC Plus Waiver financial determinations.

It should be noted that the authorization for Medicaid-funded LTSS may be rescinded by the LTSS provider (including CCC Plus health plan or PACE) at any point in time that the child is determined to no longer meet the criteria for Medicaid-funded LTSS.

Functional Capacity

Functional capacity is the degree of independence that a child, as age appropriate, or the child and caregiver as a unit, perform ADLs, joint motion, medication administration, and the individual's behavior and orientation status as measured on the UAI.

Functional capacity can be measured and is commonly used as a basis for differentiating levels of long-term services and supports. Child and caregiver as a unit is used to describe the usual caregiving responsibilities that are provided at certain ages by a caregiver (e.g. children under two as developmentally appropriate receive diaper changes, assistance with bathing, dressing, assistance with IADLS, etc.). This capacity assessment should be conducted face-to-face and to the extent possible observed by the LTSS Screener.

A child may meet the functional capacity requirements for NF care when <u>one</u> of the following applies:

1. Rated dependent in two or more of the ADLs, *<u>and</u>* also rated semi-dependent *<u>or</u>* dependent in Behavior Pattern *<u>and</u>* Orientation, *<u>and</u>* semi-dependent or dependent in Joint Motion *<u>or</u>* dependent in Medication Administration; *<u>or</u>*

2. Rated dependent in five to seven of the ADLs *<u>and</u>* also rated dependent in Mobility; *<u>or</u>*

3. Rated semi-dependent or dependent in two or more of the ADLs *<u>and</u>* also rated dependent in Mobility *<u>and</u>* Behavior Pattern *<u>and</u>* Orientation.

The following abbreviations are used on the UAI and mean:

I = independent	**d= semi-dependent**	**D= dependent**

Activities of Daily Living (ADLs)

[redacted]

Without help	I
Mechanical Help (MH) only	d
Human Help only (HH)	D
MH & HH	D
Performed by others	D
Is not performed	D
Continent	I
Incontinent less than weekly	d
External/In-dwelling device/Ostomy self-care	d
Incontinent weekly or more	D
Ostomy - not self-care	D
Continent	I
Incontinent less than weekly	d
External/In-dwelling device/ Ostomy self-care	d
Incontinent weekly or more	D
External device - not self-care	D
Indwelling catheter - not self-care	D
Ostomy - not self-care	D
Without help	I
Mechanical help (MH) only	d
Human help only (HH)	D
MH & HH	D
Spoon Fed	D
Syringe or Tube Fed	D
Tube fed by IV or clysis	D
Within normal limits or instability corrected	I
Limited motion	d
Instability - uncorrected or immobile	D
Goes outside without help	I
Goes outside with Mechanical help (MH) only	d
Goes outside with Human help only (HH)	D
Goes outside with MH & HH	D
Confined - moves about	D
Confined – does not move about	D
No medications	I
Self-administered – monitored less than weekly	I
By lay persons administered/monitored	D
By licensed/ professional nurse administered/ monitored	D

Oriented	I
Disoriented – Some spheres, some of the time	d
Disoriented – Some spheres, all the time	d
Disoriented – All spheres, some of the time	D
Disoriented – All spheres, all of the time	D
Comatose	D
Appropriate	I
Wandering/Passive-Less than Weekly	I
Wandering/Passive - Weekly or More	d
Abusive/Aggressive/Disruptive - Less than Weekly	D
Abusive/Aggressive/Disruptive - Weekly or More	D
Comatose	D

Medical or Nursing Needs

A child with medical or nursing needs is a child whose health needs require medical or nursing supervision or care above the level that could be provided through assistance with ADLs, medication administration, and general supervision and is not primarily for the care and treatment of mental diseases (12VAC30-60-303.D). Medical or nursing supervision or care beyond this level is required when any one of the following describes the child's need for medical or nursing supervision:

1. The child's medical condition requires observation and assessment to ensure evaluation of the child's need for modification of treatment *or* additional medical procedures to prevent destabilization, *and* the child, as developmentally appropriate, has demonstrated an inability to self-observe *or* evaluate the need to contact skilled medical professionals; *or*

2. Due to the complexity created by the child's multiple, inter-related medical conditions, the potential for the child's medical instability is high or medical instability exists; *or*

3. The child requires *at least one ongoing* medical or nursing service. Ongoing

means that the medical/nursing needs are continuing, not temporary, or where the individual is expected to undergo or develop changes with increasing severity in status. "Ongoing" refers to the need for daily direct care and/or supervision by a licensed nurse that cannot be managed on an outpatient basis.

If applicable, specify the ongoing medical or nursing need in eMLS. An individual who is receiving rehabilitation services and/or special medical procedures does not automatically have ongoing medical or nursing needs as there should be documentation to support the rehabilitation services and/or special medical procedures such as physician orders or progress notes.

Note: NF LOC for an individual is not determined by an individual's age, nor specific diagnosis or therapy used.

The following is a non-exclusive list of medical *or* nursing services that MAY indicate a need for medical *or* nursing supervision or care:

a. Application of aseptic dressings;

b. Routine catheter care;

c. Respiratory therapy;

d. Supervision for adequate nutrition and hydration for children who show clinical evidence of malnourishment or dehydration or have a recent history of weight loss or inadequate hydration which, if not supervised, would be expected to result in malnourishment or dehydration (this also includes observation and supervision of special diets, e.g. diabetic, renal, cardiac, etc.);

e. Therapeutic exercise and positioning;

f. Routine care of colostomy or ileostomy or management of neurogenic bowel and bladder;

g. Use of physical (e.g., side rails, Posey vests, geri-chairs, locked units) or chemical restraints (e.g. overuse of sedatives), or both;

h. Routine skin care to prevent pressure ulcers for children who are immobile or whose medical condition increases the risk of skin breakdown;

i. Care of small uncomplicated pressure ulcers and local skin rashes;

j. Management of those with sensory, metabolic, or circulatory impairment with demonstrated clinical evidence of medical instability;

k. Chemotherapy;

l. Radiation;

m. Dialysis including observation of and care of the access port;

n. Suctioning;

- Tracheostomy care;

p. Infusion therapy;

q. Oxygen;

Examples of Medical or Nursing Needs:

- Drainage Tubes
- End-Stage Disease
- Naso-gastric Tube Feeding
- Total Parenteral Nutrition management and care as directed
- Severe Daily Pain Management as directed by physician
- Transplant management and care as directed
- Uncontrolled Seizures management and observation
- Use of Ventilator

Please note that in rare circumstances, a medical situation that requires complex medical care or equipment to sustain life may be a reason for an individual to meet NF LOC even when the individual does not meet functional capacity criteria. In these instances, a DMAS-108 (for adults) or a DMAS-109 (for children) would be completed. Additional information is found under Private Duty Nursing (PDN) services.

PDN exception note: If the child is rated dependent in some functional limitations, but does not meet the functional capacity requirements, it should be determined if the individual requires the daily direct services or supervision of a licensed nurse for PDN services that cannot be managed on an outpatient basis (e.g. clinic, physician visits, home health services).

Rating Criteria for Children's Assessments

It is mandatory, when assessing children, to use the rating criteria below that indicates the child's functional capacity and medical/nursing need. When reviewing children for dependencies, Screening teams should rate at the highest dependency level which accurately assesses the child's needs and allows the child (and their caregiver) to perform the activity safely, reliably and completely from beginning to end.

Please note that age-appropriate rating criteria involves the child and the caregiver as a unit. The concept of the child and the caregiver as a unit applies only to children.

Rating Criteria for Bathing:

Bathing entails getting in and out of the tub, preparing the bath (e.g., turning on the water), actually washing oneself, and towel drying. Some individuals may report various methods of bathing that constitute their usual pattern. For example, they may bathe themselves at a sink or basin five days a week, but take a tub bath two days of the week when an aide assists them. The questions refer to the method used **most or all of the time** to bathe the entire body.

Screening considerations for children, as age appropriate, include: safety concerns such as seizure activity; balance; head positioning; awareness of water depth, temperature, or surroundings (i.e. location of faucet); and/or other characteristics that make bathing very difficult such as complex medical needs or equipment. If the child's situation includes any of these, rate accordingly, as age appropriate.

- **Does Not Need Help (I):** The child and caregiver as a unit, or the child, as age appropriate, gets in and out of the tub or shower, turns on the water, bathes entire body, or takes a full sponge bath at the sink.
    - Children younger than 12 months are developmentally expected to be totally dependent on another person/caregiver for bathing. If there are no other complex medical needs or equipment, then the child is rated as independent.
    - Children age 1 to 4 are developmentally expected to physically participate in bathing but require caregiver supervision, physical assistance, and help getting in and out of the tub. If the child and caregiver as a unit can achieve this task; the child is participating as appropriate; and there are no other complex medical needs or equipment, then they are independent.
    - Children age 5 to 18 years are developmentally expected to physically and cognitively perform all essential components of bathing safely and without assistance. The child should be able to bathe independently (if they are not able to achieve this task, then refer to one of the other functional capacities listed below and rate accordingly).

- **Mechanical Help Only (d):** The child and caregiver as a unit, or the child, as age appropriate, needs equipment or an assistive device such as a shower/tub chair/stool, pedal/knee controlled faucet, grab bars, long-handled brush, and/or a mechanical lift to complete the bathing process. This does not include a baby tub for infants.

- **Human Help Only (D):**

Supervision (Verbal Cues, Prompting): The child, needs supervision, prompting and/or verbal cues to safely complete washing the entire body. Developmental stage should be considered as to what is appropriate.

Physical Assistance (Set-up, Hands-On Care): The child requires someone to fill the tub or bring water to the child, wash part of the body, help the child get in and out of the tub or shower, and/or help the child towel dry. Developmental stage should be considered as to what is appropriate.

Children who only need help to wash their backs or feet would not be included in this category.

- Children younger than 12 months are developmentally expected to be totally dependent on another person/caregiver for bathing. If there are no other complex medical needs or equipment, then the child is rated independent. If the child has a complex medical need, then this category may be appropriate.
- Children age 1 to 4 are developmentally expected to physically participate in bathing but require caregiver supervision, physical assistance, and help getting in and out of the tub. If the child and caregiver as a unit can achieve this task; the child is participating; and there are no other complex medical needs or equipment, then the child is rated independent. If the child has a complex medical need, then this category may be appropriate.
- Children age 5 to 18 years are developmentally expected to physically and cognitively perform all essential components of bathing safely and without assistance. The child should be able to bathe independently (if they are not able achieve this task then this category may be appropriate).

Mechanical and Human Help (D): The child usually needs equipment or a device and requires assistance of other(s) as defined above under Mechanical Help and Human Help to bathe. Developmental stage should be considered as to what is appropriate.

- Children younger than 12 months are developmentally expected to be totally dependent on another person/caregiver for bathing. If the child and caregiver as a unit can achieve this task and there are no other complex medical needs or equipment, then the child is rated independent. If the child has a complex medical need, then this category may be appropriate.
- Children age 1 to 4 are developmentally expected to physically participate in bathing but require caregiver supervision, physical assistance, and help in and out of the tub. If the child and caregiver as a unit can achieve this task; the child is participating; and

there are no other complex medical needs or equipment, then the child is rated independent. If the child has a complex medical need, then this category may be appropriate.

- Children age 5 to 18 years are developmentally expected to physically and cognitively perform all essential components of bathing safely and without assistance. The child should be able to bathe independently (if they are not able achieve this task then this category may be appropriate).

Performed by Others (D): The child is completely bathed by other(s) and does not take part in the activity at all. Developmental stage should be considered as to what is appropriate.

- Children younger than 12 months are developmentally expected to be totally dependent on another person/caregiver for bathing. If there are no other complex medical needs or equipment, then the child is rated independent. If the child has a complex medical need, then this category may be appropriate.
- Children age 1 to 4 are developmentally expected to physically participate in bathing but require caregiver supervision, physical assistance, and help in and out of the tub. If the child and caregiver as a unit can achieve this task; the child is participating; and there are no other complex medical needs or equipment, then the child is rated independent. If the child has a complex medical need, then this category may be appropriate.
- Children age 5 to 18 years are developmentally expected to physically and cognitively perform all essential components of bathing safely and without assistance. The child should be able to bathe independently (if they are not able achieve this task then this category may be appropriate).

Rating Criteria for Dressing:

Dressing is the process of getting clothes from closets and/or drawers, putting them on, fastening, and taking them off. Clothing refers to clothes, braces and artificial limbs worn daily. Individuals who wear pajamas or gown with robe and slippers as their usual attire are considered dressed.

Screening considerations for children, as age appropriate, include: safety concerns such as seizure activity; balance; awareness to surroundings; proneness to skin irritation/allergies; and/or other characteristics that make dressing very difficult and may include complex medical needs or equipment maybe considered. If the child's situation includes any of these, rate accordingly, as age appropriate.

- **Does Not Need Help (I):** The child and caregiver as a unit, or the child, as age appropriate, usually dresses without the help from others. If the only help the child received is tying shoes, do not count as needing help.
    - Children younger than 12 months of age are developmentally expected to be totally dependent on another person/caregiver for dressing. If there are no other complex medical needs or equipment, then the child is independent.
    - Children age 1 to 4 are developmentally expected to participate in dressing, which includes placing arms in sleeves or legs into pants, pulling at hats, socks or mittens, and require supervision, reminders, physical assistance, help with fasteners or shoes, and/or selecting clothes. If the child and caregiver as a unit can achieve this task; the child participates; and there are no other complex medical needs or equipment, then the child is rated independent.
    - Children age 5 to 18 years are developmentally expected to be independent and able to physically and cognitively perform all essential components of dressing, safely and appropriately to weather, and without assistance (if they are not able to achieve this task, then refer to one of the other functional capacities listed below and rate accordingly).

- **Mechanical Help Only (d):** The child, as age appropriate, usually needs equipment or adaptive devices such as a long-handled shoehorn, zipper pulls, specially designed clothing or a walker with an attached basket to complete the dressing process.

- **Human Help Only (D):**

Supervision (Verbal Cues, Prompting): The child usually requires prompting and/or verbal cues to complete the dressing process. Developmental stage should be considered as to

what is appropriate.

Physical Assistance (Set-up, Hands-On Care): The child usually requires assistance from another person who helps in obtaining clothing, fastening hooks, putting on clothes or artificial limbs, etc. Developmental stage should be considered as to what is appropriate.

If the only help the child needs is someone tying shoes, do not count as needing help.

- Children younger than 12 months are developmentally expected to be totally dependent on another person/caregiver for dressing. If there are no other complex medical needs or equipment, then the child is rated independent. If the child has a complex medical need, then this category may be appropriate.
- Children age 1 to 4 are developmentally expected to participate in dressing which includes placing arms in sleeves or legs into pants, pulling on hats, socks or mittens, and require supervision, reminders, physical assistance, help with fasteners or shoes, and/or selecting clothes. If the child and caregiver as a unit can achieve this task; the child participates; and there are no other complex medical needs or equipment, then the child is rated independent. If the child has a complex medical need, then this category may be appropriate.
- Children ages 5 to 18 years are developmentally expected to be independent and able to perform all essential components of safely dressing and dressing appropriately to the weather, and without assistance (if the child is not able to achieve this task, then this category may be appropriate).

- **Mechanical and Human Help (D):** Child usually needs equipment or a device and requires assistance of other(s) to dress as defined above under Mechanical Help and Human Help to dress.
  - Children younger than 12 months are developmentally expected to be totally dependent on another person/caregiver for dressing. If there are no other complex medical needs or equipment, then the child is rated independent. If the child has a complex medical need, then this category may be appropriate.
  - Children age 1 to 4 are developmentally expected to participate in dressing which includes placing arms in sleeves or legs into pants, pulling on hats, socks or mittens, and require supervision, reminders, physical assistance, help with

fasteners or shoes, and/or selecting clothes. If the child and caregiver as a unit can achieve this task; the child participates; and there are no other complex medical needs or equipment, then the child is rated independent. If the child has a complex medical need, then this category may be appropriate.

- Children ages 5 to 18 years are developmentally expected to be independent and able to perform all essential components of safely dressing and dressing appropriately to the weather, and without assistance (if the child is not able to achieve this task, then this category may be appropriate).

- **Performed by Others (D):** Child is completely dressed by another individual and does not take part in the activity at all.

  - Children younger than 12 months are developmentally expected to be totally dependent on another person/caregiver for dressing. If the child and caregiver as a unit can achieve this task and there are no other complex medical needs or equipment, then the child is rated independent. If the child has a complex medical need, then this category may be appropriate.
  - Children age 1 to 4 are developmentally expected to participate in dressing which includes lacing arms in sleeves or legs into pants, pulling at hats, socks or mittens, and require supervision, reminders, physical assistance, help with fasteners or shoes, and/or selecting clothes. If the child and caregiver as a unit can achieve this task; the child participates; and there are no other complex medical needs or equipment, then the child is rated independent. If the child has a complex medical need, then this category may be appropriate.
  - Children ages 5 to 18 years are developmentally expected to be independent and able to perform all essential components of dressing safely and dressing appropriately to weather, and without assistance (if they are not able to achieve this task then this category may be appropriate).

- **Is Not Performed (D):** Refers only to children confined to bed who are considered not dressed.

Rating Criteria for Toileting:

Toileting is the ability to get to and from the bathroom, get on/off the toilet, clean oneself,

manage clothes and flush. A commode at any site may be considered the "bathroom" only if in addition to meeting the criteria for "toileting" the individual empties, cleanses, and replaces the receptacle, such as the bed pan, urinal or commode, without assistance from other(s).

This category includes appropriate use and disposal of incontinent supplies or pads by the child.

Screening considerations for children, as age appropriate, include: safety concerns such as frequent infections; hygiene needs; utilizes incontinence supplies; and/or other characteristics that make toileting very difficult including complex medical needs or equipment. If the child's situation includes any of these, rate accordingly, as age appropriate.

- **Does Not Need Help (I):** The child and caregiver as a unit, or the child, as age appropriate, achieves the toileting process. The child uses the bathroom, cleans self, and arranges clothes without the help from others. The child appropriately uses and disposes of incontinent supplies or pads.

    - Children from birth to 3 years of age are developmentally expected to be dependent on another person/caregiver for assistance in toileting or diapering. Children starting at 24 months of age (2 years of age) are expected to begin toilet training. If the child and caregiver as a unit can achieve the task and there are no other complex medical needs or equipment, then the child is rated independent.
    - Children 4-5 years of age are developmentally expected to need intermittent supervision, cuing, minor physical assistance, and may have occasional night-time bedwetting and accidents during waking hours. Children starting at 24 months of age (2 years of age) are expected to be toilet training. If the child and caregiver as a unit can achieve this task and there are no other complex medical needs or equipment, then the child is rated independent.
    - Children 6 to 18 years of age are developmentally expected to be independent and able to physically and cognitively perform all essential components of toileting safely and without assistance except for children aged 6 that may need help with wiping. If the child is not able to achieve these tasks, then refer to one of the other functional capacities listed below and rate accordingly.

- **Mechanical Help Only (d):** The child and caregiver as a unit, or the child, as age appropriate, needs grab bars, step stools, transfer board, handrails, walkers, wheelchairs, and/or canes for support during the toileting process. This also includes children who use the bathroom without help during the day and uses a bedpan, urinal, or bedside commode without help during the night and can empty this receptacle without assistance. This category includes use and disposal of incontinent supplies or pads by the child. This does not include a "potty" chair used for toilet training children under 6 years of age.

- **Human Help Only (D):**

Supervision (Verbal Cues, Prompting): The child, as age appropriate, usually requires prompting and/or verbal cues to complete the toileting process. Children 6 years of age and older who need supervision would receive this category rating.

Physical Assistance (Set-up, Hands-On Care): The child, as age appropriate, usually requires assistance from another person who helps in getting to/from the bathroom, adjusting clothes, transferring on and off the toilet, cleansing after elimination or assists with use and disposal of incontinence supplies or pads. The child participates in the activity.

  - Children younger than 4 years of age are developmentally expected to be dependent on another person/caregiver for assistance in toileting or diapering. Children starting at 24 months of age (2 years of age) are expected to begin toilet training. If the child and caregiver as a unit can achieve this task and there are no other complex medical needs or equipment, then the child is rated independent. If the child has a complex medical need then this category may be appropriate.
  - Children 4-5 years of age are developmentally expected to need intermittent supervision, cuing, minor physical assistance, and may have occasional night-time bedwetting and accidents during waking hours. Children starting at 24 months of age (2 years of age) are expected to begin toilet training. If the child and caregiver as a unit can achieve these tasks and there are no other complex medical needs or equipment, then the child is independent. If the child has a

complex medical need then this category may be appropriate.

- Children 6 to 18 years of age are developmentally expected to be independent and able to physically and cognitively perform all essential components of toileting safely and without assistance except for children aged 6 that may need help with wiping. If the child is not able to achieve these tasks then this category may be appropriate. This category includes supervision and/or physical assistance with incontinent supplies or pads.

- **Mechanical and Human Help (D):** The child usually needs equipment or a device and requires assistance of other(s) as defined above under Mechanical Help and Human Help to toilet.

  - Children younger than 4 years of age are developmentally expected to be dependent on another person/caregiver for assistance in toileting or diapering. Children starting at 24 months of age (2 years of age) are expected to begin toilet training. If the child and caregiver as a unit can achieve these tasks and there are no other complex medical needs or equipment, then the child is rated independent. If the child has a complex medical need, then this category may be appropriate.
  - Children 4-5 years of age are developmentally expected to need intermittent supervision, cuing, minor physical assistance, and may have occasional night-time bedwetting and accidents during waking hours. Children starting at 24 months of age (2 years of age) are expected to begin toilet training. If the child and caregiver as a unit can achieve these tasks and there are no other complex medical needs or equipment, then the child is rated independent. If the child has a complex medical need, then this category may be appropriate.
  - Children 6 to 18 years of age are developmentally expected to be independent and able to physically and cognitively perform all essential components of toileting safely and without assistance except for children aged 6 that may need help with wiping. If the child is not able to achieve the tasks of toileting, then this category may be appropriate.

- **Performed by Others (D):** The child age 5 and over, uses the bathroom, but is totally dependent on another's assistance in getting to/from the bathroom, adjusting clothes, transferring on and off the toilet, cleansing after elimination and/or is totally dependent on another's assistance with the use and disposal of incontinent supplies or pads, and the child does not participate in the activity at all, then this category is

chosen.

- Children younger than 4 years of age are developmentally expected to be dependent on another person/caregiver for assistance in toileting or diapering. Children starting at 24 months of age (2 years of age) are expected to begin toilet training. If the child and caregiver as a unit can achieve this task and there are no other complex medical needs or equipment, then the child is rated independent. If the child has a complex medical need, then this category may be appropriate.
- Children 4-5 years of age are developmentally expected to need intermittent supervision, cuing, minor physical assistance, and may have occasional night-time bedwetting and accidents during waking hours. Children starting at 24 months of age (2 years of age) are expected to begin toilet training. If the child and caregiver as a unit can achieve this task and there are no other complex medical needs or equipment, then the child is rated independent. If the child has a complex medical need, then this category may be appropriate.
- Children 6 to 18 years of age are developmentally expected to be independent and able to physically and cognitively perform all essential components of toileting safely and without assistance except for children aged 6 that may need help with wiping. If the child is not able to achieve the tasks of toileting, then this category may be appropriate. This category includes total assistance by others with incontinent supplies or pads.

- **Is Not Performed (D):** The child age 5 and over does not use the bathroom or go to/from the bathroom, adjust clothes, transfer on and off the toilet, cleanse after elimination, or independently use and dispose of incontinent supplies or pads.

Rating Criteria for Transferring:

Transferring means the individual's ability to move between the bed, chair, and/or wheelchair. If a person needs help with some transfers but not all, rate assistance at the highest level.

Screening considerations for children, as age appropriate, include: safety concerns such as the child's ability to move between the bed, chair, and/or wheelchair. If the child's situation includes safety concerns, rate accordingly, as age appropriate.

- **Does Not Need Help (I):** The child and caregiver as a unit, or the child, as age appropriate, achieves the transferring process without human assistance or use of equipment.
    - Children from birth to 5 years of age are developmentally expected to need total dependence or assistance from a caregiver in transferring. If the child and caregiver as a unit are able to achieve the transferring process, then the child is rated independent.
    - Children age 6 years of age and older are developmentally expected to be independent and able to physically and cognitively perform all essential components of transferring safely, and without assistance. If the child is not able to achieve this task, then refer to one of the other functional capacities listed below and rate accordingly.

- **Mechanical Help Only (d):** The child and caregiver as a unit, or the child, as age appropriate, usually needs equipment or a device, such as lifts, hospital beds, sliding boards, pulleys, trapezes, railings, walkers or the arm of a chair, to safely transfer, *and* the child manages these devices without the aid of another person.

- **Human Help Only (D):**

Supervision (Verbal Cues, Prompting): The child, as age appropriate, usually needs verbal cues or guarding to safely transfer.

Physical Assistance (Set-up, Hands-On Care): The child and caregiver as a unit, or the child, as age appropriate, usually requires the assistance of **another person who** lifts some of the

individual's body weight and provides physical support in order for the child to safely transfer.

- Children from birth to 5 years of age are developmentally expected to need assistance from a caregiver in the transferring process. If the child and caregiver as a unit are able to achieve the transferring process, then the child is rated as independent.
- Children age 6 years of age and older are developmentally expected to be independent and able to physically and cognitively perform all essential components of the task safely and without assistance. If the child is not able to achieve in the task then this category may be appropriate.

- **Mechanical and Human Help (D):** The child and caregiver as a unit, or the child, as age appropriate, usually needs equipment or a device and requires the assistance of other(s) to transfer as defined above under Mechanical Help and Human Help to transfer.
  - Children from birth to 5 years of age are developmentally expected to need assistance from a caregiver in the transferring process. If the child and caregiver as a unit are able to achieve the transferring process, then the child is rated as independent.
  - Children age 6 years of age and older are developmentally expected to be independent and able to physically and cognitively perform all essential components of the task safely and without assistance. If the child is not able to achieve in the task, then this category may be appropriate.

- **Performed By Others (D):** The child and caregiver as a unit, or the child, as age appropriate, is usually lifted out of the bed and/or chair by another person and does not participate in the process. If the child does not bear weight on any body part in the transferring process; he/she is not participating in the transfer. Individuals who are transferred with a mechanical lift and do not participate are included in this category.
  - Children from birth to 5 years of age are developmentally expected to need assistance from a caregiver in the transferring process. If the child and caregiver as a unit are able to achieve the transferring process and are not using a

mechanical lift, then the child is rated as independent.

- Children age 6 years of age and older are developmentally expected to be independent and able to physically and cognitively perform all essential components of the task safely and without assistance. If the child is not able to achieve in the task, then this category may be appropriate.

- **Is Not Performed (D):** The child is confined to the bed.

Rating Criteria for Eating/Feeding:

Eating/Feeding is the process of getting food/fluid by any means into the body. This activity includes cutting food, transferring food from a plate or bowl into the individual's mouth, opening a carton and pouring liquids, and holding a glass to drink. This activity is the process of eating food after it is placed in front of the individual.

Screening considerations for children, as age appropriate, include: safety concerns such as the child's ability to regulate amount of intake; chew; swallow; monitoring to prevent choking or aspiration; utilize utensils; seizure activity; dietary restrictions; allergies; eating disorders; requires more than one hour per feeding for ages birth to 37 months (3 years and 1 month); requires more than 3 hours per feeding for ages 5 to 18; has other forms of feeding such as tube or intravenous; or other serious complications. If the child's situation includes any of these, rate accordingly, as age appropriate.

- **Does Not Need Help (I):** The child and caregiver as a unit, or the child, as age appropriate, is able to perform all of the activities of eating/feeding without using equipment or the supervision or assistance of another.

  - Children from birth to 12 months of age are developmentally expected to be dependent on another person/caregiver for eating/feeding and monitoring for safety. If the child and caregiver as a unit can achieve the tasks of eating/feeding and there are no other complex medical needs, equipment, or age appropriate risk as stated above under considerations, then the child is rated independent.

- Children from ages 1-4 are developmentally expected to physically participate and may need constant supervision for safety and/or assistance in eating/feeding. If the child and caregiver as a unit can achieve the tasks of eating/feeding and there are no other complex medical needs, equipment, or risk as stated above under considerations, then the child is rated as independent.
- Children ages 5-18 are developmentally expected to physically and/or cognitively perform all essential components of eating/feeding safely, and without assistance, after food is placed in front of the child. If the child is not able to independently eat/feed, then refer to one of the other functional capacities listed below and rate accordingly.

- **Mechanical Help Only (d):** The child, as age appropriate, usually needs equipment or a device, such as hand splints, adapted utensils, and/or nonskid plates, in order to complete the eating/feeding process. A child needing mechanically adjusted diets (pureed food) and/or food chopped would be rated this category.

- **Human Help Only (D):**

Supervision (Verbal Cues, Prompting): The child as age appropriate, feeds self, but needs verbal cues and/or prompting to initiate and/or complete the eating/feeding process.

Physical Assistance (Set-up, Hands-On Care): The child and caregiver as a unit, or the child, as age appropriate, needs assistance to bring food to the mouth, butter bread, open cartons and/or pour liquid due to an actual physical or mental disability.

This category must not be checked if the child is able to feed himself but it is more convenient for the caregiver to complete the activity.

- Children from birth to 12 months of age are developmentally expected to be dependent on another person/caregiver for eating/feeding and monitoring for safety. If the child and caregiver as a unit can achieve the tasks of eating/feeding and there are no other complex medical needs, equipment, or age appropriate risk

as stated above under considerations, then the child is rated independent.

- Children from ages 1-4 are developmentally expected to physically participate and may need constant supervision for safety and/or assistance in eating/feeding. If the child and caregiver as a unit can achieve the tasks of eating/feeding and there are no other complex medical needs, equipment, or risk as stated above under considerations, then the child is rated as independent.
- Children ages 5-18 are developmentally expected to physically and/or cognitively perform all essential components of eating/feeding safely, and without assistance, after food is placed in front of the child. If the child is not able to independently eat/feed, then refer to one of the other functional capacities listed below and rate accordingly.

- **Mechanical and Human Help (D):** The child and caregiver as a unit, or the child, as age appropriate, usually needs equipment or a device and requires assistance of other(s) to eat as defined above under Mechanical Help and Human Help.
    - Children from birth to 12 months of age are developmentally expected to be dependent on another person/caregiver for eating/feeding and monitoring for safety. If the child and caregiver as a unit can achieve the tasks of eating/feeding and there are no other complex medical needs, equipment, or age appropriate risk as stated above under considerations, then the child is rated independent.
    - Children from ages 1-4 are developmentally expected to physically participate and may need constant supervision for safety and/or assistance in eating/feeding. If the child and caregiver as a unit can achieve the tasks of eating/feeding and there are no other complex medical needs, equipment, or risk as stated above under considerations, then the child is rated as independent.
    - Children ages 5-18 are developmentally expected to physically and/or cognitively perform all essential components of eating/feeding safely, and without assistance, after food is placed in front of the child. If the child is not able to independently eat/feed, then refer to one of the other functional capacities listed below and rate accordingly.

- **Performed By Others (D**): This category included children who are spoon fed; fed by syringe or tube, or children who are fed intravenously (IV).

Spoon fed means the child does not bring any food to his mouth and is fed completely by others.

Fed by syringe or tube means the child usually is fed a prescribed liquid diet via a feeding syringe, NG-tube (tube from the nose to the stomach) or G-tube (opening into the stomach).

Fed by I.V. means the child usually is fed a prescribed sterile solution intravenously.

Total parenteral nutrition (TPN) is the administration of a nutritionally adequate solution through an indwelling catheter into the superior vena cava.

- Children from birth to 12 months of age are developmentally expected to be dependent on another person/caregiver for eating/feeding and monitoring for safety. This may include the child being spoon fed by a caregiver or learning to self-feed. If the child and caregiver as a unit can achieve the tasks of eating/feeding, then the child is rated as independent. If the child has a complex medical need or risk as stated above, then this category may be appropriate.
- Children from ages 1-4 are developmentally expected to physically participate and may need constant supervision for safety and/or assistance in eating/feeding. If the child and caregiver as a unit are able to achieve the tasks of eating/feeding, then the child is rated as independent. If the child has a complex medical need or risk as stated above, then this category may be appropriate.
    - Children ages 5-18 are developmentally expected to physically and/or cognitively perform all essential components of eating/feeding safely, and without assistance, after food is placed in front of the child. If the child has a complex medical need or risk as stated above, then this category may be appropriate.

Rating Criteria for Bowel:

Bowel continence is the physiological process of elimination of feces.

Continence is the ability to control bowel elimination. Incontinence may have one of several different causes, including specific disease processes and side effects of medications. Helpful questions include, "Do you get to the bathroom on time?"; "How often do you have accidents?", and "Do you use pads or diapers?"

- **Does Not Need Help (I):** This category includes age appropriate behavior:

1**)** The child voluntarily controls the elimination of feces. **OR**

2) If the child is on a bowel program and never empties his or her bladder without stimulation or a specified bowel regimen, then the child is rated as independent. The bowel/bladder training is noted under medical/nursing needs because in this case, there is no voluntary elimination; evacuation is planned.

If a child on a bowel regimen also has occasions of bowel incontinence, then he or she would be rated as incontinent, either less than weekly or weekly or more. **OR**

3) If a child uses incontinent supplies such as briefs, pads or diapers and can independently change and dispose of items as age appropriate, then the child is rated as independent.

  - Children younger than 4 years of age are developmentally expected to need help with toileting and diapering. If the child can have a bowel movement without the use of a medical or mechanical intervention, then the child is rated independent.
  - Children 4-5 years of age are developmentally expected to need help with toileting and may have occasional accidents during waking hours (this is not considered incontinence). If the child can have a bowel movement without the use of a medical or mechanical intervention, then the child is rated as independent.
  - Children 6 to 18 years of age are expected to voluntarily control the elimination of feces. If the child can empty his or her bowel without the use of medical or mechanical intervention, then the child is rated as independent. For children who use incontinence supplies such as briefs, pads, or diapers for involuntary elimination of feces and who are able to properly use or dispose of the items, then the child is rated independent. If the child is not able to achieve control of elimination and cannot properly use or dispose of incontinence supplies, then refer to one of the other functional capacities listed below and rate accordingly.

- **Incontinent Less than Weekly [does not occur every week] (d):** The child has involuntary elimination of feces but it does not occur every week (e.g., every other week). The individual is rated as "incontinent less than weekly."

  - Children younger than 4 years of age are developmentally expected to need help with toileting and diapering. If the child can have a bowel movement without the

use of a medical or mechanical intervention, then the child is rated independent.

- Children 4-5 years of age are developmentally expected to need help with toileting and may have occasional accidents during waking hours (this is not considered incontinence). If the child can have a bowel movement without the use of a medical or mechanical intervention, then the child is rated as independent.
- Children 6 to 18 years of age are expected to voluntarily control the elimination of feces. If the child can empty his or her bowel without the use of medical or mechanical intervention, then the child is rated as independent. If the child is not able to maintain continence, then this category may be appropriate. For children who use incontinence supplies such as briefs, pads, or diapers for involuntary elimination of feces and who are unable to properly use or dispose of the items, then this category may be appropriate.

- **Ostomy - Self-Care (d):** The child has an artificial anus established by an opening into the colon (colostomy) or ileum (ileostomy) and he independently cares for the ostomy, stoma, and skin cleansing, dressing, application of appliance, irrigation, etc. and if needed with ostomy, can appropriately change and dispose of incontinence supplies used.

  - This category should only be used if the child can complete all components of this task independently.

- **Incontinent Weekly or More [Occurring at least once a week or more] (D):** The child has involuntary elimination of feces at least once a week or more. Includes children who use incontinence supplies such as briefs, pads, or diapers for involuntary elimination of feces occurring at least once a week or more and, as age appropriate, cannot correctly use or dispose of incontinence supplies

  - Children younger than 4 years of age are developmentally expected to need help with toileting and diapering. If the child can have a bowel movement without the use of a medical or mechanical intervention, then the child is rated independent.
  - Children 4-5 years of age are developmentally expected to need help with toileting and may have occasional accidents during waking hours (this is not considered incontinence). If the child can have a bowel movement without the use of a medical or mechanical intervention, then the child is rated as independent.
  - Children 6 to 18 years of age are expected to voluntarily control the elimination of feces. If the child can empty his or her bowel without the use of medical or

mechanical intervention, then the child is rated as independent. If the child is not able to maintain continence, then this category may be appropriate. For children who use incontinence supplies such as briefs, pads, or diapers for involuntary elimination of feces and who are unable to properly use or dispose of the items, then this category may be appropriate.

- **Ostomy - Not Self-Care (D)**: The child has an artificial anus established by an opening into the colon (colostomy) or ileum (ileostomy) and another person cares for the ostomy, stoma, skin cleansing, dressing, application of appliance, irrigations, etc. and may also need assistance with the changing and appropriate disposal of incontinence supplies.
    - This category should be used if the child cannot complete all components of this task independently.

Rating Criteria for Bladder:

Bladder continence is the physiological process of elimination of urine.

Continence is the ability to control urination (bladder). Incontinence may have one of several different causes, including specific disease processes and side effects of medications. Helpful questions include, "Do you get to the bathroom on time?"; "How often do you have accidents?", and "Do you use pads or diapers?"

- **Does Not Need Help (I):** This category includes:

1) The child voluntarily empties his or her bladder. **OR**

2) Children on dialysis who have no urine output would be rated as independent as the child does not perform this process. Dialysis will be noted under medical/nursing needs. **OR**

3) Similarly, children who perform the Crede method for himself or herself for bladder elimination would also be rated as independent. **OR**

4) As age appropriate, the child uses incontinent supplies such as briefs, pads or diapers

and can independently change and dispose of them appropriately, the child is rated as independent.

- Children younger than 4 years of age are developmentally expected to need help with toileting and diapering. If a child falls into this age group, the child is rated as independent unless the child has some other complex medical need such as an external device, indwelling catheter, or ostomy.
- Children 4-5 years of age are developmentally expected to need help with toileting and may have occasional accidents during waking hours (this is not considered incontinence). If a child falls into this age group, the child is rated as independent unless the child has some other complex medical need such as an external device, indwelling catheter, or ostomy.
    - Children 6 to 18 years of age are expected to voluntarily control the elimination of urine and can empty his or her bladder. If a child uses incontinent supplies such as briefs, pads or diapers and can independently change and dispose of them appropriately, then the child is rated as independent. If a child falls into this age group, the child is rated as independent unless the child has some other complex medical need such as an external device, indwelling catheter, or ostomy.

- **Incontinent Less than Weekly [does not occur every week] (d):** The child has involuntary emptying or loss of urine but it does not occur every week (e.g., every other week).

    - Children younger than 4 years of age are developmentally expected to need help with toileting and diapering. If a child falls into this age group, the child is rated as independent unless the child has some other complex medical need such as an external device, indwelling catheter, or ostomy.
    - Children 4-5 years of age are developmentally expected to need help with toileting and may have occasional accidents during waking hours (this is not considered incontinence). If a child falls into this age group, the child is rated as independent unless the child has some other complex medical need such as an external device, indwelling catheter, or ostomy.
    - Children 6 to 18 years of age are expected to voluntarily control the elimination of urine and can empty his or her bladder. If the child is not capable of maintaining continence or utilizing incontinence supplies such as briefs, pads, or diapers, then this category may be appropriate.

- **External Device, Indwelling Catheter, or Ostomy - Self Care (d):** The child has an urosheath or condom with a receptacle attached to collect urine (external catheter); a hollow cylinder passed through the urethra into the bladder (internal catheter), a surgical procedure that establishes an external opening into the ureter(s) (ostomy) or may also include in and out catheterizations occurring multiple times a day (not indwelling). The child completely cares for urinary devices (changes the catheter or external device, irrigates as needed, empties and replaces the receptacle) and the skin surrounding the ostomy. This includes children who use any of these devices and may also need to use incontinence supplies such as briefs, pads, or diapers but can correctly change and dispose of them.

    - This category should only be used if the child can complete all components of this task independently.

- **Incontinent Weekly or More [Occurring once a week or more] (D):** The child has involuntary emptying or loss of urine at least once a week or more.
        - Children younger than 4 years of age are developmentally expected to need help with toileting and diapering. If a child falls into this age group, the child is rated as independent unless the child has some other complex medical need such as an external device, indwelling catheter, or ostomy.
        - Children 4-5 years of age are developmentally expected to need help with toileting and may have occasional accidents during waking hours (this is not considered incontinence). If a child falls into this age group, the child is rated as independent unless the child has some other complex medical need such as an external device, indwelling catheter, or ostomy.

    - Children 6 to 18 years of age are expected to voluntarily control the elimination of urine and can empty his or her bladder. If they are not capable of maintaining continence, then this category may be appropriate. This includes children who use incontinence supplies such as briefs, pads, or diapers for involuntary emptying or loss of urine occurring at least once a week or more and who cannot correctly change or dispose of the items.

- **External Device - Not Self-Care (D):** The child has an urosheath or condom with a receptacle attached to collect urine. Another person cares for the child's external device or additional incontinence supplies such as briefs, pads, or diapers. This

category should be used if the child cannot manage all tasks associated with maintaining an external device independently.

- **Indwelling Catheter - Not Self-Care (D):** The child has a hollow cylinder passed through the urethra into the bladder. Another person cares for the child's indwelling catheter, additional incontinence supplies such as briefs, pads, or diapers or must perform in and out catheterizations multiple times a day. This category includes children who self-catheterize, but who need assistance to set-up, clean up, etc. This category should be used if the child cannot complete all components of the tasks associated with an indwelling catheter independently.

- **Ostomy - Not Self-Care (D):** The child has a surgical procedure that establishes an external opening into the ureter(s). Another person cares for the child's ostomy and may assist with the use, changing, and appropriate disposal of incontinence supplies such as briefs, pads or diapers. This category should be used if the child cannot manage all components of the tasks associated with ostomy care independently.

Rating Criteria for Mobility:

Mobility is the extent of the individual's movement outside his or her usual living quarters. Evaluate the individual's ability to walk steadily and his or her level of endurance.

Ambulation is the ability to get around indoors (walking) and outdoors (mobility), climb stairs and wheel. Individuals who are confined to a bed or chair must be shown as needing help for all ambulation activities. This is necessary in order to show their level of functioning/dependence in ambulation accurately. Individuals who are confined to a bed or a chair are rated Is Not Performed for all ambulation activities.

Walking is the process of moving about indoors on foot or on artificial limbs.

Wheeling is the process of moving about by a wheelchair. The wheelchair itself is not considered a mechanical device for this assessment section.

Stair Climbing is the process of climbing up and down a flight of stairs from one floor to another. If the individual does not live in a dwelling unit with stairs, ask whether he can climb stairs if necessary.

Special Note: Children from birth through 5 years of age may require supervision for safety and physical assistance.

Screening considerations for children, as age appropriate, include: ability to safely maneuver (ambulate) without assistance, creep up stairs, and kneel without support, and assume standing position; seizure activity; frequent falls; balance; and/or visual concerns.

- **Does Not Need Help (I):** The child, as age appropriate, goes outside of his or her residence on a routine basis. If the child only goes outside for trips to a medical appointment or for treatments by ambulance, car, or van rate either in the "confined - moves about" or "confined - does not move about" categories.
    - Children from birth to 6 months of age should be dependent on another person/caregiver for mobility. If the child and caregiver as a unit can achieve mobility and there are no other complex medical needs or equipment, the child is rated as independent.
    - Children ages 7-12 months of age should be dependent on another person/caregiver for mobility and should be able to maintain a sitting position when placed and able to move self by rolling, crawling, or creeping. The child requires supervision for safety. If the child can achieve developmental milestones and there are no other complex medical needs or equipment, the child is rated as independent. If the child is not able to achieve developmental milestones, then refer to one of the other functional capacities listed below.
    - Children ages 13-18 months of age (1-year-old) should be dependent on another person/caregiver for mobility and should be able to able to crawl, creep, pull to stand up, and sit alone. The child requires supervision for safety and intermittent assistance. If the child can achieve the developmental milestones and there are no other complex medical needs or equipment, the child is rated as independent. If the child is not able to achieve developmental milestones or requires a stander,

then refer to one of the other functional capacities listed below.

- Children ages 19-24 months of age (1 ½ to 2-year-old) should be dependent on another person/caregiver for mobility and be able to walk well, master stair climbing but still require supervision for safety and intermediate assistance. If the child can achieve developmental milestones and there are no other complex medical needs or equipment, the child is rated as independent. If the child is not able to achieve developmental milestones or requires a stander or other medical assistance such as use a wheelchair, then refer to one of the other functional capacities listed below.
- Children ages 25 months to 4 years of age should be able to walk well, master physical skills involved in running and jumping but still require supervision for safety and may need intermittent assistance. If the child can achieve developmental milestones and there are no other complex medical needs or equipment, the child is rated as independent. If the child is not able to achieve developmental milestones or requires a stander or other medical assistance such as use a wheelchair, then refer to one of the other functional capacities listed below.
- Children from age 5 to 18 years of age should be able to physically perform all essential components of the tasks of mobility safely and without assistance. If the child is not able to achieve mobility or requires a stander or other medical assistance such as use a wheelchair, then refer to one of the other functional capacities listed below.

- **Mechanical Help Only (d):** The child usually needs equipment or a device to go outside independently. Equipment or device includes splint, special shoes, leg braces, crutches, walkers, wheelchairs, canes, handrails, chairlifts, and special ramps.
  - This category should only be used if the child can utilize equipment or devices independently.

- **Human Help Only (D):**

Supervision (Verbal Cues, Prompting): The child, as age appropriate, usually requires assistance from another person who provides supervision, cues, or coaxing in mobility.

Physical Assistance (Set-up, Hands-On Care): The child, as age appropriate, usually receives assistance from another person who physically supports or steadies the child to go outside.

- Children from birth to 6 months of age should be dependent on another person/caregiver for mobility and should be rated as independent unless they have a complex medical need or equipment.
- Children ages 7-12 months of age should be dependent on another person/caregiver for mobility and supervision for safety and should be rated as independent unless they have a complex medical need, equipment, or are unable to reach developmental milestones of maintaining a sitting position when placed or able to move self by rolling, crawling, or creeping.
- Children ages 13-18 months of age (1-year-old) should be dependent on another person/caregiver for mobility and supervision for safety and should be rated as independent unless they have a complex medical need, equipment, or are unable to reach developmental milestones of crawling, creeping, pulling to stand up, and sitting alone.
- Children ages 19-24 months of age (1 ½ to 2-year-old) should be dependent on another person/caregiver for mobility and supervision for safety including intermittent physical assistance and should be rated as independent unless they have a complex medical need, equipment, or require a stander or other medical assistance such as use a wheelchair or are unable to reach developmental milestones of walking well and mastering stair climbing.
- Children ages 25 months to 4 years of age should be dependent on another person/caregiver for mobility and supervision for safety including intermittent physical assistance and should be rated as independent unless they have a complex medical need, equipment, or require a stander or other medical assistance such as use a wheelchair or are unable to reach developmental milestones of walking well or mastering physical skills involved in running and jumping.
- Children from age 5 to 18 years of age should be able to physically perform all essential components of the task of mobility safely and without assistance. If they are not able to achieve mobility or require a stander or other medical assistance such as use a wheelchair, then this category may be appropriate.

- **Mechanical and Human Help (D):** The child, as age appropriate, usually needs equipment or a device and requires assistance of other(s) to go outside as defined

above under Mechanical Help and Human Help.

- Children from birth to 6 months of age should be dependent on another person/caregiver for mobility and should be rated as independent unless they have a complex medical need or equipment.
- Children ages 7-12 months of age should be dependent on another person/caregiver for mobility and supervision for safety and should be rated as independent unless they have a complex medical need, equipment, or are unable reach developmental milestones of maintaining a sitting position when placed or able to move self by rolling, crawling, or creeping.
- Children ages 13-18 months of age (1-year-old) should be dependent on another person/caregiver for mobility and supervision for safety and should be rated as independent unless they have a complex medical need, equipment, or are unable to reach developmental milestones of crawling, creeping, pulling to stand up, and sitting alone.
- Children ages 19-24 months of age (1 ½ to 2-year-old) should be dependent on another person/caregiver for mobility and supervision for safety including intermittent physical assistance and should be rated as independent unless they have a complex medical need, equipment, or require a stander or other medical assistance such as use a wheelchair or are unable to reach developmental milestones of walking well and mastering stair climbing.
- Children ages 25 months to 4 years of age should be dependent on another person/caregiver for mobility and supervision for safety including intermittent physical assistance and should be rated as independent unless they have a complex medical need, equipment, or require a stander or other medical assistance such as use a wheelchair or are unable to reach developmental milestones of walking well or mastering physical skills involved in running and jumping.
- Children from age 5 to 18 years of age should be able to physically perform all essential components of the task of mobility, safely, and without assistance. If they are not able to achieve mobility or require a stander or other medical assistance, such as use a wheelchair, then this category may be appropriate.

- **Confined - Moves About (D):** The child does not customarily go outside of his or her residence, but does go outside of his or her room.
  - Refers only to children confined to residency due to complex medical needs or equipment.

- **Confined - Does Not Move About (D):** The child usually stays in his or her room.
    - Refers only to children confined to bed due to complex medical needs or use of equipment.

Rating Criteria for Joint Motion:

Joint motion is the child's ability to move his or her fingers, arms, and legs (active ROM) or, if applicable, the ability of someone else to move the child's fingers, arms, and legs (passive ROM).

- **Within Normal Limits Or Instability Corrected (I): means the child's joints can be moved to functional motion without restriction, or a joint does not maintain functional motion and/or position when pressure or stress is applied, but has been corrected by the use of an appliance or by surgical procedure.**

- **Limited Motion (d): Means partial restriction in the movement of a joint including any inflammatory process in the joint causing redness, pain, and/or swelling that limits the motion of the joint.**

- **Instability Uncorrected Or Immobile (D): means a joint does not maintain functional motion and/or position when pressure or stress is applied and the disorder has not been surgically corrected or an appliance is not used, or there is total restriction in the movement of a joint (e.g., contractures, which are common in individuals who have had strokes).**

Rating Criteria for Medication Administration:

Medication Administration refers to the person(s) who administers medications such as the child and caregiver as a unit, the child as age appropriate, or if the child is being referred elsewhere, the person(s) who will administer medications following referral.

- **Without Assistance or No Medications (I):** means the child and caregiver as a unit or the child independently administers their own medication or does not take any medications.

- **Administered/Monitored by Lay Person(s) (D):** The child and caregiver as a unit or the child needs additional assistance of a person without pharmacology training to either administer or monitor medications. This includes medication aides that may be-certified but not licensed or programmed medication dispensers. If meds are given by lay and professional staff, rate at the higher level.

- **Administered/Monitored by Professional Nursing Staff (D):** The child needs licensed or professional health personnel to administer or monitor some or all of the medications. If meds are given by lay and professional staff, rate at the higher level.

Rating Criteria for Behavior Pattern and Orientation:

Behavior Pattern is the manner of conducting oneself within one's environment without placing oneself at risk.

Orientation is the awareness of an individual within his or her environment in relation to time, place, and person. It can also mean the recognition of danger.

See crosswalk at the end of this section and as a quick reference guide, Attachment A.

Screening considerations for children, as age appropriate, include: assistance to engage in safe actions and interactions; refrain from unsafe actions and interactions; exhibits disruptive or dangerous behavior such as: verbal and physical abuse to self or others; wandering; removing or destroying property; acting in a sexually aggressive manner; reported neurological impairment; hyper/hypo sensitivity to external stimulus; constant vocalizations/perseveration; impaired safety skills; engages in smearing behavior; sleep deprivation; reported cognitive impairment; lack of awareness; unable to respond to cues; unable to communicate basic needs and wants; disorientation/disassociation; unable to follow directions; unable to process information or social cues; and unable to recall personal information. If the child exhibits any of these, rate accordingly as developmentally appropriate.

BEHAVIOR PATTERN (Children PAS)

- **Appropriate (I):** The child's behavior pattern is suitable or fitting to the environment and age of the child. Appropriate behavior is of the type that adjusts to accommodate expectations in different environments and social circumstances. Behavior pattern does not refer to personality characteristics such as "selfish," "impatient," or "demanding," but is based on direct observations of the individual's actions. If the behavior is not appropriate, then refer to one of the other functional capacities listed below.
    - Children from birth to 5 months are developmentally expected to respond to sounds by startling; fixate on human's face; respond to caregivers face and voice; move extremities; and smile responsively. If the child can meet developmental milestones, rate as independent. If they are not able to achieve developmental milestones, then rate accordingly.
    - Children from 6-12 months are developmentally expected to respond to sounds; own name; string vowels together when babbling (ah, eh, oh); make sounds to show joy and displeasure; play with others; respond to emotions; show anxiety with strangers; and like to look at self in mirror. If the child can meet developmental milestones, rate as independent. If they are not able to achieve developmental milestones, then rate accordingly.
    - Children from 13-36 months are developmentally expected to respond to simple spoken requests, use simple gestures like shaking head no or waving bye; say mama or dada or uh-oh or other single words; point to show someone what they want or to identify; know names of familiar people and things; demonstrate shyness or nervousness with strangers; cry when caregiver leaves; show fear in some situations; has favorite things and people; hands things to others as play; plays with doll; copies others; gets excited with other children; and may show defiant behavior. If the child can meet developmental milestones, rate as independent. If they are not able to achieve developmental milestones, then rate accordingly.
    - Children from 37 months to 4 years of age are developmentally expected to effectively share information and wants and needs; use simple words, phrases, or short sentences; be able to ask for at least 10 things using appropriate names; understand instructions; and

demonstrate the ability to initiate conversation; identify self and significant others; recognize person, places, events, and objects in their community. If the child can meet developmental milestones, rate as independent. If they are not able to achieve developmental milestones, then rate accordingly.
- Children from 5-18 years of age are developmentally expected to identify self, place of residence, and significant others. For age 6 years and older, engages others in a socially appropriate manner and recognizes and appropriately responds to dangerous situations that might put health and safety at risk or lead to exploitation (this includes wandering and flight behavior). If the child can meet developmental milestones, rate as independent. If they are not able to achieve developmental milestones, then rate accordingly.

- **Inappropriate Wandering, Passive, or Other:**

  Wandering/Passive < weekly = (I);

  Wandering/Passive Weekly or More = (d):

  The child's usual behavior is manifested in a way that does not present major management problems. Wandering is characterized by physically moving about aimlessly or mentally being non-focused. Passive behavior is characterized by a lack of awareness or interest in personal matters and/or in activities taking place in close proximity. Other characterizations of behavior such as impaired judgment, regressive behavior, agitation, or hallucinations that is not disruptive are included in this category. If the behavior is not appropriate or the child has a risk as stated above under considerations, then this category may be appropriate.

  - Children from birth to 5 years of age should be dependent on another person/caregiver for mobility and supervision for safety and should be rated as independent unless they have a complex medical condition.
  - Children from 5-18 years of age are developmentally expected to identify self, place of residence, and significant others. For age 6 years and older, engages others in a socially appropriate manner and recognizes and appropriately responds to dangerous situations that might put health and safety at risk or lead to exploitation (this includes wandering and flight behavior). If the child cannot meet developmental milestones, then this category may be appropriate.

- **Inappropriate Abusive, Aggressive, or Disruptive:**

  Abusive/Aggressive/Disruptive < Weekly = (D);

  Abusive/Aggressive/Disruptive Weekly or More = (D):

The child's behavior is manifested by acts detrimental to the life, comfort, safety, and/or property of the child and/or others. Agitations, hallucinations, or assaultive behavior that is detrimental are included in this category and specified in the space provided. If the behavior is described as above or the child has a risk as stated under considerations, then this category may be appropriate.

- Children birth to 12 months should be dependent on another person/caregiver for supervision for safety and this category does not apply unless they have a complex medical condition.
- Children 13 months-18 years of age; this category may be appropriate.

- **Comatose refers to the semi-conscious or comatose (unconscious) state. (D)**

ORIENTATION (Children PAS)

- **Oriented (I):** The individual has no apparent problems with orientation and is aware of who he or she is, where he or she, the day of the week, the month, and people around him or her.

  - Children from birth to 5 months are developmentally expected to respond to sounds by startling; fixate on human's face; respond to caregivers face and voice; move extremities; and smile responsively. If the child can meet developmental milestones, rate as independent. If they are not able to achieve developmental milestones, then rate accordingly.
  - Children from 6-12 months are developmentally expected to respond to sounds; own name; string vowels together when babbling (ah, eh, oh); make sounds to show joy and displeasure; play with others; respond to emotions; show anxiety with strangers; and like to look at self in mirror. If the child can meet developmental milestones, rate as independent. If they are not able to achieve developmental milestones, then rate accordingly.
  - Children from 13-36 months are developmentally expected to respond to simple spoken requests, use simple gestures like shaking head no or waving bye; say mama or dada or uh-oh or other single words; point to show someone what they want or to identify; know names of familiar people and things; demonstrate shyness or nervousness with strangers; cry when caregiver leaves; show fear in some situations; has favorite things and people; hands things to others as play; plays with doll; copies others; gets excited with other children; and may show defiant behavior. If the child can meet developmental milestones, rate as independent. If they are not able to achieve developmental milestones, then rate accordingly.
  - Children from 37 months to 4 years of age are developmentally expected to effectively share information and wants and needs; use simple words, phrases, or short sentences; be able to ask for at least 10 things using appropriate names; understand instructions; and demonstrate the ability to initiate conversation; identify self and significant others; recognize person, places, events, and objects in their community. If the child can meet

developmental milestones, rate as independent. If they are not able to achieve developmental milestones, then rate accordingly.

- Children from 5-18 years of age are developmentally expected to identify self, place of residence, and significant others. For age 6 years and older, engages others in a socially appropriate manner and recognizes and appropriately responds to dangerous situations that might put health and safety at risk or lead to exploitation (this includes wandering and flight behavior). If the child can meet developmental milestones, rate as independent. If they are not able to achieve developmental milestones, then rate accordingly.

- **Disoriented-Some Spheres, Some of the Time (d):** The individual sometimes has problems with one or two of the three cognitive spheres of person, place, or time. Some of the Time means there are alternating periods of awareness-unawareness.

  - Children from birth to 5 months are developmentally expected to respond to sounds by startling; fixate on human's face; respond to caregivers face and voice; move extremities; and smile responsively. If the child can meet developmental milestones, rate as independent. If they are not able to achieve developmental milestones, then rate accordingly.
  - Children from 6-12 months are developmentally expected to respond to sounds; own name; string vowels together when babbling (ah, eh, oh); make sounds to show joy and displeasure; play with others; respond to emotions; show anxiety with strangers; and like to look at self in mirror. If the child can meet developmental milestones, rate as independent. If they are not able to achieve developmental milestones, then rate accordingly.
  - Children from 13-36 months are developmentally expected to respond to simple spoken requests, use simple gestures like shaking head no or waving bye; say mama or dada or uh-oh or other single words; point to show someone what they want or to identify; know names of familiar people and things; demonstrate shyness or nervousness with strangers; cry when caregiver leaves; show fear in some situations; has favorite things and people; hands things to others as play; plays with doll; copies others; gets excited with other children; and may show defiant behavior. If the child can meet developmental milestones, rate as independent. If they are not able to achieve developmental milestones, then rate accordingly.
  - Children from 37 months to 4 years of age are developmentally expected to effectively share information and wants and needs; use simple words, phrases, or short sentences; be able to ask for at least 10 things using appropriate names; understand instructions; and demonstrate the ability to initiate conversation; identify self and significant others; recognize person, places, events, and objects in their community. If the child can meet developmental milestones, rate as independent. If they are not able to achieve developmental milestones, then rate accordingly.

- Children from 5-18 years of age are developmentally expected to identify self, place of residence, and significant others. For age 6 years and older, engages others in a socially appropriate manner and recognizes and appropriately responds to dangerous situations that might put health and safety at risk or lead to exploitation (this includes wandering and flight behavior). If the child can meet developmental milestones, rate as independent. If they are not able to achieve developmental milestones, then rate accordingly.

- **Disoriented-Some Spheres, All of the Time (d):** The individual is disoriented in one or two of the three cognitive spheres of person, place, and time. All of the time means this is the individual's usual state.

  - Children from birth to 5 months are developmentally expected to respond to sounds by startling; fixate on human's face; respond to caregivers face and voice; move extremities; and smile responsively. If the child can meet developmental milestones, rate as independent. If they are not able to achieve developmental milestones, then rate accordingly.
  - Children from 6-12 months are developmentally expected to respond to sounds; own name; string vowels together when babbling (ah, eh, oh); make sounds to show joy and displeasure; play with others; respond to emotions; show anxiety with strangers; and like to look at self in mirror. If the child can meet developmental milestones, rate as independent. If they are not able to achieve developmental milestones, then rate accordingly.
  - Children from 13-36 months are developmentally expected to respond to simple spoken requests, use simple gestures like shaking head no or waving bye; say mama or dada or uh-oh or other single words; point to show someone what they want or to identify; know names of familiar people and things; demonstrate shyness or nervousness with strangers; cry when caregiver leaves; show fear in some situations; has favorite things and people; hands things to others as play; plays with doll; copies others; gets excited with other children; and may show defiant behavior. If the child can meet developmental milestones, rate as independent. If they are not able to achieve developmental milestones, then rate accordingly.
  - Children from 37 months to 4 years of age are developmentally expected to effectively share information and wants and needs; use simple words, phrases, or short sentences; be able to ask for at least 10 things using appropriate names; understand instructions; and demonstrate the ability to initiate conversation; identify self and significant others; recognize person, places, events, and objects in their community. If the child can meet developmental milestones, rate as independent. If they are not able to achieve developmental milestones, then rate accordingly.
  - Children from 5-18 years of age are developmentally expected to identify self, place of residence, and significant others. For age 6 years and older, engages others in a socially appropriate manner and recognizes and appropriately responds to dangerous situations

that might put health and safety at risk or lead to exploitation (this includes wandering and flight behavior). If the child can meet developmental milestones, rate as independent. If they are not able to achieve developmental milestones, then rate accordingly.

- **Disoriented-All Spheres, Some of the Time (D):** The individual is disoriented to person, place, and time periodically, but not always.
    - Children from birth to 5 months are developmentally expected to respond to sounds by startling; fixate on human's face; respond to caregivers face and voice; move extremities; and smile responsively. If the child can meet developmental milestones, rate as independent. If they are not able to achieve developmental milestones, then rate accordingly.
    - Children from 6-12 months are developmentally expected to respond to sounds; own name; string vowels together when babbling (ah, eh, oh); make sounds to show joy and displeasure; play with others; respond to emotions; show anxiety with strangers; and like to look at self in mirror. If the child can meet developmental milestones, rate as independent. If they are not able to achieve developmental milestones, then rate accordingly.
    - Children from 13-36 months are developmentally expected to respond to simple spoken requests, use simple gestures like shaking head no or waving bye; say mama or dada or uh-oh or other single words; point to show someone what they want or to identify; know names of familiar people and things; demonstrate shyness or nervousness with strangers; cry when caregiver leaves; show fear in some situations; has favorite things and people; hands things to others as play; plays with doll; copies others; gets excited with other children; and may show defiant behavior. If the child can meet developmental milestones, rate as independent. If they are not able to achieve developmental milestones, then rate accordingly.
    - Children from 37 months to 4 years of age are developmentally expected to effectively share information and wants and needs; use simple words, phrases, or short sentences; be able to ask for at least 10 things using appropriate names; understand instructions; and demonstrate the ability to initiate conversation; identify self and significant others; recognize person, places, events, and objects in their community. If the child can meet developmental milestones, rate as independent. If they are not able to achieve developmental milestones, then rate accordingly.
    - Children from 5-18 years of age are developmentally expected to identify self, place of residence, and significant others. For age 6 years and older, engages others in a socially appropriate manner and recognizes and appropriately responds to dangerous situations that might put health and safety at risk or lead to exploitation (this includes wandering and flight behavior). If the child can meet developmental milestones, rate as independent. If they are not able to achieve developmental milestones, then rate accordingly.

- **Disoriented-All Spheres, All of the Time (D):** The individual is always disoriented to person, place, and time.
    - Children from birth to 5 months are developmentally expected to respond to sounds by startling; fixate on human's face; respond to caregivers face and voice; move extremities; and smile responsively. If the child can meet developmental milestones, rate as independent. If they are not able to achieve developmental milestones, then rate accordingly.
    - Children from 6-12 months are developmentally expected to respond to sounds; own name; string vowels together when babbling (ah, eh, oh); make sounds to show joy and displeasure; play with others; respond to emotions; show anxiety with strangers; and like to look at self in mirror. If the child can meet developmental milestones, rate as independent. If they are not able to achieve developmental milestones, then rate accordingly.
    - Children from 13-36 months are developmentally expected to respond to simple spoken requests, use simple gestures like shaking head no or waving bye; say mama or dada or uh-oh or other single words; point to show someone what they want or to identify; know names of familiar people and things; demonstrate shyness or nervousness with strangers; cry when caregiver leaves; show fear in some situations; has favorite things and people; hands things to others as play; plays with doll; copies others; gets excited with other children; and may show defiant behavior. If the child can meet developmental milestones, rate as independent. If they are not able to achieve developmental milestones, then rate accordingly.
    - Children from 37 months to 4 years of age are developmentally expected to effectively share information and wants and needs; use simple words, phrases, or short sentences; be able to ask for at least 10 things using appropriate names; understand instructions; and demonstrate the ability to initiate conversation; identify self and significant others; recognize person, places, events, and objects in their community. If the child can meet developmental milestones, rate as independent. If they are not able to achieve developmental milestones, then rate accordingly.
    - Children from 5-18 years of age are developmentally expected to identify self, place of residence, and significant others. For age 6 years and older, engages others in a socially appropriate manner and recognizes and appropriately responds to dangerous situations that might put health and safety at risk or lead to exploitation (this includes wandering and flight behavior). If the child can meet developmental milestones, rate as independent. If they are not able to achieve developmental milestones, then rate accordingly.

- **Comatose (D):** The individual is in a semi-comatose or unconscious state or is otherwise non-communicative**.**

Behavior and Orientation are considered as a combination for service authorization. Please see the chart below that provides the combinations that determine whether or not an individual is independent (I), semi-dependent (d), or dependent (D) in both behavior and orientation for the purposes of Screening for Medicaid LTSS.

Attachment A provides the following crosswalk as a "pull out" tool which can be used in determining eligibility.

ORIENTATION PATTERN	**BEHAVIOR PATTERN**	Appropriate	Wandering/ Passive Less Than Weekly	Wandering/ Passive Weekly or More	Abusive/Aggressive/ Disruptive Less Than Weekly	Abusive/ Aggressive/Disruptive Weekly or More
	Oriented	**I**	**I**	**I**	**d**	**d**
	Disoriented: **Some** spheres S**ome** of the time	**I**	**I**	**d**	**d**	**D**
	Disoriented: **Some** spheres **All** of the time	**I**	**I**	**d**	**d**	**D**
	Disoriented: **All** spheres **Some** of the time	**d**	**d**	**d**	**D**	**D**
	Disoriented: **All** spheres **All** of the time	**d**	**d**	**d**	**D**	**D**
	Comatose	**D**	**D**	**D**	**D**	**D**

Reminder: An individual must meet all criteria to meet NF LOC, i.e., the individual has limited functional capacity, medical or nursing needs, and is at risk of NF placement within 30 days without services.

Attachment B of this manual provides a worksheet for summarizing the results of the LTSS Screening and determining functional, medical or nursing need, and at-risk status of the individual.

Target Population & General Criteria for HCBS (PAS)

LTSS Screeners are responsible for providing general information regarding Medicaid

HCBS as well as non-Medicaid service and support options. As such, LTSS Screeners should be knowledgeable about available community services and supports and have a current list available, with contact information, for individuals who are screened.

NOTE: The following information regarding the CCC Plus Waiver and PACE are program snapshots. For additional details, please refer to the individual program provider manuals found on the Virginia Medicaid portal found under provider resources at https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/Home/homepage/.

Virginia has two HCBS programs that require a Medicaid LTSS Screening as described in this manual. These programs are:

- Program of All-Inclusive Care for the Elderly (PACE); and
    - Commonwealth Coordinated Care Plus (CCC Plus) Waiver

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

PACE is a program that serves individuals who meet the level of care for NFs. It is an alternative to long term NF placement. PACE services are all inclusive and highly coordinated, focusing on improving the individual's whole life. Services include adult day care, acute care, dental services, care by a physician, transportation, pharmaceuticals, home health, all rehabilitation services and any other services that the Interdisciplinary Team agrees is needed by the individual.

PACE is a capitated rate program jointly funded by Medicare and Medicaid.

The general requirements for PACE are:

1. Be fifty-five (55) years of age or older; and
2. Reside in a PACE program’s service area; and
3. Meet NF LOC; and
4. Have a safe plan of care developed allowing the individual to live in the community;

and

5. Agree to the terms and conditions of participation in the PACE program; and,
6. Have an income equal to or less than 300% of the current Social Security Income.

NOTE: The PACE program requires LTSS Screenings for **ALL** individuals entering the program regardless of payment source. The Screening teams must complete the LTSS Screening for individuals who are anticipating accessing PACE services, even if the individual will access those services under a private pay status. DMAS will reimburse the LTSS Screening team for these Screenings. For all individuals screened for PACE, the LTSS Screening Team must send a copy of the successfully processed Screening packet to the selected PACE site.

Services available through PACE are all-inclusive and include all acute, medical, dental, long-term services and supports, etc. For this reason, a list is not included here.

Commonwealth Coordinated Care Plus (CCC Plus) Waiver

Individuals utilizing this waiver may be enrolled in the Commonwealth Coordinated Care Plus (CCC Plus) Program (Virginia's Medicaid managed long-term care services and supports program) or be Fee for Service (FFS).

To participate in the CCC Plus Waiver, individuals must meet ***all*** of the following general requirements:

1. Meet the NF LOC criteria, has medical or nursing needs, and is at risk for NF or hospital placement within 30 days in the absence of HCBS;
2. Has been determined financially eligible for Medicaid coverage;
3. Is not a resident of a NF or assisted living facility (ALF) that serves four or more individuals;
4. Has insufficient community resources *or* no other community resources available to meet their needs;
5. Has a safe plan of care developed allowing them to live in the community; and
6. Has a viable back-up plan for available caregivers.

Services available through the CCC Plus Waiver include:

- Adult Day Health Care
  - Assistive Technology (AT). This is not a stand-alone service and must be authorized in addition to one of the other services available in this waiver.
  - Environmental Modification (EM). This is not a stand-alone service and must be authorized in addition to one of the other services available in this waiver.
  - Personal Care Services (Agency and Consumer-Directed options)
  - Personal Emergency Response System (PERS): Installation and may or may not include monthly monitoring. This is not a stand-alone service and must be authorized in addition to one of the other services available in this waiver.
- Medication Monitoring (can only be received in conjunction with PERS)
  - Private Duty Nursing (PDN)
  - Respite Services (Agency and Consumer-Directed options)
  - Service Facilitation (for Consumer Direction)
- Transition Services

Individuals living with MI, ID or other RC, including autism, individuals in therapeutic foster care or individuals living with behavioral health conditions may qualify for the CCC Plus Waiver; however, all individuals utilizing the CCC Plus Waiver must meet the CCC Plus Waiver criteria i.e. functional need, medical or nursing need, and risk for institutionalization within 30 days. Eligible individuals may be enrolled in the CCC Plus Waiver, while also being on a wait list for one of the DD waivers. Individuals seeking enrollment in a DD waiver must meet that waiver's criteria and individuals already receiving a DD waiver who wish to change and receive CCC Plus Waiver services, must have a LTSS Screening and meet CCC Plus Waiver criteria.

Private Duty Nursing (PDN) Services Offered through the CCC Plus Waiver or EPSDT

Adults requiring PDN and children requiring Early and Periodic Screening, Diagnostic and Treatment (EPSDT) PDN services may be screened for the CCC Plus Waiver the same as other individuals; however, these individuals require more substantial medical nursing interventions. CCC Plus Waiver PDN services shall be covered only for Medicaid-eligible individuals who have been determined eligible for CCC Plus Waiver services and who also require the level of care provided in either a

specialized care NF, or long-stay hospital, or are determined to have needs with can only be addressed by a private duty nurse and who meet criteria assessment evaluated on the DMAS-108 (adults) or DMAS-109 (children). PDN services shall be the critical services necessary to delay or avoid the individual's placement in an appropriate facility. Eligibility for the CCC Plus Waiver based on PDN services needs is determined by using the DMAS-108 (for adults) and the DMAS-109 (for children) forms in conjunction with the Medicaid LTSS Screening forms. Medical and nursing needs are documented on the DMAS-108 or DMAS-109.

The DMAS 109 form should only be submitted for children who qualify for at least 50 points or more on the form (ventilator, trach or combinations of conditions as direction on the DMAS-109 form). Completing the form for children who meet the DMAS-109, 50 point criteria, allows them to be enrolled in the CCC Plus Waiver as a medically complex individual even though their PDN must be provided through the EPSDT program. Please review directions specified on the DMAS-109 form.

EPDST provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid. EPSDT is key to ensuring that children and adolescents receive appropriate preventive, dental, mental health, and developmental, and specialty services. More information about Virginia's EDPST Program can be found at http://www.dmas.virginia.gov/#/maternalepsdt.

For LTSS screening teams, eMLS will allow opening DMAStheDMAS-108 and DMAS-109 forms when PDN service is selected on the DMAS-96 Authorization form page. Final eligibility is determined using the age appropriate PDN referral form, *in addition to* the UAI, DMAS-96 and DMAS-97.

Consumer-Directed or Agency-Direct Personal Care

Agency-directed care is where services are coordinated and received through an agency who is responsible for hiring and training its employees. Consumer-directed care is where the individual (or an appointee) is the employer of the persons providing services. Individuals may receive personal care, adult day health care, respite (skilled and non-skilled), PDN and Personal Emergency Response System (PERS) through an agency-directed model of care. Individuals may also receive personal care and non-skilled respite through a consumer-directed model of care. The choice of the model of care is made freely by the individual or their representative, if the individual is not able to make

a choice.

Movement Between NF, CCC Plus Waiver and PACE After Initial Screening for Medicaid-Funded LTSS

Individuals meeting NF LOC criteria are able to choose their services and transition among certain LTSS settings (NF, CCC Plus Waiver and PACE) after the initial Medicaid LTSS Screening and service enrollment/authorization occurs, provided all the requirements are met for the newly selected setting or program. Examples of additional criteria that must be met from one services program to another include: age requirement for PACE, and the completion of a Level I Screening and if needed, a Level II evaluation and determination for MI, ID and RC, for all admissions to a Medicaid-certified NF. Movement provides choice to the individual and enables the individual to more freely move between NF and CCC Plus Waiver, PACE or between NFs.

After an initial Medicaid LTSS Screening is conducted and successfully processed in eMLS, enrollment in services shall occur as soon as possible after LTSS Screening but no later than one year from date of the LTSS Screening. If enrollment does not occur within one (1) year a new LTSS Screening is required.

LTSS annual LOC review will be monitored using established processes for the CCC Plus Waiver (as found in the CCC Plus Waiver Manual) and the Minimum Data Set (MDS) in NFs. PACE sites will follow their usual process for monitoring annual LOC. A new LTSS screening is not needed nor is an updated Screening required for persons enrolled for Medicaid LTSS unless an individual is **terminated** from enrollment for services.

When there is a transition of services from one provider to another, it is up to the FFS LTSS provider, individual's CCC Plus health plan or PACE site to ensure that all documentation including LTSS Screening packet is forwarded to a new provider in order for an appropriate and safe plan of care to be developed. If the existing provider does not have a copy of the LTSS Screening packet, any of the providers serving the individual or the original LTSS Screening team should assist in providing a LTSS Screening packet. Copies of the LTSS Screening packet can be printed from eMLS.

If an individual is unenrolled from Medicaid and/or Medicaid LTSS enrollment is terminated and the individual wishes to restart/reinitiate LTSS, a new Screening is required. In this situation, the initiation of services is considered a new application for LTSS.

Preauthorizations and Referrals (PAS)

DMAS Authority for Authorization of Medicaid Payment

The Screening teams have the responsibility to determine if the individual meets the initial required NF LOC. The DMAS eMLS system does not determine the LOC. The LTSS Screening team determines eligibility and by selecting a category of service on the DMAS-96 Authorization Form (CCC Plus Waiver, PDN services, PACE or NF), the Screener is documenting the authorization determination. This determination is needed for Medicaid reimbursement of LTSS. Any information that is needed to support the Screening team's LOC decision must be documented on the last page (narrative section) of the DMAS-P98 (UAI-B) in eMLS. FFS LTSS providers are responsible for developing the plan of care and requesting authorization for services. FFS authorizations are submitted to the DMAS-designated service authorization contractor. CCC Plus health plans will manage these processes for individuals enrolled in the CCC Plus managed care program.

In those cases where the individual has been referred for a Level II evaluation for SMI, ID/RC, the responsibility and authority for the authorization of services is shared with the state DBHDS and contracted evaluation team. The Level II authorization must occur **prior** to service initiation for NF services. The LTSS Screening teams must document the findings of the Level II in eMLS.

NFs will not be reimbursed by DMAS for NF placement or services until a LTSS Screening has been completed and successfully processed in eMLS (as described in this manual) and the individual is determined to meet the initial required LOC criteria for LTSS (except for special circumstances allowing NF admission without LTSS Screening). It is the NF's responsibility not to accept an individual for LTSS nor submit a LOC change from skilled services (including rehabilitation services) to LTSS before the completion of a Screening.

Freedom of Choice

The Screening team *shall* inform the individual of the feasible alternatives available for LTSS and allow the individual to choose either institutional or HCBS programs (Title 42: Subpart H§441.353(d).) Regardless of the LTSS services authorization, the individual *shall* be given choice of settings (HCBS or NF) and of services and providers. The Screening

team must document the individual's choices on the Individual Choice-Institutional Care or Waiver Services Form (DMAS-97). **This includes documenting that an individual has chosen to decline services, if that is the case.**

All of the following information, which is included on the DMAS-97, *shall* be discussed with the individual or his or her representative during the Screening, and *documented* on the DMAS-97:

- The findings and results of the individual's evaluation and needs;
- A choice between NF, CCC Plus Waiver, or PACE;
- For individuals selecting NF, the individual's understanding that when there is a suspected or known diagnosis of a MI, ID or RC, a Level II Screening is required to determine if additional services are necessary;
- The individual's right to a fair hearing and the appeal process;
- The individual's right to choose provider(s).When an individual is participating in the CCC Plus program the Screener will inform the individual that the health plan will provide a list of available providers enrolled with the plan; when an individual is FFS the Screener will provide a list of available community providers;
- The individual's right to choice of service(s);
- The individual's potential to have a patient pay amount, based on his or her income regardless of the amount of NF/HCBS programs;
- The individual understands that, by using the Consumer-Directed (CD) Option of

service delivery, he or she bears the responsibilities associated with employing his or her own personal care attendants (*NOTE: DMAS is not the employer for CD personal care attendants providing personal care, companion services, or respite services)*; and

- The individual's (or representative's) consent to exchange information with DMAS by signing and dating the DMAS-97 form. This consent will remain in effect until revoked by the individual (or representative) in writing.

The Screening team must document that the individual was *provided a choice* on the DMAS-97 form in eMLS and have the individual sign a copy for file records. If a provider is chosen, this selection should be noted on the DMAS-97 form. If services are declined that should also be noted.

The Screening team must also inform the individual and/or the representative of **all** of the following requirements:

1. The authorization for Medicaid-funded LTSS does not mean that the individual will become financially Medicaid-eligible;

2. Financial eligibility for Medicaid coverage must be determined by a benefits (eligibility) worker at the LDSS and that may include responsibility for a patient-pay amount; and

3. Medicaid shall not reimburse for services unless the individual has been determined to be financially Medicaid-eligible and meets the LOC criteria for service authorization.

The Screening team will send a letter documenting its decision to the selected provider, health plan health plan and individual. The approval and denial sample letters have been revised and are located for screener access on the Medicaid Web Portal under *Provider Services/Provider Forms Search* at:

https://www.virginiamedicaid.dmas.virginia.gov/wps/portal. Under *Category*, use the drop-down menu and click on *Pre-Admission Screening* to access the sample letters, DMAS-P238, Approval Letter and DMAS-P239, Denial Letter.

Additional Non-Medicaid Covered Services

An individual shall be notified of non-Medicaid community services that can provide support based on their needs. The individual or family may choose the additional services from any source, including a community-based agency or be determined eligible or possibly eligible for other programs by local human services agencies.

Referrals for NF, CCC Plus Waiver and PACE

The LTSS Screening team must consider the individual's health, safety, and welfare as well as the individual's choice of provider and setting when considering HCBS such as the CCC Plus Waiver or PACE. If the individual already has an APS or CPS worker assigned through the local DSS and it is known by the LTSS Screening team or contact can be accessed, this individual should be consulted. In order to authorize HCBS, the individual must meet all of the criteria for the specific HCBS program prior to authorization. CCC Plus Health Plan Care Coordinators will work with plan members to assure health, safety, and welfare for the member while respecting the individual's choice of provider and setting for services.

HCBS should first be discussed with the individual; however, NF services cancan be authorized with documentation addressing why HCBS cannot be authorized. This action can allow for temporary placement in a NF setting until a safe plan of care can be developed for HCBS.

For individuals choosing a NF, LTSS Screeners must ensure the completion of the DMAS-95 (screening for MI, ID/RC) and make appropriate referral for a Level II evaluation and determination if MI/ID/RC are suspected. Both the MI/ID/RC screening (Level I) and evaluation (Level II) process must be completed prior to NF admission.

The Screening team must document the individual's choices on the DMAS-97 in eMLS.

FFS and CCC Plus Excluded Population Process

For individuals that are FFS or in a CCC Plus excluded population or program, the LTSS Screening team must inform the individual of Medicaid policies and alternatives to NF placement (CCC Plus Waiver and PACE). If the individual being screened is FFS, the LTSS Screening team must offer a written list of Medicaid-enrolled provider agencies and/or CD services facilitators in their area, and PACE providers (if applicable). The individual's choice of provider should be documented. A current list of DMAS enrolled CCC Plus Waiver providers can be found at:

https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/SearchForProviders. Under Provider Type select Case Management – Waiver and Service Facilitation (for consumer-directed services), Personal Care (for agency-directed services), or PDN. For PACE choose PACE Provider.

Per the individual's choice, the Screening team will forward a complete Medicaid LTSS Screening Packet to the selected provider. The provider (CD Services Facilitator or Agency) will manage the LTSS enrollment process.

CCC Plus Program Process

If the individual is enrolled in a health plan CCC Plus health, then the LTSS Screening team *will forward* all screening documentation to the CCC Plus health plan fax number (listed later in this Chapter) for follow-up with the individual by the individual's care coordinator. The health plan will manage the LTSS enrollment process.

The LTSS Screener should provide general information regarding NF, CCC Plus Waiver, and if applicable, PACE services, as well as inform the individual that the CCC Plus care coordinator will provide a list of available network choices to the individual. Individuals may also visit the following DMAS webpage to investigate providers who are enrolled with their health plan: https://www.dmas.virginia.gov/for-members/find-a-provider/

eMLS

PACE Program Process:

Individuals interested in PACE should be provided contact information for the PACE program serving the locality (if PACE is available). Individuals should be directed to discuss their interest with the PACE staff. If the individual chooses PACE services, this choice should be noted on the authorization form. The local PACE program will notify DMAS regarding the potential enrollee and manage the PACE enrollment process for the individual.

Documentation Requirements (PAS)

Distribution of Screening Forms

The LTSS Screening team sends the following forms as outlined below. No LTSS Screening packet should be distributed until it has "Successfully Processed" as noted in eMLS. Once a LTSS Screening is submitted via eMLS, the LTSS Screener is responsible for returning to the eMLS portal after 24 hours to confirm the forms were Successfully Processed and print copies of the packet as needed. No handwritten forms/screening packets should be forwarded to a provider or individual.

Please note that it should be standard practice for LTSS Screening entities to provide copies of the LTSS Screening packet to the individual or the authorized representative. LTSS Screening packets should also be provided to newly chosen providers if all information security (PHI) guidelines are followed and it is within the record and retention timeframes for the Screening entity.

Medicaid LTSS Screening, Form Distribution

CCC Plus Member Forms Sent to Health Plan	FFS Members Forms Sent to Provider	PACE Admissions Forms Sent to Provider

NF Admission Full Screening Package sent to Admitting NF	CCC Plus Waiver	NF Admission Full Screening Package sent to Admitting NF	CCC Plus Waiver	
DMAS-P98	DMAS-P98	DMAS-P98	DMAS-P98	DMAS-P98
DMAS-95 • Level I • Level II (if appropriate)		DMAS-95 • Level I • Level II (if appropriate		
DMAS-96	DMAS-96	DMAS-96	DMAS-96	DMAS-96
DMAS-97	DMAS-97	DMAS-97	DMAS-97	DMAS-97
	DMAS-108 (as appropriate)		DMAS-108 (as appropriate)	
	DMAS-109 (as appropriate)		DMAS-109 (as appropriate)	

*A copy of the DMAS-96 is always forwarded to the benefits unit of the LDSS.

** The original signed copy of the DMAS-97 should be maintained with the individual's official record and transferred to the new provider if the individual transitions to a new service provider. All other providers may retain a printed copy of the DMAS-97 noting names of original signers.

*** The individual screened for LTSS or the representative must receive a notification letter providing appeal rights and a copy of the full LTSS Screening packet. Please note that the notification letter is not to be used for authorization of services. Only a LTSS Screening packet which includes the DMAS-96 Authorization for LTSS Form can be used to confirm authorization.

Screeners will need to retain copies of the Screening packet per retention policy cited in this manual or upon request retrieve LTSS Screening packets from eMLS.

For Medicaid Members who are enrolled with a CCC Plus program health plan, Screeners will need to determine whether individuals are currently CCC Plus members, and if so, forward the completed Screening packet to the health plan for use by the individual's assigned care coordinator. Contact and FAX numbers are listed below.

CCC Plus Health Plan	FAX Number for Screening Documents	Care Coordination Phone Number
Aetna Better Health of Virginia	844-459-6680	855-652-8249 Press #1 and ask for Case Management
Anthem HealthKeepers Plus	855-471-7937	855-323-4687 (Option 4) TTY 711
Magellan Complete Care of Virginia	866-210-1523	800-424-4524
Optima Health Community Care	844-552-7508	866-546-7924 or 757-552-8398
United Healthcare Community Plan	855-770-7088	Providers 877-843-4366 Members 1-866-622-7982
Virginia Premier Health Plan	800800-846-4254	877-719-7358 press option 1, then 3

For individuals enrolled in the CCC Plus program, the health plan is responsible for submitting the DMAS-225 to the LDSS benefits program (eligibility section) once services are initiated for the individual.

For FFS for NF, CCC Plus Waiver and PACE, the direct service provider is responsible for

notifying the LDSS eligibility section via a DMAS-225 that services have been initiated for the individual.

Electronic Medicaid LTSS Screening System (eMLS- electronic screening system for LTSS)

LTSS Screening teams shall enter the Screening information directly into the eMLS –the electronic screening system for LTSS… eMLS is required for recording the results of LTSS Screenings, maintaining records, and noting authorization or non-authorization for the CCC Plus Waiver, PACE or LTSS provided in a NF. LTSS Screeners should note that the system is not used for maintaining other types of screenings using the UAI form, such as assessments for Assisted Living Facilities (ALFs) nor does the system automatically enroll individuals into the aforementioned programs/services.

1. On-line Screening forms identify all required data elements for successful submission..

2. Submissions are imported directly into the DMAS' Virginia Medicaid Management Information System (VAMMIS) each evening for processing and review..

3. The LTSS Screener submitting the LTSS Screening must log into eMLS to verify the status of the LTSS Screening the day following the LTSS Screening submission. Status tracking may indicate 'successfully processed," 'denied', 'ed' or 'incomplete'. When a LTSS Screening indicates "Submitted for Processing" it means the LTSS Screening has not yet been processed by the computer systems. If LTSS Screeners find this message more than 24 hours after submission, the LTSS Screener should contact ScreeningAssistance@dmas.virginia.gov ..

4. If additional information or corrections are needed, each item can be viewed by the LTSS Screener who entered the data and submitted the forms for the screening. A description of the information or correction needed will appear directly below each data element in eMLS..

5. Default social security numbers (SSN) should not be used except under circumstances when a child has not yet been issues a SSN. The DMAS approved default social security number sequence is 000-MM-DDYY using the individual's Date of Birth (no other sequence is allowed-000s, 222s,333s, etc.); if having trouble or receiving denial codes contact: screeningassistance@dmas.virginia.gov. Any and all LTSS Screenings utilizing a default SSN must be revises once a SSN has been issued. LTSS Screeners should contact screeningassistance@dmas.virginia.gov for assistance with this process.
6. All LTSS Screenings can be printed from eMLS

7. An indication of successfully submitted, submitted for processing, incomplete, pended or denied only indicates the status of submitted data. eMLS has been built to assist the LTSS Screener in assuring all required information is entered into the system, it does automatically complete the Medicaid LTSS authorization form . .÷

8. Upon successful completion of entering the LTSS Screening data, VAMMIS will generate a claim for payment of the LTSS Screening to the hospital or local health department associated with the individual's screening. And

9. The claim payment will be paid for specific social security and Medicaid numbers; thus, enabling the individual entering the data to track the claim and subsequent payment.

Detailed information is available regarding accessing the DMAS Provider Web Portal (eMLS).

1. Screening eMLS User Guide, Tutorial and Frequently asked Questions (FAQs) are available on the Virginia Medicaid Provider Web Portal located at https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/PreAdmission.

2. Questions may also be submitted through the DMAS screening assistance email address at: ScreeningAssistance@dmas.virginia.gov

Notification Instructions

The LTSS Screening team must complete **all** of the following documentation requirements for individuals being screened for LTSS (NF, CCC Plus Waiver and PACE):

1. The LTSS Screening team shall mail a letter to the individual screened or his or her representative indicating the LTSS determination. Letters are required if an individual is approved or denied for services. If denied LTSS, the individual will receive appeal rights with instructions on how to appeal the Screening team's decision. *The appeal process is described in Chapter II of this manual.*

2. The approval and denial sample letters are located for LTSS Screener access on the Medicaid Web Portal under *Provider Services/Provider Forms Search* at:

   https://www.virginiamedicaid.dmas.virginia.gov/wps/portal. Under *Category*, use the drop down menu and click on *Pre-Admission Screening* to access the sample letters, DMAS-P238 and DMAS-P239.

3. LTSS Screening teams are required to send the DMAS-96 Authorization Form to the local DSS benefits program (eligibility office) in the locality in which the individual resides. LDSS office contact information can be found at http://dss.virginia.gov/localagency/index.cgi

4. Should the provider agency, the CCC Plus health plan or individual screened need another copy of the LTSS Screening packet, the LTSS Screening team will make copies of the completed LTSS Screening packet available during the below stated retention times.

5. For adults who receive a LTSS Screening, the LTSS Screening team must retain a copy of all referenced screening documents for a period of not less than six (6) years from the date of the LTSS Screening. For children, LTSS Screening teams must retain

documents for at least six (6) years after such minors have reached **21** years of age. These documents may be electronically stored, i.e.in eMLS

6. In addition to the electronic copy of the DMAS-97, Individual Choice - Institutional Care or Waiver Services Form, a paper copy of the DMAS-97 form with the individual's or the representative's signature shall be retained in the individual's record by the LTSS Screening Team. DMAS-97 forms are required for individuals who are authorized for LTSS. If waiver services are declined for any reason, the reason for declining shall be recorded on the DMAS-97.

Individual Does Not Meet NF LOC

If the individual does not meet the required number of dependencies or semi-dependencies/functional needs, has no medical or nursing need and/or is not at-risk for hospitalization or institutionalization, the individual is considered not to meet the NF LOC.

1. When one of the following specific care needs solely describes the individual's condition that individual is considered not to meet the required level of care need for LTSS: The individual requires minimal assistance with ADLs, including those individuals whose only need in all areas of functional capacity is for prompting to complete the activity;
2. The individual independently uses mechanical devices such as a wheelchair, walker, crutch, or cane;
3. The individual requires limiting diets such as a mechanically altered, low-salt, low-residue, diabetic, reducing, or other restrictive diets;
4. The individual requires medications that can be independently self-administered or administered by the caregiver;
5. The individual requires protection to prevent him or her from obtaining alcohol or drugs or to address a social or environmental problem;
6. The individual requires minimal staff observation or assistance for confusion, memory impairment, or poor judgment; or
7. The individual's primary need is for behavioral management that can be provided in a community-based setting.

When the individual does not meet the NF LOC, all of the following procedures apply:

1. The Screening team will document this denial decision on the Member's Case Summary, UAI B and on the DMAS-96 form, indicating that no authorization for Medicaid payment has been approved for this individual.

   NOTE: Authorization for the LTSS is not determined by the eMLS system. The eMLS system will accept and "Successfully Process" both authorized and non-authorized LTSS screenings.

2. The Screening team must send a letter to the individual screened or the representative. The individual will receive appeal rights within this decision letter providing instructions on how to appeal the Screening team's decision, if the individual chooses. *The client appeals process is described in Chapter II of this manual.*
3. The approval and denial sample letters are located for screener access on the Medicaid Web Portal under *Provider Services/Provider Forms Search* at: https://www.virginiamedicaid.dmas.virginia.gov/wps/portal.

   Use the drop down menu and click on *Pre-Admission Screening* to access the sample letters, DMAS-P238 and DMAS-P239.

4. The Screening team must send a copy of the completed DMAS-96 form to the appropriate LDSS office, benefits program (eligibility section), in order for correct financial eligibility to be determined.
5. It is essential for LTSS Screening teams to maintain current information on available community resources, such as health services, home-delivered meals, etc., to assist in developing community alternatives to institutionalization.

Validity of Screening (PAS)

Once an individual has an approved Screening, which has been successfully processed through eMLS, it is valid as long as the individual continues to be enrolled in Medicaid LTSS either through a NF or HCBS program. Enrollment in home and community-based services (CCC Plus Waiver and PACE) should occur as soon as possible after the completion of the LTSS screening but at least within 1 year of the LTSS Screening assessment date. If an enrollment has not occurred in that time period another LTSS Screening must be conducted to assure the need for services including assessing functional capacity, medical or nursing need, and documenting that without services the person would likely be hospitalized or need NF services within 30 days.

The HCBS provider or CCC Plus health plan shall be responsible for conducting periodic

evaluations to ensure that the individual continues to meet the CCC Plus Waiver or PACE criteria. These evaluations will occur at least annually and may occur more often if the provider has a concern that the individual no longer meets the functional level of care required for Medicaid-funded LTSS or there has been a significant change in condition.

For individuals admitted to a NF, the NF shall be responsible for conducting periodic evaluations to ensure that the individual meets, and continues to meet, the NF LOC criteria.

Competency Training and Testing Requirements (PAS)

Beginning, July 1, 2019, each person performing the LTSS Screening and the physician signing the Medicaid LTSS Authorization Form (DMAS-96) shall complete mandatory training and testing before conducting screenings for an authorized screening entity. A score of at least 80% on each module shall constitute satisfactory competency assessment results. At the conclusion of satisfactory completion of all modules and tests, a certificate indicating a certification number will be awarded. This certification number must be entered each time a LTSS Screener completes submission of a LTSS Screening in eMLS. The registration for the online, Medicaid LTSS Screening training may be found at: https://medicaidltss.partnership.vcu.edu/register

This training shall be repeated no less than every three years. The most current competency assessment results shall be kept in the Screening entity's personnel records for each staff member performing LTSS Screenings and signing/certifying the LTSS Screening packet. Training documentation shall be provided to DMAS upon request. Failure to comply with the training and competency assessment requirements may result in retraction of Medicaid LTSS Screening payments.

Screening for Medicaid-Funded LTSS Resources and Questions (PAS)

Additional information about the Medicaid LTSS Screening process may be found on the DMAS web portal at:

https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/PreAdmission.

List of Medicaid Memos Applicable to Screenings

- October 3, 2012: Development of Special Criteria for the Purposes of PAS

Content from this memo has been updated, reformatted and incorporated into this chapter.

- Oct 25, 2013: Pre-Admission Screening Guidance
- Feb 26, 2014: Procedure Change for the Pre-Admission Screening Process (PASRR) for Individuals Transferring from DBHDS State Facilities to Nursing Facilities - Effective March 1, 2014
- Jun 25, 2014: Composition of Pre-Admission Screenings for Teams
- January 9, 2015 and April 17, 2015 regarding implementation of the automated electronic pre-admission Screening (ePAS process and VDH and VDSS contact information can be found on the DMAS Medicaid web portal, under *Provider Services/ Medicaid Memos to Providers* at:

  https://www.virginiamedicaid.dmas.virginia.gov/wps/portal.

- Oct 12, 2017: Enhancements to Long-Term Services and Supports (LTSS) Electronic Screening System (eMLS)
- Sep 26, 2018: Final Regulations Pertaining to Medicaid Long-Term Services and Support Screenings - Effective November 1, 2018
- Nov 19, 2018: Preadmission Screening and Resident Review Process
- Apr 12, 2019: Mandatory Training for Screeners for Long-Term Services and Supports (LTSS) Screening
- Apr 12, 2019: Screening Prior to Nursing Facility Admission or No Medicaid Reimbursement and Implementation of Verification of Screening- Effective July 1, 2019
- Jun 11, 2019: Clarification to Mandatory Training for Screeners for Long-Term Services and Supports (LTSS) Screening
- Nov 18, 2019: Mandatory Use of Electronic Portal for Submission of Long-Term Services and Supports (LTSS)
- January 8, 2020: Clarification of the Correction Process for Medicaid Long-Term Services and Supports Screenings

  January 9, 2020: Final Exempt Action Pertaining to Medicaid Long-Term Services and Supports Screening Removal of Three-Day Allowance After Hospital Discharge

May 19, 2020: Availability of Physician Training for Medicaid LTSS

Attachment A: Crosswalk for Combination Determinations (PAS)

Behavior and Orientation are considered as a combination for service authorization. Please see the chart below that provides the combinations that determine whether or not an individual is independent (I), semi-dependent (d), or

dependent (D) in both behavior and orientation for the purposes of Screening for Medicaid-funded LTSS.

ORIENTATION PATTERN	BEHAVIOR PATTERN	Appropriate	Wandering/ Passive Less Than Weekly	Wandering/ Passive Weekly or More	Abusive/Aggressive/ Disruptive Less Than Weekly	Abusive/ Aggressive /Disruptive Weekly or More
	Oriented	**I**	**I**	**I**	**d**	**d**
	Disoriented: **Some** spheres **Some** of the time	**I**	**I**	**d**	**d**	**D**
	Disoriented: **Some** spheres **All** of the time	**I**	**I**	**d**	**d**	**D**
	Disoriented: **All** spheres **Some** of the time	**d**	**d**	**d**	**D**	**D**
	Disoriented: **All** spheres **All** of the time	**d**	**d**	**d**	**D**	**D**
	Comatose	**D**	**D**	**D**	**D**	**D**

Reminder: An individual must meet all criteria to meet NF LOC, i.e. the individual has limited functional capacity, medical or nursing needs, and is at imminent risk of NF placement within 30 days without services.

Attachment B: Worksheet to Determine Need for Medicaid-Funded LTSS (PAS)

The following worksheet is a helpful tool in determining if an individual, adult or child, meets NF LOC criteria.

Individual being assessed: _____ Date: __ _____

STEP 1: Based on a completed Virginia Uniform Assessment Instrument (UAI) - check how the individual scores in the following categories.

ADLs	Check If Independent (I)	Check if Semi-Dependent (d)	Check if Dependent (D)
Bathing			
Dressing			
Toileting			
Transferring			
Eating/Feeding			
Bowel			
Bladder			

STEP 2: Number of "Other" Dependencies

OTHER	Check If Independent (I)	Check If Semi-Dependent (d)	Check If Dependent (D)
Medication Administration			
Mobility			
Joint Motion			
Behavior Pattern & Orientation			

STEP 3: Apply the responses in Step 2 to the criteria below.

To be considered to meet the functional capacity requirements for NF level of care an individual **must meet the minimum requirements of one of the following three categories.**

CATEGORY 1: Individuals must meet items #1 and #2 in category 1; plus either item #3 or #4.

1) Rated dependent in 2 or more ADLs: ___ *YES;*

PLUS

2) Rated semi-dependent **or** dependent in behavior pattern and orientation

(behavior pattern and orientation are rated jointly) ___ *YES;*

PLUS

3) Rated semi-dependent or dependent in joint motion ___ *YES;*

OR

4) Rated dependent in medication administration: ___ *YES.*

CATEGORY 2: Individuals must meet all items in this category.

1) Rated dependent in 5 to 7 ADLs: ___ *YES;*

PLUS

2) Rated dependent in mobility: ___ *YES.*

CATEGORY 3: Individuals must meet all items in this category.

1) Rated semi-dependent or dependent in 2 or more ADLS: ___ *YES:*

PLUS

[If individual are rated as DEPENDENT and/or SEMI-DEPENDENT (combination) in 2-7 ADLs it counts as a yes.]

2) Rated dependent in mobility: ___ *YES,*

PLUS

3) Rated dependent in behavior and orientation: ___ *YES.*

STEP 4: Individuals MUST have a medical or nursing need to meet criteria for LTSS.

This means:

1) the individual's medical condition requires observation and assessment to assure evaluation of needs due to an inability for self-observation or evaluation; OR

2) the individual has complex medical conditions that may be unstable or have the potential for instability; OR

3) the individual requires at least one ongoing medical or nursing service. (See the Screening for LTSS manual section for examples and additional explanation.)

Does individual does have medical nursing needs? ___ *YES*

If *YES (briefly describe):*

<u>STEP 5:</u> Determination of whether the individual meets criteria for long-term services and supports.

1. Individual meets at least one of the three categories in Step 3: ___ *YES*
2. Individual has medical or nursing needs as defined in Step 4: __ *YES*
3. Individual meets the definition of ''at risk" *for institutionalization within 30 days:* __*YES*

This individual meets NF LOC criteria (i.e., 1. 2. and 3. above are answered "YES"):

__ YES ***__ NO***

Assessor: _____ Date: _____

Billing Instructions (PAS)

Updated: 7/31/2015

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

Two major areas are covered in this chapter:

General Information - This section contains information about the timely filing of claims, claim inquiries, and supply procedures.

Billing Procedures - Instructions are provided on the completion of claim forms, submitting adjustment requests, and additional payment services.

Electronic Submission of Claims

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

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

EDI Coordinator

Virginia Medicaid Fiscal Agent

P.O. Box 26228

Richmond, Virginia 23260-6228

Phone: (866) 352-0766

Fax number: (888) 335-8460

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

Billing Instructions: Direct Data Entry

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

if claims were submitted by 5pm. DDE is provided at no cost to the provider.

Timely Filing

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: Billing Invoices (PAS)

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

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

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

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

Requests for Billing Materials (PP)

Paper versions of the Health Insurance Claim Form CMS-1500 (02-12) and CMS-1450 (UB-04) are available from the U.S. Government Bookstore at https://bookstore.gpo.gov/.

Providers may use the paper forms only if specifically requested to do so by DMAS. DMAS does not provide CMS-1500 and CMS-1450 (UB-04) forms.

Although not mandated by HIPAA, DMAS has opted to produce an Unsolicited 277

transaction to report information on pended claims.

Billing Procedures (Hospital)

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

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

Department of Medical Assistance Services

P.O. Box 27443

Richmond, Virginia 23261-7443

Or

Department of Medical Assistance Services

CMS Crossover

P. O. Box 27444

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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.

Reimbursement for Initial Pre-Admission Screenings (PAS)

A $100.00 fee per pre-admission screening will be paid to acute-care hospitals and private psychiatric hospitals. Local Screening Committees (composed of local health departments and local departments of social services) will be paid the federal share of their costs. For the local screening teams, the local health departments will receive an interim fee for each completed and approved screening. (Please reference the DMAS website for rate information at the following link: http://www.dmas.virginia.gov/pr-rate_setting.htm. The final reimbursement will be cost settled.

Reimbursement for local departments of social services will be based on costs allocated through the VDSS cost allocation plan (using a random moment sampling (RMS) process). Reimbursement represents compensation for all services rendered and completion of the forms required to authorize Medicaid payment for nursing facility placement or community-based long-term care waiver services.

Local screening teams will receive the remaining balance of the payments directly from their respective State Agencies.

Provider do not submit claims for initial assessments. DMAS creates and submits the claims for processing on the provider's behalf based on completed data entry of the initial assessment.

Payments for additional screenings (Level II) to determine mental illness, mental retardation/intellectual disability or substance abuse services occur depending upon the service authorization. For nursing facility placements; an interagency transfer of funds will occur quarterly. For home- and community-based-care waiver services, payment will occur at the time the completed pre-admission screening is processed and all other providers associated with the completion of the screening are reimbursed.

Each pre-admission screening package sent to the Department of Medical Assistance Services (DMAS) for reimbursement is reviewed for accuracy, completeness, and adherence to DMAS policies and procedures. An incomplete, illegible, or inaccurate package will not be processed for payment. Reimbursement will be made only for a screening which includes all the required forms that have been correctly completed and submitted to DMAS. The Pre-Admission Screening Missing Information form in Appendix D notes some of the errors that cause reimbursement denials or delays, or both, and return of incomplete or incorrect forms to the Screening Committee. Screening Committees are encouraged to review this form to assure that these errors are not repeated. Pre-admission screening forms must be submitted to DMAS within 30 days of the assessment date to assure prompt reimbursement. To expedite the reimbursement process for pre-admission screening, submit the pre-admission screening package with the contents in the following order:

DMAS-96; UAI;

DMAS-95 MI/MR Supplemental form

DMAS-95 MI/MR Level II form (for nursing facility placements) or the DMAS-101B for waiver placements (if applicable);

DMAS-97);

No additional reimbursement will be paid for updating the assessment during the same pre- admission screening process. For example, if an individual is in an acute-care hospital and a nursing facility pre-admission screening is required, the hospital will be reimbursed for only one pre-admission screening per hospital admission. There will be no reimbursement for screenings received by DMAS 12 months or more after the date of the completion of the screening.

Screenings are considered valid for the following time frames:

Zero to Six Months: Screenings are valid and do not require updates;

Month Six to Month Twelve: Screening updates are required; and no additional reimbursement is made by DMAS;

Over 12 Months: A new screening is required and additional reimbursement is made by DMAS.

Reimbursement for Assisted Living Facility (ALF) Reassessments (PAS)

There are two types of Medicaid-funded reassessments for residents in ALFs:

1. Short reassessment for residential assisted living;
2. Long reassessment for regular assisted living.

DMAS will reimburse pre-admission screening providers for the completion of the required annual reassessments for assisted living services.

The provider must complete a CMS-1500 (instructions follow within the Chapter) to receive reimbursement for reassessments. Reassessments are the only assessments that require provider submit actual claim forms for processing.

The reimbursement rates are as follows:

1. Short reassessments are paid at $25.00 per assessment;
2. Long reassessments are paid at $75.00 per assessment.

The CPT/HCPCS procedure code (Locator 24D) on the CMS-1500 invoice to bill DMAS for short reassessments is S0220.

The CPT/HCPCS procedure code (Locator 24D) on the CMS-1500 invoice to bill DMAS for long reassessments is S0220 U1.

Reimbursement for Assisted Living Facility (ALF) Targeted Case Management Services (PAS)

There are two types of Medicaid-funded case management services for Auxiliary Grant residents in ALFs:

1. Twelve-month reassessment only; or
2. Ongoing targeted ALF case management.

Most of the Auxiliary Grant residents of ALFs will only need the required twelve-month reassessment. Ongoing Medicaid-Funded Targeted ALF Case Management is a

service provided to those Auxiliary Grant residents who are receiving residential or assisted living services and who:

1. Require coordination of multiple services, or have some problem which must be addressed to ensure the resident's health and welfare, or both; and
2. Are not able and do not have other support available to assist in coordination of and access to services or problem resolution; and
3. Need a level of coordination that is beyond what the ALF can reasonably be expected to provide.

The assessor must authorize and arrange for case management services through a qualified case manager if such services are determined to be needed. It is the responsibility of the ALF to determine whether or not they (ALF) are capable of providing the required coordination of services. Based upon information obtained from staff of the ALF where an individual may be placed, the entity completing the initial and/or 12 month reassessment must determine whether the ALF can meet the care needs and whether ongoing case management is needed. The individual selects a case management agency of his or her choice in the area where he or she will reside.

The CPT/HCPCS procedure code (Locator 24D) on the CMS-1500 invoice to bill DMAS for targeted case management services is T2022. These services may only be billed once per quarter per member.

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.