



Plan First

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# Plan First

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# Plan First

## General Information

Updated: 2/22/2019

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

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

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

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

## Program Background

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

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 Originally enacted by the Social Security amendments of 1965 (Public Law 89-97), Title XIX was approved on July 30, 1965.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

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

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

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

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

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

## **General Scope of the Program**

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

### Covered Services

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

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

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

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

- Health education
  
- Home health services
  
- Eyeglasses for all members younger than 21 years of age according to medical necessity
  
- Hearing services
  
- Inpatient psychiatric services for members under age 21
  
- Environmental investigations to determine the source of lead contamination for children with elevated blood lead levels
  
- Other medically necessary diagnostic and treatment services identified in an EPSDT screening exam, not limited to those covered services included above
  
- Skilled nursing facilities for persons under 21 years of age
  
- Transplant procedures as defined in the section “transplant services”
  
- All states are required to offer EPSDT to all Medicaid-eligible individuals under age 21 to determine any physical and mental defects that they may have and to provide health care, treatment, and other measures to correct or ameliorate the defects or chronic conditions discovered. The services available under EPSDT are not limited to those available in the Medicaid State Plan for Medical Assistance. Services requiring preauthorization under the State Plan for Medical Assistance will continue to require pre-authorization. DMAS reserves the right to utilize medical necessity



criteria for non-State Plan services under EPSDT.

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

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

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

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

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

- Laboratory and radiograph services
  
- Legend and Non-legend drugs are covered with some limitations or exclusions. (See the Pharmacy Manual for specific limitations and requirements)
  
- Mental health, with limitations, covered under mental health and intellectual disability community services listed below:
  - Mental Health:
    - Crisis stabilization
    - Mental health support
    - Assertive community treatment
    - Intensive in-home services for children and adolescents
    - Therapeutic day treatment for children and adolescents
    - Partial hospitalization Program
    - Intensive Outpatient Program
    - Psychosocial rehabilitation
    - Crisis intervention
    - Case management
  
  - Substance Use Disorder:
    - Residential treatment for pregnant and postpartum women
    - Day treatment for pregnant and postpartum women
    - Crisis Intervention
    - Intensive Outpatient
    - Day Treatment
    - Case Management
    - Opioid Treatment

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

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

Adult (Medicaid Expansion) covered group.

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

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

- Transportation services related to medical care
- Treatment Foster Care Case Management

### General Exclusions

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

Examples of such non-covered services are as follows:

- Abortions, except when the life or health of the mother is substantially endangered
- Acupuncture
- Artificial insemination or in vitro fertilization
- Autopsy examinations
- Cosmetic surgery

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



services which are unrelated to patient care

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

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

## **MEMBER COPAYS**

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

## **Managed Care Programs**

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

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

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

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

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

### Managed Care Enrollment Broker (Maximus)

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

- **Medallion 4.0**

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

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

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

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

- **CCC Plus**

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

### MCO Provider Reimbursement

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

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

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

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

### Eligibility and MCO Enrollment Verification

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

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

## Continuity of Care

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

- The Member's MCO shall assume responsibility for all managed care contract covered services authorized by either the Department or a previous MCO, which are rendered after the MCO enrollment effective date, in the absence of a written agreement otherwise. For on-going services, such as home health, outpatient mental health, and outpatient rehabilitation therapies, etc., the member's MCO shall continue authorized services without interruption until the Contractor completes its utilization review process to determine medical necessity of continued services or to transition services to a network provider;
- DMAS shall assume responsibility for all covered services authorized by the member's previous MCO which are rendered after the effective date of dis-enrollment to the fee-for-service system, if the member otherwise remains eligible for the service(s), and if the provider is a Medicaid provider;
- If the prior authorized service is an inpatient stay, the claim should be handled as follows:
  - o If the provider contracts with the MCO under a per diem payment methodology, the financial responsibility shall be allocated between the member's current MCO and either DMAS or the new MCO. In the absence of a written agreement otherwise, the member's current MCO and DMAS or the new MCO shall each pay for the period during which the member is enrolled with the entity.
  - o If the provider contracts with the MCO under a DRG payment methodology, the MCO is responsible for the full inpatient hospitalization from admission to discharge, including any outlier charges.
- If services have been authorized using a provider who is out of network, the member's MCO may elect to reauthorize (but not deny) those services using an in-network provider.

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

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

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

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

### FAMIS Covered Services

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

The following services are covered for FAMIS enrollees:

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



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



physician's office, or outpatient hospital department

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

### Member Copays

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

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

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

\*Other co-payments may apply to other services.

### **EMERGENCY MEDICAID SERVICES FOR ALIENS**

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

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

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

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

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

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

### **Client Medical Management (CMM)**

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

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

Providers may refer Medicaid patients suspected of inappropriately using or abusing

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

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

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

Written referrals should be mailed to:

Lead Analyst, Recipient Monitoring Unit

Division of Program Integrity

Department of Medical Assistance Services

600 East Broad Street, Suite 1300

Richmond, Virginia 23219

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

## **Sources of Information**

### MediCall Automated Voice Response System

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

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

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

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

#### Automated Response System (ARS)

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

#### HELPLINE

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

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

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

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

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

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

## **ELECTRONIC FILING REQUIREMENTS**

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

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

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

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

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

## **Provider Manual Updates**

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

## **Notice of Provider Responsibility**

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

## **THE VIRGINIA MEDICAL ASSISTANCE MEDICALL SYSTEM**

### **GENERAL INFORMATION**

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

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

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

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



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

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

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

The telephone numbers are:

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

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

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

## **HOW TO USE THE SYSTEM**

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

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

- 10 digit National Provider Identifier (NPI) or Atypical Provider Identifier (API)
- Member Medicaid Number (12 digits) or Social Security Number (9 digits) **and**  
Date of Birth (8 digits) in month, day, century and year format (mmddyyyy)  
(necessary for member eligibility verification and claims status)
- From and Thru Date(s) of Service in month, day, century and year format (mmddyyyy) (necessary for member eligibility verification and claims status). The caller will have the following limits when entering dates of service:
  - The caller does not have to enter a **Thru** date of service if services were rendered on a single day. Pressing the # key prompts the system to continue.
  - Future month information is only available in the last week of the current month.
  - Inquiries cannot be on dates of service more than one year prior to the date of inquiry.

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

- Press "1" for member eligibility verification.



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

## **MEMBER ELIGIBILITY VERIFICATION**

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

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

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

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

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

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

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

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

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

## **PROVIDER CHECK LOG**

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

## CLAIMS STATUS

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

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

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

## **SERVICE AUTHORIZATION INFORMATION**

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

## **SERVICE LIMITS INFORMATION**

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

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

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

## **PRESCRIBING PROVIDER ID**

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



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

## The Automated Response System (ARS)

### GENERAL INFORMATION

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

The ARS can be accessed through the Virginia Medicaid Web portal at [www.virginiamedicaid.dmas.virginia.gov](http://www.virginiamedicaid.dmas.virginia.gov). Please visit the portal for information on registration and use of the ARS.

### CITY/COUNTY CODES

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

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

### COUNTIES

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

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

CITIES

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

976 Central  
Processing  
Unit for  
FAMIS

## **STATE MENTAL HEALTH FACILITIES**

- 983 Southern Virginia Mental Health Institute
- 985. Southeastern State Hospital
- 986. Northern Virginia Training Center
- 987. Virginia Treatment Center
- 988. Northern Virginia Mental Health Institute
- 990. Central Virginia Training Center
- 991. Western State Hospital
- 992. Southwestern State Hospital
- 993. Piedmont State Hospital
- 994. Eastern State Hospital
- 996. Hiram Davis Hospital
- 997. Catawba State Hospital

## **CLIENT MEDICAL MANAGEMENT INTRODUCTION**

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

## **MEMBER RESTRICTION**

### Utilization Review and Case Management

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

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

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

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

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

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

□

### Member Enrollment Procedures

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



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

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

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

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

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

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

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

### Designated Primary Care Physicians (PCP)

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

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

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

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

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

### Designated Pharmacies

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

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

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

### Changing Designated CMM Providers

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

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

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

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

### **A PCP No Longer in Practice**

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

### Covered Services and Limitations

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

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

### Physician Services

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

- In a medical emergency situation in which a delay in the treatment may cause death or result in lasting injury or harm to the member.
- On written referral from the PCP using the Practitioner Referral Form (DMAS-70). This also applies to covering physicians who have not been affiliated with the PCP.

- When they are a part of a CMM provider affiliation group that includes the PCP.
- For other services covered by DMAS which are excluded from the Client Medical Management Program requirements.

### Services Excluded from PCP Referral

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

Covered services that do not need a referral include:

- Early and Periodic Screening, Diagnosis, and Treatment Program (EPSDT) wellchild exams and screenings (members under age 21);
- Immunizations (member under age 21);
- Family planning services;
- Expanded prenatal services, including prenatal group education, nutrition services, and homemaker services for pregnant women and care coordination for high-risk pregnant women and infants;
- Dental services (members under age 21);

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

- School-based services.

## **CMM Provider Affiliation Groups**

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

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

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

## **Emergency Room Services**

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

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

CMM also requires a PCP referral form for:

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

### **Emergency Pharmacy Services**

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

### Provider Reimbursement and Billing Instructions

### **Management Fees**

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



## **PCP and Designated Pharmacy Providers**

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

## **Affiliated Providers**

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

## **Referral Providers**

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

## **Physicians Billing Emergency Room Services**

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

## **Facilities Billing Emergency Room Services with a Referral**

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

## **Non-designated Pharmacy Providers**

When billing on the Pharmacy Claim Form or as a Point-Of-Sale (POS) provider, enter code "03" in the "Level of Service" field to indicate emergency.

## **REFERRALS TO THE CLIENT MEDICAL MANAGEMENT PROGRAM**

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

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

Lead Analyst, Recipient Monitoring Unit

Division of Program Integrity

Department of Medical Assistance Services

600 East Broad Street, Suite 1300

Richmond, Virginia 23219

Telephone: (804) 786-6548

CMM Helpline: 1-888-323-0589

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

## **PROVIDER RESTRICTION**

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

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

## **Provider Participation Requirements (Plan First)**

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](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](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](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](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.viriniamedicaid.dmas.virginia.gov](http://www.viriniamedicaid.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 (Plan First)**

A participating provider is a person who has a current, signed participation agreement with the Department of Medical Assistance Services (DMAS). Only those providers who have a signed agreement with DMAS are able to receive reimbursement for providing covered services to Plan First members. Providers can be, but not necessarily limited to DMAS enrolled Ambulatory Surgical Centers, Federally Qualified Health Centers, Health Departments, Rural Health Clinics, hospitals,

physicians, nurse practitioners, physician assistants, independent laboratories and pharmacies.

## **Provider Enrollment (Plan First)**

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

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

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 Plan First 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](http://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](http://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 (Plan First)**

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

- Immediately notify Xerox - Provider Enrollment Services Unit, in writing, of any change in the information which the provider previously submitted to Xerox - Provider Enrollment Services Unit.
- 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.
- Ensure the recipient's freedom to reject medical care and treatment.
- Comply with Title VI of the Civil Rights Act of 1964, as amended (42 U.S.C. §2000d through 2000d-4a), which requires that no person be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance on the ground of race, color, or national origin.
- Provide services, goods, and supplies to recipients in full compliance with the requirements of the Rehabilitation Act of 1973, as amended (29 U.S.C. §794), which states that no otherwise qualified individual with a disability shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance. The Act requires reasonable accommodations for certain persons with disabilities.
- Provide services and supplies to recipients of the same quality and in the same mode of delivery as provided to the general public.
- Accept Medicaid payment from the first day of eligibility if the provider was aware that application for Medicaid eligibility was pending at the time that services began.
- Accept as payment in full the amount established by DMAS to be reasonable cost or maximum allowable charge. 42 CFR §447.15 provides that a "State Plan must provide that the Medicaid agency must limit participation in the Medicaid Program to providers who accept, as payment in full, the amount paid by the agency." A provider may not bill a recipient for a covered service regardless of whether the provider received payment from the state. The provider may not seek to collect from a Medicaid recipient, or any financially responsible relative or representative of that recipient, any amount that exceeds the established Medicaid allowance for the service rendered. The provider may not charge DMAS or the recipient for broken or missed appointments.



- Accept assignment of Medicare benefits for eligible Medicaid recipients.
- Use Program-designated billing forms for submission of charges.
- Maintain and retain business and professional records sufficient to document fully and accurately the nature, scope, and details of the health care provided. In general, such records must be retained for a period of not less than five years from the date of service or as provided by applicable state laws, whichever period is longer. However, if an audit is initiated within the required retention period, the records must be retained until the audit is completed and every exception resolved. (Refer to the section regarding documentation for medical records.)
- Furnish to authorized state and federal personnel, in the form and manner requested, access to records and facilities.
- Disclose, as requested by the Program, 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.
- Hold confidential and use for authorized Program 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 Identify Excluded Individuals and Entities**

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

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

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

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

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

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

DMAS

Attn: Program Integrity/Exclusions

600 E. Broad St, Ste 1300

Richmond, VA 23219

-or-

E-mailed to: [providerexclusions@dmas.virginia.gov](mailto:providerexclusions@dmas.virginia.gov)

## **Requirements of Section 504 of the Rehabilitation Act (NF)**

Section 504 of the Rehabilitation Act of 1973, as amended, (29 U.S.C. § 794) provides that no individual with a disability shall, solely by reason of the disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal assistance. Each Medicaid participating provider is responsible for making provisions for such disabled individuals in the provider's programs and activities.

As an agent of the federal government in the distribution of funds, DMAS is responsible for monitoring the compliance of individual providers. The provider's signature on the claim indicates compliance with the Rehabilitation Act.

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

## **Termination of Provider Participation (CMH)**

The participation agreement will be 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 of voluntary termination must be made to Xerox - Provider Enrollment Services Unit thirty (30) calendar days prior to the effective date.

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

Subsection 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 calendar days, notify the Department of this conviction and relinquish the agreement. Reinstatement will be contingent upon the provisions of State law.

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

## **Appeals of Adverse Actions**

### **Definitions:**

**Administrative Dismissal** - means:

- 1) A DMAS provider appeal dismissal that requires only the issuance of an informal appeal decision with appeal rights but does not require the submission of a case summary or any further informal appeal proceedings; or
- 2) The dismissal of a member appeal on various grounds, such as lack of a signed authorized representative form or the lack of a final adverse action from the MCO or other DMAS Contractor.

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

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

**Appeal** - means:

- 1) A member appeal is:
  - a. For members enrolled in an MCO, in accordance with 42 C.F.R. § 438.400, defined as a request for review of an MCO's internal appeal decision to uphold the MCO's adverse benefit determination. For members, an appeal may only be requested after exhaustion of the MCO's one-step internal appeal process. Member appeals to DMAS will be conducted in accordance with regulations at 42 C.F.R. §§ 431 Subpart E and 12 VAC 30-110-10 through 12 VAC 30-110-370; or
  - b. For members receiving FFS services, defined as a request for review of a DMAS adverse action or DMAS Contractor's decision to uphold the Contractor's adverse action. If an internal appeal is required by the DMAS Contractor, an appeal to DMAS may only be requested after the Contractor's internal appeal process is exhausted. Member appeals to DMAS will be conducted in accordance with regulations at 42 C.F.R. §§ 431 Subpart E and 12 VAC 30-110-10 through 12 VAC 30-110-370; or
- 2) For services that have already been rendered, a provider appeal is:
  - a. A request made by an MCO's provider (in-network or out-of-network) to review the MCO's reconsideration decision in accordance with the statutes and regulations governing the Virginia Medicaid appeal process. After a provider exhausts the MCO's reconsideration process, Virginia Medicaid affords the provider the right to two administrative levels of appeal (informal appeal and formal appeal) in accordance with the Virginia Administrative Process Act at Code of Virginia § 2.2-4000 *et seq.* and Virginia Medicaid's provider appeal regulations at 12 VAC 30-20-500 *et seq.*; or
  - b. For FFS services, a request made by a provider to review DMAS' adverse action or the DMAS Contractor's reconsideration decision in accordance with the statutes and regulations governing the Virginia Medicaid appeal process. If an adverse action requires reconsideration before appealing to DMAS, the provider must exhaust the Contractor's reconsideration process, after which Virginia Medicaid affords the provider the right to two administrative levels of appeal (informal appeal and formal appeal) in accordance with the Virginia Administrative Process Act at Code of Virginia § 2.2-4000 *et seq.* and Virginia Medicaid's provider appeal regulations at 12 VAC 30-20-500 *et seq.*

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

**Reconsideration** - means a provider's request for review of an adverse action. The MCO's or DMAS

Contractor's reconsideration decision is a pre-requisite to a provider filing an appeal to the DMAS Appeals Division.

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

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

## **MEMBER APPEALS**

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

## **PROVIDER APPEALS**

### **Non-State Operated Provider**

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

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

Program Operations Division  
Department of Medical Assistance Services  
600 East Broad Street,  
Richmond, Virginia 23219

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

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

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

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

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

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

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

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

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

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

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

### Repayment of Identified Overpayments

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

### **State-Operated Provider**

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

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

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

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

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

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



## **Client Appeals**

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

## **Medicaid Program Information**

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

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

Virginia Medicaid - PES

PO Box 26803

Richmond, Virginia 23261-6803

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

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

## **Member Eligibility**

Updated: 2/22/2019

### **Determining Eligibility**

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

Inquiries from persons who wish to apply for medical assistance should be referred to the LDSS in the locality in which the applicant resides, to the Cover Virginia Call Center at 1-855-242-8282, or the Cover Virginia website at [www.CoverVA.org](http://www.CoverVA.org). DMAS will not pay providers for services, supplies, or equipment until the applicant's eligibility has been determined. (See "Assistance to Patients



Possibly Eligible for Benefits.") Once an applicant has been found eligible, coverage for Medicaid can be retroactive for up to three months before the month in which the application was filed. A member's eligibility must be reviewed when a change in the member's circumstances occurs, and all members are subject to an annual renewal (redetermination) of eligibility.

### Groups Covered by Medical Assistance

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

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

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

- Qualified Medicare Beneficiaries (QMBs) with income over 80% of the FPL but within 100% of the FPL. This group is eligible for **Medicaid coverage of Medicare premiums, deductibles, and coinsurance only.**
- Special Low-Income Medicare Beneficiaries (SLMB) with income less than 120% of the FPL. This group is eligible for Medicaid coverage of **Medicare Part B premiums only.**
- Qualified Individuals (QI) with income equal to or greater than 120% but less than 135% of the FPL. This group is eligible for Medicaid coverage of the **Medicare Part B premiums only.**
- Qualified Disabled and Working Individuals (QDWI) with income up to 200% of the FPL. This group is eligible for Medicaid payment of **Medicare Part A premiums only.**

- Plan First – any individual with income equal to or less than 200% of FPL. This group is eligible for limited Medicaid coverage of family planning services only and not covered for full Medicaid benefits. If a member does not wish to be enrolled in Plan First, he or she should contact the local DSS to be disenrolled.

### Medically Needy Covered Groups and Spenddown

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

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

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

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

### Emergency Medicaid Services for Aliens

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

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

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

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

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

#### Medicaid Eligibility for Institutionalized Individuals

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

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

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

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

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

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

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

### FAMIS Covered Services

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

The following services are covered for FAMIS enrollees:

- Abortion only if necessary to save the life of the mother
- Behavioral therapies including, but not limited to, applied behavior analysis;
  - Assistive technology
  - Blood lead testing
- Chiropractic with benefit limitations
- Clinic services (including health center services) and other ambulatory health care services
- Community Mental Health Rehabilitation Services (CMHRS) including:
  - Intensive in-home services
  - Therapeutic day treatment
- Mental health crisis intervention
- Case management for children at risk of (or with) serious emotional disturbance

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

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

### Member Copays

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

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

<b>SERVICE*</b>	<b>Co-pay Status 1</b>	<b>Co-pay Status 2</b>
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-for-services, 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:

<b>Code</b>	<b>Message</b>
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:

<b>Service*</b>	<b>Co-pay Status 1</b>	<b>Co-pay Status 2</b>
Outpatient Hospital or Doctor	\$2 per visit	\$5 per visit

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

\*Other co-payments may apply to other services.

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

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

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

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

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

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

contacting the primary care provider first for authorization.

### Managed Care Programs

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

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

- Medallion 3.0:  
<http://www.dmas.virginia.gov/#/med3>
- Medallion 4.0:  
<http://www.dmas.virginia.gov/#/med4>
- Commonwealth Coordinated Care Plus (CCC Plus):  
<http://www.dmas.virginia.gov/#/cccplus>
- Program of All-Inclusive Care for the Elderly (PACE):  
<http://www.dmas.virginia.gov/#/longtermprograms>

### Member Without an Eligibility Card

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

### Assistance to Patients Possibly Eligible for Benefits

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

## Medicaid Applications -- Authorized Representative Policy

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

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

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

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

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

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

designate an authorized representative.

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

## **Non-Medicaid Patient Relationship**

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

## **Newborn Infant Eligibility**

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

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

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





Plan First

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## **Appeals Division**

### **Department of Medical Assistance Services**

600 E. Broad Street, 6th Floor

Richmond, Virginia 23219

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

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

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

## **Covered Services and Limitations (Plan First)**

Updated: 8/3/2021

The Department of Medical Assistance Services (DMAS) administers the Medicaid fee-for-service limited benefit family planning program, **Plan First**. The purpose of Plan First is to prevent unintended pregnancies through coverage of family planning services for eligible men and women.

## **Eligibility and Enrollment (Plan First)**

Eligible individuals include men and women who meet the following criteria:

- Meet income requirements within 200 percent of the federal poverty level;
- Meet citizenship and identity requirements;
- Be a Virginia resident; and
- Not be eligible for a full-benefit Medicaid or FAMIS covered group.

Individuals must complete an application for Medical Assistance. The local department of social services (DSS) completes an eligibility determination and will only enroll individuals between the ages of 19 and 64 if they do not meet the criteria for full benefit medical assistance coverage. Those who are between ages 19 and 64 may opt out of Plan First enrollment. Those under age 19 or over age 64 must notify the eligibility worker of their interest to be evaluated for Plan First if they are not eligible for full benefit medical assistance coverage.

Individuals enrolled in Plan First are entitled to retroactive coverage of up to three months prior to the date the application was filed, if they meet all the requirements in the retroactive period. Individuals with other insurance coverage can be enrolled in Plan First; Medicaid is the payer of last resort.

Individuals who have had a hysterectomy or sterilization procedure will not be prohibited from enrolling in Plan First. Please note that even though sterilizations are a covered service through Plan First, most individuals who have had a sterilization procedure will not have the need to access family planning services. However, there are instances when back-up contraception and follow up visits are needed to ensure that the sterilization procedure was a success.

Note: Members of Plan First are excluded from enrollment in a managed care organization (MCO).

Effective March 1, 2016, members enrolled in Plan First will receive a green and white Plan First ID card in the mail. If the member has a blue and white Commonwealth of Virginia Medicaid ID card, that card is no longer valid. Individuals previously enrolled in a Medicaid or FAMIS MCO may not continue to use any previously issued MCO card and must use the green and white Plan First ID card.

### **Benefit and Coverage Limitations (Plan First)**

Plan First services are provided by enrolled DMAS (Medicaid) providers. DMAS currently reimburses enrolled providers for limited family planning services provided to eligible Plan First members. The services are reimbursed on a fee-for-service basis and are provided under the same administrative structure as Medicaid state plan benefits except with limited family planning covered services. Eligibility should always be verified prior to rendering services to any Medicaid member so the provider is aware of which program the member is enrolled.

The following services are covered under Plan First only when provided in accordance with the limitations and requirements specified.

Plan First covers **routine and periodic family planning office visits** including:

- Annual physical exams for family planning (birth control) purposes only, including exams for men and women;
- Cervical cancer screening for women;
- Laboratory services for family planning and Sexually Transmitted Infection (STI) testing;
- Family planning education and counseling;
- Sterilization procedures\*;
- Most Food and Drug Administration (FDA) approved birth control methods provided by a clinician or obtained with a prescription\*\* (such as contraceptive implants, ring, patch, IUDs, birth control pills, diaphragms, Depo Provera, and condoms); and
- Non-Emergency Transportation, if needed, which is limited to travel to and from a family planning service or pharmacy to obtain prescribed contraception. Please contact the Non-Emergency Medical Transportation Broker at 866-386-8331 to set up transportation or gas reimbursement to Plan First appointments.
- COVID-19 vaccines

\*A completed sterilization consent form, in accordance with the requirements of 42 CFR Part 441, Subpart F, must be submitted with all claims for payment for sterilization procedures. See section on sterilization requirements in Chapter IV of the Physician/Practitioner Medicaid Provider Manual.

\*\*Please refer to the DMAS Pharmacy Provider manual for specific coverage of DMAS fee-for-service pharmaceuticals, including supply limits and the Preferred Drug List (PDL).

If the Plan First member needs follow up care or treatment services pursuant to a family planning visit or any other medically necessary service not covered through Plan First, the Plan First provider may initiate a referral to a primary care provider. Note: The Plan First member will not have Medicaid coverage for services not listed on the approved billing code list available online at <https://www.dmas.virginia.gov/for-providers/plan-first/> under Plan First - Family Planning Services Program.

Family planning office visits require the establishment of medical records, an in-depth evaluation of an individual including a complete physical exam, establishment of baseline laboratory data, contraceptive and sexually transmitted infection prevention counseling, and issuance of supplies or prescription. Counseling in the family planning setting is interactive and includes education.

Family planning office visits are generally performed annually; however, may be more frequent depending on the method of contraception (e.g. Depo-Provera injections, either intramuscular every 11 to 13 weeks, or subcutaneously every 11 to 14 weeks). Laboratory tests are generally performed or recommended during an initial family planning visit and may be processed by an outside laboratory as needed as long as the claim for the outside lab includes the approved Plan First ICD diagnosis code. Additional screening tests are often performed depending on the method of contraception desired and the protocol established by the clinic, program or provider. Subsequent routine/periodic family planning visits generally include a cervical cancer screening and other screening laboratory tests depending on the method of contraception and the established protocol.

### COVID-19 Vaccines

In accordance with the American Rescue Plan Act of 2021, COVID-19 vaccines and vaccine

administration fees will be covered for Plan First members until the last day of the first calendar quarter that begins one year after the end of the federal public health emergency.

### Service Limits

DMAS will only reimburse for service and supply codes approved for coverage through Plan First. The service and supply codes must be accompanied with an approved Plan First ICD diagnosis code. Please visit <https://www.dmas.virginia.gov/for-providers/plan-first> for a list of approved codes and specific billing information for Plan First.

Services must be performed in an office or clinic setting, except for sterilization procedures which can be covered in an outpatient or inpatient setting. (Setting limitations do not apply to COVID-19 vaccines.)

### Services Not Covered

- Treatment for medical problems (including STIs or other reproductive health problem);
- Non-family planning prescription drugs;
- Performance of, counseling for, or recommendations of abortions;
- Infertility treatments;
- Performance of a hysterectomy or partial hysterectomy;
- Medical services outside scope of pregnancy prevention;
- Repeat cervical cancer screens or diagnostic tests/exams due to abnormal results or Pap tests for women who do not need birth control;
- Mammograms;
- Vaccinations (except for COVID-19 vaccines, as discussed above);
- Exams for women/men who no longer need or want pregnancy prevention services;
- Emergency transportation or ambulance coverage – ground or air; and Medical complications resulting from a family planning, contraception or sterilization service are not reimbursable under Plan First. Examples of such complications would be a perforated uterus or overwhelming uterine infection due to an intrauterine device or severe menstrual bleeding caused by an implant or contraceptive injection requiring a dilation and curettage.

Even though sterilizations are a covered service through Plan First, most individuals who have had a sterilization procedure will no longer need to access family planning services. However, Plan First will cover back-up contraception and follow-up visits until the member can confirm with their provider the sterilization procedure was a success.

Plan First does not cover primary care services, such as a diagnostic test/exam needed after an abnormal cervical cancer screening test. Providers for Plan First should refer members to seek appropriate follow up care from a primary care provider or Federal Qualified Health Center (FQHC). A list of community health centers to which members may be referred for treatment of conditions and services not covered through Plan First can be found through the Health Resources and Services Administration website: <http://findahealthcenter.hrsa.gov>. These clinics provide services on a sliding payment scale.

## **Contraceptive Medications**

### Pharmacy Point of Sale Transactions

DMAS covers prescription contraceptives for a maximum 34-day supply of medication per prescription per member in accordance with the prescriber's orders and subject to Board of Pharmacy regulations and the DMAS Pharmacy Preferred Drug List (PDL). For prescription orders whose quantity exceeds a

34-day supply, refills may be dispensed in sufficient quantity to fulfill the prescription order within the limits of federal and state laws and regulations. Other medications will not be covered for members who are in Plan First. Plan First utilizes the same policy of contraceptive coverage as fee-for-service Medicaid. Please refer to the DMAS Pharmacy Provider Manual for additional information. A copy of the Pharmacy Provider Manual is available on the DMAS website at [www.virginiamedicaid.dmas.virginia.gov](http://www.virginiamedicaid.dmas.virginia.gov), under Provider Services. Please note that there are specific National Drug Codes (NDCs) which are covered through point of sale pharmacy and may change on a regular basis. For more information about Medicaid covered NDCs please follow up with a local pharmacist.

### Physician Administered Medications

For contraceptive injections or other contraceptives that need more than a maximum of a 34-day supply and are administered in an office or outpatient setting, the physician must purchase the device and should use the Healthcare Common Procedure Coding System (HCPCS) code for these types of contraceptives when submitting the claim on a CMS-1500 form so that the drug can be covered by Plan First. DMAS will reimburse the provider their actual invoice cost for the contraception. Please note that any prescribed FDA approved contraception may be covered through Plan First when billing the appropriate HCPCS code and dispensed by a clinician.

## **Sterilizations**

Providers must follow the guidelines for sterilizations as detailed in Chapter IV, “Covered Services and Limitations”, of the DMAS Physician/Practitioner Provider Manual. The “Sterilization” section of this chapter contains information on the conditions for coverage, informed consent process, the sterilization consent document and instructions for completion and claims information. A copy of the manual is located on the DMAS website at [www.virginiamedicaid.dmas.virginia.gov](http://www.virginiamedicaid.dmas.virginia.gov).

## **Community Resources and Referrals**

### Primary Care Services

At a minimum, the primary family planning office visit will include oral counseling to the Plan First member addressing how he or she may access primary care services, as well as information on how to locate medical providers. This may be provided to the member via the Plan First program brochure which is available on the DMAS website at [www.planfirst.org](http://www.planfirst.org).

### Community Health Centers

Community Health Centers (CHCs) are nonprofit organizations located in medically underserved areas that provide comprehensive primary health care to anyone seeking care. In addition to treating individual members, a health center emphasizes health promotion and disease prevention for entire communities. A CHC does not deny anyone primary health care services - all community residents

have equal access regardless of ability to pay, geographic location, culture, age, sex, or religion. As Federally Qualified Health Centers (FQHC), CHCs provide a wide range of services to their members. Among the core services are:

- Physician care
- X-Ray services
- Laboratory services
- Preventive services (mammography, well-child, etc.)
- Immunizations
- Transportation for health services
- Case management
- Specialty referrals

Area clinics may be located through the Health Resources and Services Administration website at: <http://findahealthcenter.hrsa.gov>.

### Every Woman's Life

Plan First provides an annual family planning physical exam, cervical cancer screening test, lab services, contraceptives and family planning education and counseling services to women through the family planning office visit. Women with an abnormal cervical cancer screening test or breast exam do not have follow up coverage through Plan First. These women should be referred to a provider, such as the Every Woman's Life (EWL) program for further testing. Women eligible for the EWL program must be age 18 to 64, under-or uninsured, have an income at or less than 200% of the Federal Poverty Level, and reside in Virginia. Women enrolled in EWL and diagnosed with breast and cervical cancer (including pre-cancerous conditions) and certified as needing treatment may be eligible for payment of medical services under the Breast and Cervical Cancer Prevention and Treatment Act (BCCPTA). EWL staff will refer these cases to their local Department of Social Services for a Medicaid eligibility determination. Women enrolled in the BCCPTA, a full coverage Medicaid program, will be disenrolled from Plan First. Once cancer treatment is completed and the woman is no longer eligible for services under the BCCPTA; the woman must apply for Plan First coverage to be reenrolled in the Plan First program. Women diagnosed with cancer by a provider who is not operating under the EWL program are not eligible for the BCCPTA.

If you have questions about EWL, or would like to make a referral, call the Virginia Department of Health's EWL toll-free line at 1-866-395-4968.

### Virginia Department of Health Family Planning Clinics

The Virginia Family Planning Program provides women and men with the ability to decide if they want to have children and if so, how many and how far apart they want to space them. The Family Planning Clinics provide a broad range of acceptable and effective family planning birth control methods and services. All services are confidential. The Family Planning Clinics are providers for Plan

First and may also offer additional services which are affordable and provided at low or no cost based on an individual's income. A Family Planning Clinic is available in every city and county health department in the state. For more information about Family Planning Clinics or to locate a local clinic, please visit the Virginia Department of Health website at <http://www.vdh.virginia.gov/lhd>.

## **Documentation Requirements (Plan First)**

The provider agreement requires that the medical records fully disclose the extent of services provided to members. Medical records must clearly document the medical necessity for covered services. This documentation must be written at the time the service is rendered and must be legible and clear in the description of the services rendered. Individual providers must follow documentation requirements as outlined in the appropriate DMAS Provider Manual for the provider's profession (i.e., Physicians must follow the documentation requirements outlined in the DMAS Physician/Practitioner Provider Manual, laboratory providers must follow the documentation requirements outlined in the DMAS Independent Laboratory Provider Manual, etc.).

## **Billing Instructions (Plan First)**

Updated: 3/1/2016

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

Three major areas are covered in this chapter:

**General Information** - This section contains information about the timely filing of claims, claim inquiries, and supply procedures.

**General Billing Procedures** - Instructions are provided on the completion of claim forms, submitting adjustment requests, and additional payment services.

**Specific Information and Billing Procedures for Plan First** - This section contains specific information about approved codes and filing claims for services for Plan First members.

## **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:





Plan First

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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](mailto: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](http://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 (Plan First)**

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

**Retroactive Eligibility** - Medicaid eligibility can begin as early as the first day of the third month prior to the month of application for benefits. All eligibility requirements must be met within that time period. Unpaid bills for that period can be billed to Medicaid the same as for any other service. If the



enrollment is not accomplished in a timely way, billing will be handled in the same manner as for delayed eligibility.

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

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

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

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

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

**Other Insurance** - The member can keep private health insurance and still be covered by Medicaid or FAMIS Plus. The other insurance plan pays first. Having other health insurance does not change the co-payment amount that providers can collect from a Medicaid member. For members with a Medicare supplemental policy, the policy can be suspended with Medicaid coverage for up to 24

months while the member has Medicaid without penalty from their insurance company. The members must notify the insurance company. The member must notify the insurance company within 90 days of the end of Medicaid coverage to reinstate the supplemental insurance.

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

#### Use of Rubber Stamps for Physician Documentation

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

### **Billing Invoices (Plan First)**

The requirements for submission of physician billing information and the use of the appropriate claim form or billing invoice are dependent upon the type of service being rendered by the provider and/or the billing transaction being completed. Providers must use the Health Insurance Claim Form, CMS-1500 (02-12), as the billing invoice.

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.

The submitter of this form understands that misrepresentation or falsification of essential information as requested by this form may serve as the basis for civil monetary penalties and assessments and may upon conviction include fines and/or imprisonment under federal and/or state law(s).

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.

### **REMITTANCE VOUCHER (PAYMENT VOUCHER)**

DMAS sends a check and remittance voucher with each weekly payment made by the Virginia Medical Assistance Program. The remittance voucher is a record of approved, pended, denied,

adjusted, or voided claims and should be kept in a permanent file for five (5) years.

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

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

### **General Billing Procedures (Plan First)**

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

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

Department of Medical Assistance Services

P.O. Box 27444



Plan First

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Richmond, Virginia 23261-7444

Or

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

## **Billing Instructions: Electronic Filing Requirements**

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

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

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

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

277 - Unsolicited Response (5010)

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

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

835 - Health Care Claim Payment/ Remittance (5010)

837 - Dental Health Care Claim or Encounter (5010)

837 - Institutional Health Care Claim or Encounter (5010)

837 - Professional Health Care Claim or Encounter (5010)

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

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

All 5010/D.0 Companion Guides are available on the web portal:

<https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/EDICompanionGuides> or contact EDI

Support at 1-866-352-0766 or Virginia.EDISupport@conduent.com.

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

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

## **Billing Instructions: ClaimCheck**

- Effective June 3, 2013, DMAS implemented the Medicaid National Correct Coding Initiative (NCCI) Procedure to Procedure (PTP) and Medically Unlikely Edits (MUE) edits. This implementation was in response to directives in the Affordable Care Act of 2010. These new edits will impact all Physicians, Laboratory, Radiology, Ambulatory Surgery Centers, and Durable Medical Equipment and Supply providers. Effective January 1, 2014, all outpatient hospital claims will be subject to the NCCI edits thru the EAPG claim processing. Please refer to the Hospital Manual, Chapter 5 for details related to EAPG. The NCCI/ClaimCheck edits are part of the daily claims adjudication cycle on a concurrent basis. The current claim will be processed to edit history claims. Any adjustments or denial of payments from the current or history claim(s) will be done during the daily adjudication cycle and reported on the providers weekly remittance cycle. All NCCI/ClaimCheck edits are based on the following global claim factors: same member, same servicing provider, same date of service or the date of service is within established pre- or post-operative time frame. All CPT and HCPCS code will be subject to both the NCCI and ClaimCheck edits. Upon review of the denial, the provider can re-submit a corrected claim. Any system edits related to timely filing, etc. are still applicable.
- **PTP Edits:**  
CMS has combined the Medicare Incidental and Mutually Exclusive edits into a new PTP category. The PTP edits define pairs of CPT/HCPCS codes that should not be reported together. The PTP codes utilize a column one listing of codes to a column two listing of codes. In the event a column one code is billed with a column two code, the column one code will pay, the column two code will deny. The only exception to the PTP is the application of an accepted Medicaid NCCI modifier. **Note:** Prior to this implementation, DMAS modified the CCI Mutually Exclusive edit to pay the procedure with the higher billed charge. This is no longer occurring, since CMS has indicated that the code in column one is to be paid regardless of charge.
- **MUE Edits:**  
DMAS implemented the Medicaid NCCI MUE edits. These edits define for each CPT/HCPCS code the maximum units of service that a provider would report under most circumstances for a single member on a single date of service and by same servicing provider. The MUEs apply to the number of units allowed for a specific procedure code, per day. If the claim units billed exceed the per day allowed, the claim will deny. With the implementation of the MUE edits, providers must bill any bilateral procedure correctly. The claim should be billed with one unit and the 50 modifier. The use of two units will subject the claim to the MUE, potentially

resulting in a denial of the claim. Unlike the current ClaimCheck edit which denies the claim and creates a claim for one unit, the Medicaid NCCI MUE edit will deny the entire claim.

- **Exempt Provider Types:**

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

- **Service Authorizations:**

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

- **Modifiers:**

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

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

## **Reconsideration**

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

Payment Processing Unit, Claim Check  
Division of Program Operations

Department of Medical Assistance Services  
 600 East Broad Street, Suite 1300  
 Richmond, Virginia 23219

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

**INSTRUCTIONS FOR USE OF THE CMS-1500 (02-12), BILLING FORM STARTING 04/01/2014 AND AFTER (PP)**

Providers typically use Direct Data Entry (DDE), however, the CMS-1500 (02-12) form must be used in those instances where DMAS has requested the use of the paper form. The following instructions have numbered items corresponding to fields on the CMS-1500 (02-12).

**SPECIAL NOTE:** The provider number in locator 24J must be the same in locator 33 unless the Group/Billing Provider relationship has been established and approved by DMAS for use.

<u>Locator</u>	<u>Instructions</u>
1	<b>REQUIRED</b> Enter an "X" in the <b>MEDICAID</b> box for the Medicaid Program. Enter an "X" in the <b>OTHER</b> box for <b>Temporary Detention Order (TDO)</b> or <b>Emergency Detention Order (EDO)</b> .
1a	<b>REQUIRED</b> <b>Insured's I.D. Number</b> - Enter the 12-digit Virginia Medicaid Identification number for the member receiving the service.
2	<b>REQUIRED</b> <b>Patient's Name</b> - Enter the name of the member receiving the service.
3	NOT REQUIRED Patient's Birth Date
4	NOT REQUIRED Insured's Name
5	NOT REQUIRED Patient's Address
6	NOT REQUIRED Patient Relationship to Insured
7	NOT REQUIRED Insured's Address
8	NOT REQUIRED Reserved for NUCC Use
9	NOT REQUIRED Other Insured's Name
9a	NOT REQUIRED Other Insured's Policy or Group Number
9b	NOT REQUIRED Reserved for NUCC Use
9c	NOT REQUIRED Reserved for NUCC Use



<b>Locator</b>		<b>Instructions</b>
9d	NOT REQUIRED	Insurance Plan Name or Program Name
<b>10</b>	<b>REQUIRED</b>	<b>Is Patient's Condition Related To:</b> - Enter an "X" in the appropriate box. a. Employment? b. Auto accident c. Other Accident? (This includes schools, stores, assaults, etc.) NOTE: The state postal code should be entered if known.
10d	Conditional	<b>Claim Codes (Designated by NUCC)</b> Enter "ATTACHMENT" if documents are attached to the claim form.
11	NOT REQUIRED	Insured's Policy Number or FECA Number
11a	NOT REQUIRED	Insured's Date of Birth
11b	NOT REQUIRED	Other Claim ID
<b>11c</b>	<b>REQUIRED If applicable</b>	<b>Insurance Plan or Program Name</b> Providers that are billing for non-Medicaid MCO copays only- please insert "HMO Copay".
<b>11d</b>	<b>REQUIRED If applicable</b>	<b>Is There Another Health Benefit Plan?</b> Providers should only check Yes, if there is other third party coverage.
12	NOT REQUIRED	Patient's or Authorized Person's Signature
13	NOT REQUIRED	Insured's or Authorized Person's Signature
<b>14</b>	<b>REQUIRED If Applicable</b>	<b>Date of Current Illness, Injury, or Pregnancy</b> <b>Enter date MM DD YY format</b> <b>Enter Qualifier 431 - Onset of Current Symptoms or Illness</b>
15	NOT REQUIRED	Other Date
16	NOT REQUIRED	Dates Patient Unable to Work in Current Occupation
<b>17</b>	<b>REQUIRED If applicable</b>	<b>Name of Referring Physician or Other Source -</b> Enter the name of the referring physician.
<b>17a</b> shaded red	<b>REQUIRED If applicable</b>	<b>I.D. Number of Referring Physician</b> - The qualifier 'ZZ' may be entered if the provider taxonomy code is needed to adjudicate the claim. Refer to the specific Medicaid Provider manual for special Billing Instructions for specific services.
<b>17b</b>	<b>REQUIRED If applicable</b>	<b>I.D. Number of Referring Physician</b> - Enter the National Provider Identifier of the referring physician.
18	NOT REQUIRED	Hospitalization Dates Related to Current Services
<b>19</b>	<b>REQUIRED If applicable</b>	<b>Additional Claim Information</b> Enter the CLIA #.
20	NOT REQUIRED	Outside Lab



<b>Locator</b>		<b>Instructions</b>
<b>21 A-L</b>	<b>REQUIRED</b>	<b>Diagnosis or Nature of Illness or Injury</b> - Enter the appropriate ICD diagnosis code, which describes the nature of the illness or injury for which the service was rendered in locator 24E. Note: Line 'A' field should be the Primary/Admitting diagnosis followed by the next highest level of specificity in lines B-L.
<b>22</b>	<b>REQUIRED If applicable</b>	<b>Resubmission Code - Original Reference Number.</b> Required for adjustment and void. See the instructions for Adjustment and Void Invoices.
<b>23</b>	<b>REQUIRED If applicable</b>	<b>Service Authorization (SA) Number</b> - Enter the PA number for approved services that require a service authorization.
<p><b>NOTE:</b> The locators 24A thru 24J have been divided into open areas and a shaded line area. <b>The shaded area is ONLY for supplemental information.</b> DMAS has given instructions for the supplemental information that is required when needed for DMAS claims processing. <b>ENTER REQUIRED INFORMATION ONLY.</b></p>		
<b>24A lines 1-6 open area</b>	<b>REQUIRED</b>	<b>Dates of Service</b> - Enter the from and thru dates in a 2-digit format for the month, day and year (e.g., 01/01/14). DATES MUST BE WITHIN THE SAME MONTH

<b>Locator</b>	<b>Instructions</b>
<b>24A lines 1-6 red shaded</b>	<p><b>REQUIRED If applicable</b></p> <p><b>DMAS requires the use of qualifier 'TPL'.</b> This qualifier is to be used whenever an actual payment is made by a third party payer. The 'TPL' qualifier is to be followed by the dollar/cents amount of the payment by the third party carriers. Example: Payment by other carrier is \$27.08; red shaded area would be filled as <b>TPL27.08</b>. No spaces between qualifier and dollars. No \$ symbol but the decimal between dollars and cents is required.</p> <p><b><u>DMAS requires the use of the qualifier 'N4'.</u></b>  <u>This qualifier is to be used for the National Drug Code (NDC) whenever a HCPCS drug related code is submitted in 24D to DMAS. No spaces between the qualifier and the NDC number.</u></p> <p><b>NOTE: The unit of measurement qualifier code is followed by the metric decimal quantity</b>  <b>Unit of Measurement Qualifier Codes:</b>  <b>F2 - International Units</b>  <b>GR - Gram</b>  <b>ML - Milliliter</b>  <b>UN - Unit</b></p> <p><b>Examples of NDC quantities for various dosage forms as follows:</b></p> <ul style="list-style-type: none"> <li>a. Tablets/Capsules - bill per UN</li> <li>b. Oral Liquids - bill per ML</li> <li>c. Reconstituted (or liquids) injections - bill per ML</li> <li>d. Non-reconstituted injections (I.E. vial of Rocephin powder) - bill as UN (1 vial = 1 unit)</li> <li>e. Creams, ointments, topical powders - bill per GR</li> <li>f. Inhalers - bill per GR</li> </ul> <p><b>BILLING EXAMPLES:</b></p> <p><b><u>TPL, NDC and UOM submitted:</u></b>  <b>TPL3.50N412345678901ML1.0</b></p> <p><b><u>NDC, UOM and TPL submitted:</u></b>  <b>N412345678901ML1.0TPL3.50</b></p> <p><b><u>NDC and UOM submitted only:</u></b>  <b>N412345678901ML1.0</b></p> <p><b><u>TPL submitted only:</u></b>  <b>TPL3.50</b></p> <p><b><u>Note: Enter only TPL, NDC and UOM information in the supplemental shaded area. (see billing examples)</u></b>  <b><u>All supplemental information is to be left justified.</u></b></p>

Locator	Instructions
	<p><b>SPECIAL NOTE:</b> DMAS will set the coordination of benefit code based on information supplied as followed:</p> <ul style="list-style-type: none"> <li>• If there is nothing indicated or 'NO' is checked in locator 11d, DMAS will set that the patient had no other third party carrier. This relates to the old coordination of benefit code 2.</li> <li>• If locator 11d is checked 'YES' and there is nothing in the locator 24a red shaded line; DMAS will set that the third party carrier was billed and made no payment. This relates to the old coordination of benefit code 5. <b>An EOB/documentation must be attached to the claim to verify nonpayment.</b></li> <li>• If locator 11d is checked 'YES' and there is the qualifier 'TPL' with payment amount (TPL15.50), DMAS will set that the third party carrier was billed and payment made of \$15.50. This relates to the old coordination of benefit code 3.</li> </ul>
24B open area	<p><b>REQUIRED</b> <b>Place of Service</b> - Enter the 2-digit CMS code, which describes where the services were rendered.</p>
24C open area	<p><b>REQUIRED</b> <b>Emergency Indicator</b> - Enter either 'Y' for YES or <b>If applicable</b> leave blank. <b>DMAS will not accept any other indicators for this locator.</b></p>
24D open area	<p><b>REQUIRED</b> <b>Procedures, Services or Supplies - CPT/HCPCS -</b> <b>ter HCPCS Code, which des</b> Enter the CPT/HCPCS code that describes the procedure rendered or the service provided.  <b>Modifier</b> - Enter the appropriate CPT/HCPCS modifiers if applicable.</p>
24E open area	<p><b>REQUIRED</b> <b>Diagnosis Code</b> - Enter the diagnosis code reference letter A-L (pointer) as shown in Locator 21 to relate the date of service and the procedure performed to the primary diagnosis. The primary diagnosis code reference letter for each service should be listed first. <b>NOTE: A maximum of 4 diagnosis code reference letter pointers should be entered.</b> Claims with values other than A-L in Locator 24-E or blank may be denied.</p>
24F open area	<p><b>REQUIRED</b> <b>Charges</b> - Enter your total usual and customary charges for the procedure/services.</p>
24G open area	<p><b>REQUIRED</b> <b>Days or Unit</b> - Enter the number of times the procedure, service, or item was provided during the service period.</p>
24H open area	<p><b>REQUIRED</b> <b>EPSDT or Family Planning</b> - Enter the appropriate <b>If applicable</b> indicator. Required only for EPSDT or family planning services.          1 - Early and Periodic, Screening, Diagnosis and Treatment Program Services          2 - Family Planning Service</p>
24I open	<p><b>REQUIRED</b> <b>NPI</b> - This is to identify that it is a NPI that is in locator 24J</p>

Locator		Instructions
24 I red-shaded	<b>REQUIRED If applicable</b>	<b>ID QUALIFIER</b> -The qualifier 'ZZ' is entered to identify the rendering provider taxonomy code.
24J open	<b>REQUIRED If applicable</b>	<b>Rendering provider ID#</b> - Enter the 10 digit NPI number for the provider that performed/rendered the care.
24J red-shaded	<b>REQUIRED If applicable</b>	<b>Rendering provider ID#</b> - The qualifier 'ZZ' is entered to identify the provider taxonomy code.
25	NOT REQUIRED	Federal Tax I.D. Number
26	<b>REQUIRED</b>	<b>Patient's Account Number</b> - Up to <b>FOURTEEN</b> alpha-numeric characters are acceptable.
27	NOT REQUIRED	Accept Assignment
28	<b>REQUIRED</b>	<b>Total Charge</b> - Enter the total charges for the services in 24F lines 1-6
29	<b>REQUIRED If applicable</b>	<b>Amount Paid - For personal care and waiver services only</b> - enter the patient pay amount that is due from the patient. <b>NOTE:</b> The patient pay amount is taken from services billed on 24A - line 1. If multiple services are provided on same date of service, then another form must be completed since only one line can be submitted if patient pay is to be considered in the processing of this service.
30	NOT REQUIRED	Rsvd for NUCC Use
31	<b>REQUIRED</b>	<b>Signature of Physician or Supplier Including Degrees or Credentials</b> - The provider or agent must sign and date the invoice in this block.
32	<b>REQUIRED If applicable</b>	<b>Service Facility Location Information</b> - Enter the name as first line, address as second line, city, state and 9 digit zip code as third line for the location where the services were rendered. <b>NOTE:</b> For physician with multiple office locations, the specific Zip code must reflect the office location where services given. Do NOT use commas, periods or other punctuations in the address. Enter space between city and state. Include the hyphen for the 9 digit zip code.
32a open	<b>REQUIRED If applicable</b>	<b>NPI #</b> - Enter the 10 digit NPI number of the service location.
32b red shaded	<b>REQUIRED If applicable</b>	<b>Other ID#:</b> - The qualifier of 'ZZ' is entered to identify the provider taxonomy code.

<b>Locator</b>		<b>Instructions</b>
<b>33</b>	<b>REQUIRED</b>	<b>Billing Provider Info and PH #</b> - Enter the billing name as first line, address as second line, city, state, and 9-digit zip code as third line. This locator is to identify the provider that is requesting to be paid. <b>NOTE: Do NOT</b> use commas, periods or other punctuations in the address. Enter space between city and state. Include the hyphen for the 9 digit zip code. The phone number is to be entered in the area to the right of the field title. Do not use hyphen or space as separator within the telephone number.
<b>33a open</b>	<b>REQUIRED</b>	<b>NPI</b> - Enter the 10 digit NPI number of the billing provider.
<b>33b red shaded</b>	<b>REQUIRED If applicable</b>	<b>Other Billing ID</b> - The qualifier 'ZZ' is entered to identify the provider taxonomy code. <b>NOTE: DO NOT</b> use commas, periods, space, hyphens or other punctuations between the qualifier and the number.

**Instructions for the Completion of the Health Insurance Claim Form, CMS-1500 (02-12), as an Adjustment Invoice**  
**The Adjustment Invoice is used to change information on an approved claim. Follow the instructions for the completion of the Health Insurance Claim Form, CMS-1500 (02-12), except for the locator indicated below.**

<b>Locator</b>	<b>Medicaid Resubmission</b>
<b>22</b>	<b>Code</b> - Enter the 4-digit code identifying the reason for the submission of the adjustment invoice.
	1023 Primary Carrier has made additional payment
	1024 Primary Carrier has denied payment
	1025 Accommodation charge correction
	1026 Patient payment amount changed
	1027 Correcting service periods
	1028 Correcting procedure/service code
	1029 Correcting diagnosis code
	1030 Correcting charges
	1031 Correcting units/visits/studies/procedures
	1032 IC reconsideration of allowance, documented
	1033 Correcting admitting, referring, prescribing, provider identification number

1053 Adjustment reason is in the Misc.  
Category

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

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

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

Mail all information to:

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

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

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

**Locator 22 Medicaid Resubmission**

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

1042	Original claim has multiple incorrect items
1044	Wrong provider identification number
1045	Wrong enrollee eligibility number
1046	Primary carrier has paid DMAS maximum allowance
1047	Duplicate payment was made
1048	Primary carrier has paid full charge
1051	Enrollee not my patient
1052	Miscellaneous
1060	Other insurance is available

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

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

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

Mail all information to:

Department of Medical Assistance Services

Attn: Fiscal & Procurement Division, Cashier

600 East Broad St. Suite 1300

Richmond, VA 23219

## **Billing Instructions: 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.

## **Special Billing Instructions For Plan First**

The Current Procedural Terminology (CPT) codes, the Healthcare Common Procedure Coding System (HCPCS) codes and the International Classification of Diseases(ICD) codes all listed in the “[DMAS Billing Procedures for Plan First and More](#)” (available online at [http://www.dmas.virginia.gov/Content\\_pgs/mch-home.aspx](http://www.dmas.virginia.gov/Content_pgs/mch-home.aspx)) are approved by the Centers for Medicare and Medicaid Services (CMS) to be covered by Plan First. These services are only covered by Plan First when accompanied by one of the approved Plan First ICD diagnosis codes identified on the claim form.

Follow up services to a family planning office visit or major complications of family planning services are not reimbursable under Plan First. Services provided that are not included on the list of approved codes specified in the “[DMAS Billing Procedures for Plan First and More](#)”, **will not be reimbursed**. Services provided that are included in the list, but not accompanied with an approved ICD diagnosis code in a diagnosis field, will not be reimbursed.

Please be aware that these services may be revised subsequent to CMS review of services. It will be the responsibility of the individual provider to adhere to the DMAS Memos. Upon CMS review of services, DMAS will modify its listing of covered services accordingly.



## **Health Departments (Family Planning Drugs and Supplies)**

### Family Planning Drugs and Devices

Health Departments must use the appropriate Healthcare Common Procedure Coding System (HCPCS) drug or supply code along with modifiers FP and U2 in Block 24-D of the CMS-1500 (02-12) claim form. Actual costs for the drugs and supplies should be reflected in the charges. DMAS will reimburse by the charged amount. Please note that the Health Departments will be required to follow the billing procedure for HCPCS J-codes noted in this chapter.

### **Invoice Processing (Plan First)**

The DMAS invoice processing system utilizes a sophisticated electronic system to process fee-for-service claims. Upon receipt, a claim is microfilmed, assigned a claim reference number, and entered into the system. The claim is then placed in one of the following categories:

Remittance Voucher (Payment Voucher) - DMAS sends a Remittance Voucher with each payment. This voucher lists the approved, pending, denied, adjusted, or voided claims and should be kept in the provider's permanent files. The first page of the voucher contains a space for special messages from DMAS. The sections of the Remittance Voucher are:

**Approved** - These are claims which have been approved and for which the provider is being reimbursed;

**Pending** - These claims are being reviewed. The final adjudication of this claim will be a later Remittance Voucher;

**Denied** - These claims are denied and are not reimbursable by DMAS as submitted (e.g., the submission of a duplicate claim of a previously-submitted claim);

**Debit** - This section lists any formerly paid claims which have been adjusted, thereby creating a positive balance;

**Credit** - This section lists any formerly paid claims which have been either adjusted or voided and have created a negative balance; and

**Provider Number** - The nine-digit Medicaid Provider or NPI identification number assigned to the individual provider. Include this number in all correspondence with DMAS.

**Rejects** - These claims cannot be processed for some reason. Rejected claims are returned to the provider with an explanation letter attached. Resubmit these claims on a new invoice with corrected data.

**No Response** - If one of the above responses has not been received within 30 days, the provider should assume non-delivery and rebill using a new invoice form.

**The provider's failure to follow up on these situations does not warrant individual or additional consideration for late billing.**

### **Special Note for NDC and Qualifier Requirement**

Effective January 1, 2008 the quantity of each NDC submitted and the unit of measurement qualifier (F2, ML, GR or UN) will also be required.

Submitting NDC-Related Data via the Paper Claim Form (CMS-1500 {02-12}), Effective January 1, 2008.

Beginning January 1, 2008, paper claims (CMS-1500 v02-12), along with submitting the J- code and the related NDCs, the quantity of each NDC submitted and the unit of measure will be required by DMAS. Claims submitted on or after January 1, 2008, will be denied if this additional information is not on your claim.

**Locator 24D:**

**Shaded:** Enter the unit of measurement (UOM) qualifier. Valid qualifiers are: F2 (international unit), ML (milliliter), GR (gram), and UN (unit). The numeric quantity of the drug (greater than zero) administered to the patient must be entered after the qualifier. Enter the actual metric decimal quantity (units) administered to the patient. **If reporting a fraction of a unit, use the decimal point.** The maximum number of bytes allowed for the quantity is 13, including the decimal point. Nine numbers may precede the decimal point and three numbers may follow the decimal.

## Utilization Review and Control (Plan First)

Updated: 12/16/2015

Under the provisions of federal regulations, Medical Assistance Programs must provide for continuing review and evaluation of care and services paid by Medicaid and the Children's Health Insurance Program (also known as Virginia's Family Access to Medical Insurance Security Plan - FAMIS), including review of utilization of the services by providers and by recipients. Federal regulations of 42CFR§§455-456 and 42CFR§§457.490 set forth requirements for detection and investigation of fraud and abuse to maintain program integrity and require implementation of a statewide program of utilization control to ensure high quality care as well as the appropriate provision of services. This chapter provides information on documentation requirements, quality management and utilization review/control requirements handled by the Department of Medical Assistance Services (DMAS).

The Provider Agreement requires that the records fully disclose the extent of services provided to individuals receiving covered services. Records must be made available to authorized state and federal personnel in the form and manner requested.

Providers must follow both the general documentation requirements for all providers as outlined in this chapter. Documentation must be in accordance with the requirements of the individual licensing board within the Department of Health Professions and the requirements detailed in this manual.

### General Documentation Requirements

Use of the electronic signatures, for clinical documentation purposes, shall be deemed to constitute a signature and will have the same effect as a written signature on a document. Providers must follow DMAS guidelines set forth regarding electronic signatures (DMAS Memorandum "Use of Electronic Signatures" 8/20/2004 available online at:

[http://dmasva.dmas.virginia.gov/Content\\_pgs/pr-memos.aspx](http://dmasva.dmas.virginia.gov/Content_pgs/pr-memos.aspx).

Only a medical doctor (MD) may use a rubber stamp and the stamped signature must be initialed and dated by the MD. However, these methods do not override other requirements that are not for DMAS purposes. If a MD chooses to use a rubber stamp on documentation requiring his or her signature, the MD whose signature the stamp represents must have documented a signed statement to the effect that he or she is the only person who has the stamp and is the only one who will use it. The MD must initial and completely date all rubber-stamped signatures.

The provider must recognize the confidentiality of medical record information and provide safeguards against loss, destruction, or unauthorized use. Written procedures must govern records' use and removal and the conditions for the release of information. The member/responsible party's written consent is required for the release of information not authorized by law.

#### Record Retention

Regulations of the Virginia Board of Medicine (18VAC85-20-26) state that practitioners must maintain a patient record for a minimum of six years following the last patient encounter with the following exceptions:

Records of a minor member, including immunizations, must be maintained until the member reaches the age of 18 or becomes emancipated, with a minimum time for record retention of six years from the last patient encounter regardless of the age of the member;

Records that have previously been transferred to another practitioner or health care provider or provided to the patient or his personal representative; or

Records that are required by contractual obligation or federal law to be maintained for a longer period of time.

After October 19, 2005, practitioners must post information or in some manner inform all patients concerning the time frame for record retention and destruction. Patient records can only be destroyed in a manner that protects patient confidentiality, such as by incineration or shredding. If an audit is initiated within the required retention period, the records must be retained until the audit is completed and every exception resolved.

NOTE: All forms mentioned in this chapter may be located at the DMAS website at: <http://dmasva.dmas.virginia.gov/>.

### **Financial Review and Verification**

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

## **DMAS Quality Management Review Responsibilities**

Quality management controls are important to ensure quality of care as well as the appropriate provision of services and the medical necessity for services. Many of the review and control requirements respond to Federal and State regulations; all participating providers must comply with all of the requirements.

DMAS or its contractors must provide for the continuing review and evaluation of the care and services covered by DMAS. This includes the review of the utilization of services rendered by providers to members.

Medical records of members currently receiving DMAS reimbursable services as well as a sample of closed medical records may be reviewed. DMAS or its contractors may also conduct an on-site investigation as follow-up to any complaints received.

Periodic, unannounced, quality management review on-site visits or desk reviews will be made. Review may include but is not limited to:

- The comprehensive care being provided;
- The adequacy of the services available to meet the current health needs and to promote the maximum physical and emotional well-being of each member for the scope of services offered;
- The necessity and desirability of the continued services;
- The documentation to support medical necessity and authorization for services; and
- For verification of agency/provider adherence to DMAS requirements in accordance with federal and state regulations.

Upon completion of an on-site review, DMAS staff will meet with staff members for an exit conference. The exit conference will provide an overview of the findings from the review. A report will be written detailing the findings. Based on the review team's report and recommendations, DMAS may take corrective action. Actions taken and the level of management involved will be based on the severity of the cited deficiencies regarding adequacy of services.

If DMAS requests corrective action plans, the provider must submit the plan, within 30 days of the receipt of notice. Subsequent visits/desk reviews may be made for the purpose of follow-up deficiencies, complaint investigations, or to provide technical assistance.

### Reimbursement Requirements

Services that fail to meet DMAS criteria are not reimbursable. Such non-reimbursable services may have payment retracted as a result of a quality management review. DMAS criteria for general reimbursement of general Medicaid/FAMIS services provided are found throughout the provider manual. It is the responsibility of the provider to adhere to the requirements documented in this manual as well as by the individuals licensing board.

## **Referring Members to Client Medical Management**

DMAS providers may refer Medicaid/FAMIS patients suspected of inappropriate use or abuse of Medicaid/FAMIS services to the Recipient Monitoring Unit (RMU) in DMAS. 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 (CMM). 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. An answering machine receives after-hours referrals. Written referrals should be mailed to:

### **Supervisor, Recipient Monitoring Unit**

Division of Program Operations

Department of Medical Assistance Services

600 East Broad Street, Suite 1300

Richmond, Virginia 23219

Telephone: (804) 786-6548

CMM Helpline: 1-888-323-0589

FAX: (804) 786-5799

When making a referral, provide the name and Medicaid/FAMIS number of the member and a brief statement regarding the nature of the utilization problems. Hospitals continue to have the option of using the "Non-Emergency Use of the Emergency Room" Referral Form when reporting emergency room abuse. Copies of pertinent documentation, such as emergency room records, are helpful when making written referrals. For a telephone referral, the provider should give his or her name and telephone number in case DMAS has questions regarding the referral.

## **Fraudulent Claims**

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

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

for Virginia, the United States Attorney General, or the appropriate law enforcement agency.

### **Provider Fraud**

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

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

Supervisor, Provider Review Unit

Program Integrity Section

Division of Cost Settlement and Audit

Department of Medical Assistance Services

600 East Broad Street, Suite 1300

Richmond, Virginia 23219

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

Director, Medicaid Fraud Control Unit

Office of the Attorney General

900 E. Main Street, 5th Floor

Richmond, Virginia 23219

### **Recipient Fraud**

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

If it is determined that benefits to which the individual was not entitled were approved, corrective action is taken by referring individuals for criminal prosecution, civil litigation, or establishing administrative overpayments and seeking recovery of misspent funds. Under provisions of the



Plan First

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Virginia *State Plan for Medical Assistance*, DMAS must sanction an individual who is convicted of Medicaid fraud by a court. That individual will be ineligible for Medicaid for a period of twelve months beginning with the month of fraud conviction.

Referrals should be made to:

Supervisor, Recipient Audit Unit

Program Integrity Section

Division of Cost Settlement and Audit

Department of Medical Assistance Services

600 East Broad Street, Suite 1300

Richmond, Virginia 23219