Baby Care

Last Updated: 09/22/2022

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Baby Care Provider Manual

General Information

Updated: 2/22/2019

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

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

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

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

Program Background

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

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 Originally enacted by the Social Security amendments of 1965 (Public Law 89-97), Title XIX was approved on July 30, 1965.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

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

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

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

Guidelines are published annually in the *Federal Register* and become effective upon publication.

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

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

General Scope of the Program

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

Covered Services

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

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

- Blood glucose monitors and test strips for pregnant women

- Case management services for high-risk pregnant women and children up to age 1 (as defined in the State Plan and subject to certain limitations)
- Christian Science sanatoria services
- Clinical psychology services
- Clinic services
- Community developmental disability services
- Contraceptive supplies, drugs and devices
- Dental services
- Diabetic test strips
- Durable medical equipment and supplies
- Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT) – For individuals under age 21, EPSDT must include the services listed below:
- Screening services, which encompass all of the following services:
    - Comprehensive health and developmental history
    - Comprehensive, unclothed physical exam

- Appropriate immunizations according to age and health history
- Laboratory tests (including blood lead screening)
- Health education

- Home health services

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

- Hearing services

- Inpatient psychiatric services for members under age 21

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

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

- Skilled nursing facilities for persons under 21 years of age

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

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

requiring preauthorization under the State Plan for Medical Assistance will continue to require pre-authorization. DMAS reserves the right to utilize medical necessity criteria for non-State Plan services under EPSDT.

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

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

- Emergency hospital services

- Emergency services for aliens

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

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

- Eye refractions

- Plan First (family planning services) – Medicaid fee-for-service program for men and

women who meet the eligibility criteria. Plan First includes coverage of those services necessary to prevent or delay a pregnancy. It shall not include services to promote pregnancy such as infertility treatments. Family planning does not include counseling about, recommendations for or performance of abortions, or hysterectomies or procedures performed for medical reasons such as removal of intrauterine devices due to infections.

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

- Intermediate care facility – Individuals with Intellectual Disabilities Services (medically needy members are not covered)

- Laboratory and radiograph services

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

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

- Mental Health:

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

- Substance Use Disorder:

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

- Case Management
- Opioid Treatment
- Outpatient Treatment

- Community Living Waiver:

- Nurse-midwife services
- Nursing facility services

- Occupational therapy

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

- Optometry services

- Outpatient hospital services

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

- Papanicolaou smear (Pap) test

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

- Podiatry services

- Prostate specific antigen (PSA) test (1998)

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

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

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

- Reconstructive surgery - post-mastectomy (1998)

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

- Renal dialysis clinic services

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

- Routine preventive and wellness services, including annual wellness exams, immunizations, smoking cessation, and nutritional counseling services for the MAGI Adult (Medicaid Expansion) covered group.

- Rural Health Clinic services

- School-based services

- Services for individuals age 65 and older in institutions for mental diseases

- Specialized nursing facility services

- Speech-language therapy services

- CCC Plus Waiver services - For children and adults who are chronically ill or severely impaired, needing both a medical device to compensate for the loss of a vital body function and require substantial and ongoing skilled nursing care to avert further disability or to sustain their lives. Authorized services include Private Duty Nursing, Private Duty Respite Care services, Personal Care (Adults Only), Assistive Technology, Environmental Modifications and Transition services.

- Telemedicine for selected services.

- Tobacco Cessation screening, counseling and pharmacotherapies.

- Transplant services: kidney and corneal transplants, heart, lung, and liver transplants, without age limits; under EPSDT, liver, heart, lung, small bowel and bone marrow transplants and any other medically necessary transplant procedures

that are not experimental or investigational, limited to persons under 21 years of age. Coverage of bone marrow transplants for individuals over 21 years of age is allowed for a diagnosis of lymphoma or breast cancer, leukemia, or myeloma.

- Transportation services related to medical care

- Treatment Foster Care Case Management

General Exclusions

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

Examples of such non-covered services are as follows:

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

- Acupuncture

- Artificial insemination or in vitro fertilization

- Autopsy examinations

- Cosmetic surgery

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

- Meals-on-Wheels or similar food service arrangements and domestic housekeeping services which are unrelated to patient care

- Medical care provided by mail or telephone (not including telemedicine)

- Medical care provided in freestanding psychiatric hospitals except through EPSDT and SUD waiver, or for individuals aged 65 and over

- Personal comfort items

- Physician hospital services for non-covered hospital stays

- Private duty nursing services – Other than for children under an appropriate waiver or EPSDT and adults under the appropriate waiver

- Procedures prohibited by State or federal statute or regulations

- Prostheses (other than limbs, and the items necessary for attaching them, and breast prostheses)

- Psychological testing done for purposes of educational diagnosis or school admission or placement

- Routine foot care

- Screening services: Exceptions: Pap smears, mammograms, and PSA tests consistent with the guidelines published by the American Cancer Society.

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

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

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

- Unkept or broken appointments

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

- Weight loss programs

MEMBER COPAYS

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

Managed Care Programs

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

Medallion 4.0 serves as the delivery system for children, pregnant women, and individuals in the MAGI Adult Group who are not determined to be "medically complex." CCC Plus provides a higher acuity of care coordination services and serves as the delivery system that provides coverage for individuals who are aged, blind or disabled, or who are dually eligible for Medicare and Medicaid, or who receive long-term services and supports, or individuals in the MAGI adult group determined to be "medically complex." "Medically complex" is defined as individuals who have complex medical and/or behavioral health condition and a functional impairment, or an intellectual or developmental disability.

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

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

Managed Care Enrollment Broker (Maximus)

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

- **Medallion 4.0**

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

To get the free mobile app, search for Virginia Managed Care on the Apple App Store or Google Play and download. After downloading the app, members will log in using a two-step identification process, Medicaid ID, and social security number, or social security number and date of birth; non-members can log-in as guests.

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

- **CCC Plus**

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

MCO Provider Reimbursement

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

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

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

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

Eligibility and MCO Enrollment Verification

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

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

Continuity of Care

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

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

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

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

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

Family Access to Medical Insurance Security (FAMIS) Plan

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

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

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

FAMIS Covered Services

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

The following services are covered for FAMIS enrollees:

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

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

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

Member Copays

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

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

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

*Other co-payments may apply to other services.

EMERGENCY MEDICAID SERVICES FOR ALIENS

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

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

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

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

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

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

Client Medical Management (CMM)

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

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

Providers may refer Medicaid patients suspected of inappropriately using or abusing

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

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

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

Written referrals should be mailed to:

Lead Analyst, Recipient Monitoring Unit

Division of Program Integrity

Department of Medical Assistance Services

600 East Broad Street, Suite 1300

Richmond, Virginia 23219

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

Sources of Information

MediCall Automated Voice Response System

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

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

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

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

Automated Response System (ARS)

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

HELPLINE

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

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

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

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

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

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

ELECTRONIC FILING REQUIREMENTS

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

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

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

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

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

Provider Manual Updates

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

Notice of Provider Responsibility

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

THE VIRGINIA MEDICAL ASSISTANCE MEDICALL SYSTEM

GENERAL INFORMATION

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

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

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

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

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

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

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

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

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

The telephone numbers are:

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

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

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

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

HOW TO USE THE SYSTEM

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

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

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

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

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

- Press “1” for member eligibility verification.

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

MEMBER ELIGIBILITY VERIFICATION

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

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

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

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

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

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

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

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

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

PROVIDER CHECK LOG

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

CLAIMS STATUS

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

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

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

SERVICE AUTHORIZATION INFORMATION

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

SERVICE LIMITS INFORMATION

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

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

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

PRESCRIBING PROVIDER ID

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

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

The Automated Response System (ARS)

GENERAL INFORMATION

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

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

CITY/COUNTY CODES

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

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

COUNTIES

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

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

CITIES

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

976 Central Processing Unit for FAMIS

STATE MENTAL HEALTH FACILITIES

983 Southern Virginia Mental Health Institute

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

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

996. Hiram Davis Hospital
997. Catawba State Hospital

CLIENT MEDICAL MANAGEMENT INTRODUCTION

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

MEMBER RESTRICTION

Utilization Review and Case Management

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

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

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

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

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

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

Member Enrollment Procedures

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

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

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

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

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

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

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

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

Designated Primary Care Physicians (PCP)

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

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

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

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

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

Designated Pharmacies

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

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

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

Changing Designated CMM Providers

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

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

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

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

A PCP No Longer in Practice

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

Covered Services and Limitations

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

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

Physician Services

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

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

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

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

Services Excluded from PCP Referral

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

Covered services that do not need a referral include:

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

- Immunizations (member under age 21);

- Family planning services;

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

- Dental services (members under age 21);

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

- School-based services.

CMM Provider Affiliation Groups

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

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

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

Emergency Room Services

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

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

CMM also requires a PCP referral form for:

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

Emergency Pharmacy Services

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

Provider Reimbursement and Billing Instructions

Management Fees

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

PCP and Designated Pharmacy Providers

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

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

Affiliated Providers

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

Referral Providers

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

Physicians Billing Emergency Room Services

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

Facilities Billing Emergency Room Services with a Referral

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

Non-designated Pharmacy Providers

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

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

REFERRALS TO THE CLIENT MEDICAL MANAGEMENT PROGRAM

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

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

Lead Analyst, Recipient Monitoring Unit

Division of Program Integrity

Department of Medical Assistance Services

600 East Broad Street, Suite 1300

Richmond, Virginia 23219

Telephone: (804) 786-6548

CMM Helpline: 1-888-323-0589

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

PROVIDER RESTRICTION

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

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

Provider Participation Requirements (Baby Care)

Updated: 1/19/2022

Managed Care Enrolled Members

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

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

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

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

Ø Medallion 3.0:

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

Ø Commonwealth Coordinated Care (CCC):

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

Ø Commonwealth Coordinated Care Plus (CCC Plus):

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

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

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

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

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

Participating Provider

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

Provider Enrollment

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

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

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

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

Requests for Enrollment

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

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

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

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

Provider Screening Requirements

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

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

Limited Risk Screening Requirements

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

Moderate Risk Screening Requirements

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

High Risk Screening Requirements

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

Application Fees

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

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

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

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

Out-of-State Provider Enrollment Requests

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

Revalidation Requirements

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

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

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

Ordering, Referring, and Prescribing (ORP) Providers

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

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

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

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

claims to ensure the timely adjudication of claims.

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

Participation Requirements

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

- Immediately notify Provider Enrollment Services in writing of any change in the information that the provider previously submitted to DMAS.
- Ensure freedom of choice to individuals who are eligible for medical assistance under the Virginia Medicaid Program (eligible individuals) in seeking medical care from any institution, pharmacy, or practitioner qualified to perform the required service(s) and participating in the Virginia Medicaid Program at the time the service was performed.
- Ensure the eligible individual's freedom to reject medical care and treatment.
- Comply with Title VI of the Civil Rights Act of 1964, as amended (42 U.S.C. §§ 2000d through 2000d-4a), which requires that no person be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance on the ground of race, color, or national origin.
- Provide services, goods, and supplies to eligible individuals in full compliance with the requirements of the Rehabilitation Act of 1973, as amended (29 U.S.C. § 794), which states that no otherwise qualified individual with a disability shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance. The Rehabilitation Act requires reasonable accommodations for certain persons with disabilities.
- Provide services and supplies to eligible individuals in the same mode of delivery and of the same quality and as provided to the general public.
- Charge DMAS for the provision of services and supplies to eligible individuals in amounts not to exceed the provider's usual and customary charges to the general public.
- Accept as payment in full the amount established by DMAS to be reasonable cost or maximum allowable charge. 42 CFR § 447.15 provides that a "State Plan must provide that the Medicaid agency must limit participation in the Medicaid Program to providers who accept, as payment in full, the amount paid by the agency." A provider may not bill an eligible individual for a covered service regardless of whether the provider received payment from the state. The provider may not seek to collect from an eligible individual, or any financially responsible relative or representative of that individual, any amount that exceeds the established Medicaid allowance for the service rendered. A provider may not charge DMAS or an eligible individual for missed or broken appointments.
- Accept assignment of Medicare benefits for eligible individuals.
- Use DMAS-designated billing forms for submission of charges.
- Maintain and retain business and professional records sufficient to document fully and accurately the nature, scope, and details of the health care provided. In general, such records must be retained for a period of not less than six years from the date of service or

as provided by applicable state laws, whichever period is longer. However, if an audit is initiated within the required retention period, the records must be retained until the audit is completed and every exception resolved. (Refer to the section titled "Documentation of Records," page 4.)

- Furnish to authorized state and federal personnel, in the form and manner requested, access to records and facilities.
- Disclose, as requested by DMAS, all financial, beneficial, ownership, equity, surety, or other interests in any and all firms, corporations, partnerships, associations, business enterprises, joint ventures, agencies, institutions, or other legal entities providing any form of health care services to eligible individuals.
- Hold confidential and use for authorized DMAS purposes only all medical assistance information regarding eligible individuals. A provider shall disclose information in his or her possession only when the information is used in conjunction with a claim for health benefits or the data are necessary for the functioning of DMAS. DMAS shall not disclose medical information to the public.

Provider Qualifications

All providers enrolled in the Virginia Medical Assistance Program must adhere to the conditions of participation outlined in their individual provider agreements. The BabyCare program includes two components: case management for high risk pregnant women and infants up to age two and expanded prenatal services.

Risk Screens

Maternal and Infant Risk Screens (DMAS 16-P) must be completed by a licensed physician, certified nurse midwife, nurse practitioner or physician assistant. The licensed practitioner does not have to be an enrolled Medicaid provider to complete the risk screens. However, to receive reimbursement, the licensed practitioner will need to be enrolled as a Medicaid provider.

BabyCare Case Management Services

BabyCare providers may include Health Department Clinics, Federally Qualified Health Centers, Rural Health Clinics, Department of Social Services, Private Home Health Agencies and Community Services Boards.

Licensing requirements to be a BabyCare service provider include one of the following:

- A registered nurse (RN) who has an unrestricted license by the Department of Health Professions, Board of Nursing with a minimum of one year of experience in community health nursing and experience in working with pregnant women; or
- A social worker who has either a master's or bachelor's degree in social work from a school of social work accredited or approved by the Council on Social Work Education with a minimum of one year of experience in health and human services and experience in working with

pregnant women and their families.

Expanded Prenatal Services

In addition to the comprehensive prenatal services that are provided to all Medicaid/FAMIS/FAMIS MOMS clients, the BabyCare Program offers expanded prenatal services such as client education classes, homemaker services, nutritional services and substance use disorder services (SUD).

Client Education

Covered client education courses include smoking cessation classes, childbirth classes and parenting classes. Providers must offer DMAS approved courses taught by qualified patient education instructors to receive DMAS reimbursement.

Instructor and Course Certification Standards

Client education must be rendered by certified providers who meet DMAS approved education, license, or certification requirements. DMAS-approved client education providers include individuals employed by the Virginia Department of Health who are approved to provide education in the health department setting. Health Departments should maintain a copy of the employees approved certification/training in the personnel file at the agency.

Individuals who have certification from programs other than the Health Department may forward their course content, a copy of the certificate and the BabyCare provider enrollment application to DMAS at the following address to be reviewed for approval:

DMAS

Attention: BabyCare, Request for Patient Education Certification Approval

600 East Broad Street, Suite 1300

Richmond, Virginia 23219

Fax: 804-225-3961

DMAS will coordinate with Xerox Provider Enrollment Services the Patient Education Certification requests which are approved.

Courses should meet criteria similar to those listed in Appendix B, Client Education Course Contents. Course goals should include improving the pregnancy outcome. Instructor certification standards include the following:

- The instructor must complete a formalized course given by a recognized accredited health care organization or education related agency which may be community or hospital based;
- Instructor training must be a formal course of study based on an established, written curriculum;

- Instructor training must include principles of teaching, adult learning and group education as well as content specific to the type of certification (e.g., preparation for childbirth, preparation for parenting, smoking cessation); and
- Mechanisms for practice teaching and/or observed teaching practicum should be included.

Homemaker

Homemaker services must be provided by a DMAS-certified provider. The homemaker agency must employ or subcontract with and directly supervise an RN or LPN who will provide supervision to the homemaker aides. Only an RN is authorized to conduct the initial assessment and subsequent reassessments. The supervising RN or LPN must be currently licensed to practice nursing in the Commonwealth. The homemaker duties may be performed by a companion, nursing assistant or home health aide.

Each aide hired by the provider agency shall be evaluated by the provider agency to ensure compliance with minimum qualifications as required by the DMAS. Each aide must:

1. Be 18 years of age or older;
2. Be able to read and write English to the degree necessary to perform the tasks expected;
3. Possess a valid social security number;
4. Prior to assigning an aide to an individual, the provider agency must obtain documentation that the aide has satisfactorily completed a training curriculum consistent with DMAS requirements. The DMAS requirements may be met in one of three ways:
    - Registration as a Certified Nurse Aide with the Virginia Board of Nursing, Department of Health Professions;
    - Graduation from an educational curriculum approved in Virginia, which offers certificates qualifying the student as a Nursing Assistant, or Home Health Aide; or
    - Completion of provider-offered training, which is consistent with the basic course outline found in the "Exhibits" at the end of this chapter and subject to prior approval from DMAS;
5. Be physically able to do the work;
6. Have a satisfactory work record, as evidenced by two references from prior job experiences, including no evidence of convicted abuse, neglect, or exploitation of aged or incapacitated adults or children;
7. Submit a criminal history record check. Providers are responsible for complying with § 32.1-162.9:1 of the Code of Virginia regarding criminal record checks. The criminal record check shall be available for review by DMAS staff who are authorized by the agency to review these files. The personal care aide will not be compensated for services provided to the individual once the records check verifies the personal care aide has been convicted of any of the crimes that are described in § 32.1- 162.9:1 or § 37.2-416 of the Code of Virginia. Personal care aides who have not been convicted of crimes will be reimbursed for care provided prior to the results of a criminal history record check;
8. Receive periodic Tuberculosis (TB) screenings;
9. Child Protective Services Background Check;
10. Adult Protective Services Background Check.

Homemaker service providers may be related to the BabyCare individual, but may not be the parent

of a minor child receiving services, the individual's spouse, or legally responsible relatives of the individual. Payment may not be made for services furnished by other family members who live in the same home as the individual, unless there is objective written documentation as to why there are no other providers available to provide the care. Family members who provide Homemaker services must meet the same standards as providers who are unrelated to the BabyCare individual.

Nutrition

Nutrition services must be provided by a Registered Dietitian (R.D.) or person with a master's degree in nutrition, maternal and child health, or clinical dietetics with experience in public health, maternal and child nutrition or clinical dietetics.

Substance Use Disorder Services

Providers of substance use disorder services must be licensed and approved by the Department of Behavioral Health Developmental Services (DBHDS). Please refer to the DMAS Community Mental Health Rehabilitative Services Manual for specific provider requirements. A copy of this manual is available on the DMAS website at www.virginiamedicaid.dmas.virginia.gov.

Requirements of the Section 504 of the Rehabilitation Act

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

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

Utilization of Insurance Benefits

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

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

- **Title XVIII (Medicare)** – The Virginia Medicaid Program will pay the amount of any deductible or coinsurance up to the Medicaid limit for covered health care benefits under Title XVIII of the Social Security Act for all eligible persons covered by Medicare and Medicaid.
- **Workers' Compensation** - No payments shall be made for a patient covered by

Workers' Compensation.

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

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

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

Termination of Provider Participation

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

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

DMAS Provider Enrollment Services

PO Box 26803

Richmond, Virginia 23261-6803

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

1.325(D." DMAS

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

3. Refuse to enter into or renew an agreement or contract, or elect to terminate an existing agreement or contract, with any provider who has been convicted of or otherwise pled guilty to a

felony, or pursuant to Subparts A, B, and C of 42 C.F.R. Part 1002, and upon notice of such action to the provider as required by 42 C.F.R. § 1002.212.

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

Termination of a Provider Contract Upon Conviction of a Felony

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

Appeals of Adverse Actions

Definitions:

Administrative Dismissal – means:

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

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

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

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

"clean claim" at § 447.45(b) is not an adverse benefit determination.

Appeal – means:

1) A member appeal is:

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

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

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

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

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

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

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

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

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

MEMBER APPEALS

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

PROVIDER APPEALS

Non-State Operated Provider

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

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

Program Operations Division

Department of Medical Assistance Services

600 East Broad Street,

Richmond, Virginia 23219

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

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

For services that have been rendered and applicable reconsideration or MCO internal appeal rights

have been exhausted, providers have the right to appeal adverse actions to DMAS.

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

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

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

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

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

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

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

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

Repayment of Identified Overpayments

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

State-Operated Provider

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

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

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

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

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

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

Secretary or Secretaries shall be final.

Client Appeals

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

Program Information

Federal regulations governing program operations require the Virginia Medicaid Program 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. Individual providers may request that publications not be mailed to them by completing a Mailing Suspension Request form and returning it DMAS Provider Enrollment Services (PES) at the address given on the form. The Mailing Suspension Request form must be completed and signed by each provider within the group who is requesting that Program information not be sent. The address is:

Virginia Medicaid - PES PO Box 26803
Richmond, Virginia 23261-6803
Phone: 804-270-5105 or 1-888-829-5373
Fax: 804-270-7027

Provider Risk Category Table

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

Member Eligibility

Updated: 2/22/2019

Determining Eligibility

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

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

Groups Covered by Medical Assistance

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

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

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

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

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

Medically Needy Covered Groups and Spenddown

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

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

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

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

Emergency Medicaid Services for Aliens

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

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

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

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

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

Medicaid Eligibility for Institutionalized Individuals

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

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

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

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

Family Access to Medical Insurance Security (FAMIS) Plan

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

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

FAMIS Covered Services

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

The following services are covered for FAMIS enrollees:

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

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

  - Assistive technology

  - Blood lead testing

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

  - Intensive in-home services

  - Therapeutic day treatment

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

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

Member Copays

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

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

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

*Other co-payments may apply to other services.

Member Eligibility Card

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

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

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

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

Bank Identifier

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

Name of Eligible Person

An eligibility card is issued to each person eligible for full Medicaid/FAMIS benefits and QMBs. Members enrolled in Plan First receive a green and white identification card. Check the name

against another proof of identification if there is any question that the card does not belong to the member.

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

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

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

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

Card #
The sequential number of the member's card is given. If a card is lost or stolen and another Manual Title All Manuals Chapter III Page 7 Chapter Subject Member Eligibility Page Revision Date 02/22/2019 is issued, the prior card will be de-activated and will not confirm eligibility using the magnetic "swipe" mechanism.

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

Verification of Member Eligibility

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

Program/Benefit Package Information

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

Limited Benefit Programs for Which Members Receive Eligibility Cards

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

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

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

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

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

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

Special Indicator Code (Copayment Code)

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

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

The following copay exemptions apply:

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

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

The FAMIS member co-pays are:

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

*Other co-payments may apply to other services.

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

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

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

Under the assignment of benefits regulations, DMAS can act on behalf of the member (subscriber) and recover third-party payment from the primary carrier. Workers' Compensation and other

liability insurances (e.g., automobile liability insurance or home accident insurance) are always considered as primary carriers for cases where coverage is applicable to the injury being treated. Because the member's eligibility card cannot indicate this coverage, it is necessary that cause-of-injury information be obtained from the member.

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

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

Managed Care Programs

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

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

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

Member Without an Eligibility Card

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

Assistance to Patients Possibly Eligible for Benefits

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

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

Medicaid Applications -- Authorized Representative Policy

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

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

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

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

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

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

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

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

Non-Medicaid Patient Relationship

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

Newborn Infant Eligibility

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

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

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

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

Medicaid Eligibility for Hospice Services

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

Guidelines on Institutional Status

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

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

Inmates of a Public Institution

Inmates of public institutions fall into three groups:

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

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

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

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

Incarcerated Individuals

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

Incarcerated individuals include:

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

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

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

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

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

Juveniles

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

a. Prior to Court Disposition

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

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

b. After Court Disposition

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

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

c. Type of Facility

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

Who is Not an Inmate of a Public Institution

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

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

Member Appeals

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

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

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

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

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

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

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

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

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

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

Covered Services and Limitations (Baby Care)

Updated: 5/2/2017

The BabyCare program includes the following components:

- Behavioral health screenings by a physician, physician assistant or nurse practitioner as defined in Chapter II of this manual;
- Case management for high risk pregnant women and their infants up to two years of age, completed by a case manager who is licensed either as a registered nurse or qualified social worker (MSW/BSW) as defined in Chapter II of this manual; and
- Expanded prenatal services for pregnant women including individual education classes (including tobacco dependence education), nutrition services, homemaker services and substance use disorder services (SUD) by a DMAS approved provider as detailed in Chapter II of this manual.

BabyCare services described in this chapter are covered under the Virginia Medical Assistance Program. Forms referenced in this chapter may be found under the Maternal and Child Health / BabyCare section on the DMAS website at http://dmas.virginia.gov/Content_pgs/mch-home-aspx, Virginia Medicaid web portal, or Chapter IV of this manual under attachments.

Eligibility (Baby Care)

Behavioral health screenings and BabyCare case management services are available for pregnant women and infants who are enrolled in Fee-for-Service (FFS) Virginia Medicaid, Family Access to Medical Insurance Security (FAMIS), FAMIS Plus or FAMIS MOMS programs. Expanded prenatal services are available to pregnant members in FFS, FAMIS, FAMIS Plus or FAMIS MOMS programs. The covered services available to enrollees in a MCO are described below. Pregnant women are eligible for BabyCare services during pregnancy and up to the end of the month following their 60th day post-partum. Infants are eligible for BabyCare services up to their second birthday.

To be eligible for BabyCare services, pregnant women or infants up to age two must be at risk for poor birth/health outcomes. Specific requirements are detailed in this chapter.

Managed Care Organizations (MCOs)

MCOs participating with the Virginia Medical Assistance Program have their own high risk maternity and infant programs including case management and expanded prenatal services (services comparable to those identified in 12VAC30-50-410 and 12VAC30-50- 510). Each MCO has established authorization and approval requirements for these programs. In addition, in order to provide and be reimbursed for services to a managed care member, providers must have a contract with the MCO. Providers should contact the appropriate MCO about the requirements of their maternity and infant program. A list of the MCO high risk maternity and infant program contact information for MCO members can be found as an attachment at the end of Chapter IV under

Business Rules.

Substance use disorder services (SUD) for pregnant and postpartum women are described in the DMAS Community Mental Health Rehabilitative Services Manual and are not included in MCO contracts. Members who are pregnant may access substance abuse treatment through any approved DMAS-enrolled SATS provider. Also, the MCO may refer a member to these services. It is the responsibility of the provider of these services to coordinate service delivery and the member's needs with the MCO.

Eligibility / Claim Status / Service Authorization

Virginia Medicaid Web Portal

DMAS offers a web-based Internet option to access information regarding Medicaid or FAMIS member eligibility, claims status, payment status, service limits, service authorizations, and electronic copies of remittance advices. Providers must register through the Virginia Medicaid Web Portal in order to access this information. The Virginia Medicaid Web Portal can be accessed by going to: www.virginiamedicaid.dmas.virginia.gov. If you have any questions regarding the Virginia Medicaid Web Portal, please contact the State Healthcare Web Portal 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.

Behavioral Health Screening Tool

DMAS reimburses for administration and interpretation of the Behavioral Health Risks Screening Tool {DMAS 16-P (Provider) through the BabyCare program. This screening tool replaces the BabyCare Maternity Risk Screen (DMAS 16) and the BabyCare Infant Risk Screen (DMAS 17). The purpose for this screening is to identify and assist pregnant women as well as new mothers who may be at risk for mental health, substance use or intimate partner violence as well as infants who may be at risk for developmental issues secondary to their family situation and mother's risks. Early identification and referral for intervention of these risks are paramount in helping improve the outcomes of pregnancy as well as health/well-being of the infant. BabyCare reimburses for administration of this instrument for pregnant/postpartum women and infants up to two years of age who are enrolled in a fee-for-service using Current Procedural Terminology (CPT) codes. 96160 and/or 96161 on or after January 1, 2017. The new procedure codes are as follows:

96160 – Administration of patient-focused maternal health risk assessment instrument (e.g. health

hazard appraisal) with scoring and documentation per standardized instrument, and/or;

96161- Administration of care-giver focused infant health risk assessment instrument (e.g. depression inventory) for the benefit of the patient, with scoring and documentation per standardized instrument.

Pregnant and postpartum women are at greater risk to experience depression, substance use and/or be victims of violence than women who are not pregnant and often these risks occur together. Research also shows that many times after the six week postpartum visit, the provider who has the most regular contact with new mothers is the pediatric provider. Thus, in order to identify women who may be experiencing any of these issues, DMAS has collaborated with the Virginia Department of Health (VDH), Department of Behavioral Health and Developmental Services (DBHDS) and private stakeholders to increase the use of assessments of health and behavioral risks for pregnant/postpartum women and mothers of infants up to age two, using a standardized universal tool to screen for depression, substance use and/or violence. This Behavioral Health Risks Screening Tool is located online under the Maternal and Child Health Services/ BabyCare section located: http://www.dmas.virginia.gov/Content_pgs/mch-home.aspx. DMAS has identified this instrument due to the ease of use and the universality to detect emotional problems, alcohol, tobacco and other drug use, as well as violence. This tool is meant for a brief screening, not to assess the severity of the risks. The practitioner will determine the need for further review, referral and/or intervention as necessary.

Screening Pregnant and Postpartum Women for Substance Use

Screening During Pregnancy

Screening and brief intervention for substance use may be sufficient in helping a woman interrupt her use of alcohol or drugs during pregnancy. Other women may require additional assessments, referrals and treatment services. . The use of alcohol or drugs during pregnancy will affect the health and well-being of the mother and the newborn. Interrupting a woman's substance use and providing comprehensive services for both the mother and child during pregnancy can significantly improve birth outcomes as well as the child's later development. The Behavioral Health Risks Screening Tool uses the Institute for Health and Recovery's Integrated 5P's Screening Tool questions to detect substance use. Further screening, assessment and intervention may be required.

The provider may seek reimbursement for administering the Behavioral Health Risks Screening Tool through the most appropriate DMAS program (Community Mental Health and Rehabilitation Services or BabyCare) depending on the provider qualifications and services provided. The DMAS Community Mental Health and Rehabilitation Services program reimburses for substance use screenings and brief intervention using a DMAS approved screening tool. There are specific requirements for providers to receive reimbursement through this program. Please refer to the DMAS Community Mental Health Rehabilitation Provider manual online at the Virginia web portal found at http://www.dmas.virginia.gov or https://www.virginiamedicaid.dmas.virginia.gov/wps/myportal/_ProviderManuals for more information about substance use screening reimbursement including provider requirements and approved tools.

Screening Postpartum

The National Survey of Drug Use and Health (NSDUH) reports that many women resume substance use within the first 3 months after childbirth. Most women who stop using alcohol or drugs during their pregnancy resume use within the first year after they deliver. The most dramatic increases in substance use occur within the first 3 months postpartum.

To encourage screening women postpartum and up through the infants second birthday, BabyCare has approved for pediatric providers to be reimbursed for administering the Behavioral Health Risks Screening Tool. The pediatric provider administers the tool to the mother of their infant patients (up to age two) through the BabyCare screening code (96160 (maternal) and/or 96161(infant), and bills under the infant's benefit as a risk screening for the infant.

Note: The Virginia Department of Behavioral Health and Developmental Services (DBHDS) has more information about tips and resources for screening pregnant/postpartum women http://www.dbhds.virginia.gov/individuals-and-families/substance-abuse/pregnantwomen-families

Screening Pregnant and Postpartum Women for Intimate Partner Violence

Pregnant women should be screened at various times throughout pregnancy and postpartum for intimate partner violence. Screening should occur periodically because some women do not disclose abuse the first time they are asked and abuse may begin later in pregnancy or postpartum. The Behavioral Health Risks Screening Tool has questions which help detect if she is experiencing violence.

Screening Pregnant Women for Perinatal and Postpartum Depression (PPD)

Perinatal and postpartum depression (PPD) is a serious illness that develops during pregnancy or within one year of the pregnancy ending. PPD is a condition that affects 8% to 20% of women after delivery, especially during the first four weeks and can occur anytime during the child's first year. Studies have shown that untreated maternal depression can have a negative effect on an infant's cognitive, neurologic, and motor skill development. During pregnancy, depression can lead to preeclampsia, preterm delivery, and low birth weight. The Behavioral Health Risks Screening Tool uses the 3-Question Edinburgh Postnatal Depression Scale which can detect perinatal and postpartum depression.

Screening Mothers of Infants Up to Age Two

BabyCare will reimburse pediatric providers for administering the Behavioral Health Risks Screening Tool to mothers of infants up to age two, under the infant's medical benefit for FFS Medicaid, FAMIS or FAMIS Plus. The purpose is to identify mothers of infants who may be experiencing depression, substance abuse or intimate personal violence and thus increasing the risk that the child will have developmental issues as a result. Providers must meet qualifications as listed in Chapter II of this manual to be reimbursed through BabyCare.

Infants identified as having possible developmental delay should be referred to the Infant and Toddler Connection as well as the infant's primary care provider. This supports the role of the medical home in coordinating follow up and allows the primary care provider the opportunity to

assist the parent(s) in taking steps to promote optimal development. Instructions about how to refer children to the Infant and & Toddler Connection may be found online at: http://www.infantva.org.

Referral and Follow Up for Positive Screen

Providers should discuss the need for further assessment, referral and treatment options with women who screen positive or if the provider has concerns. Options for referral and treatment services are based on the resources available in the individual's community. Providers may initiate a referral with the BabyCare case manager for assistance with coordinating available resources and providing support. Other resource options include but are not limited to the following:

- Virginia 2-1-1 (www.211virginia.org);
- Local Community Services Boards;
- Medical Treatment Facilities;
- Primary Care Providers; and
- Managed Care Organizations.

Service Requirements and Limits for Screenings (96160 and/or 96161)

There is a limit of four units per pregnant member/per provider and four units per infant member/per provider that may be billed within a year. The provider would bill one unit of 96160 and/or 96161 for the administration and brief intervention of the *Behavioral Health Risks Screening Tool.*

Service Limits *(per provider)*	**CPT Code: 96160 and/or 96161**
Maternal	96160 4 per pregnancy (DMAS recommends one per trimester and one postpartum.)
Infant	96161 4 per year

Universal Referral Form

DMAS is a member of Virginia's Home Visiting Consortium, a collaborative effort of the early childhood home visiting programs, which serves families of children from pregnancy through age five. The Consortium is part of Virginia's Plan for Smart Beginnings (www.smartbeginnings.org). To help increase the quality and effectiveness of home visiting services, the Consortium has created a Universal Referral Form to use as a template among all home visiting programs. The Universal Referral Form may act as a referral mechanism for BabyCare services, Part C and other services that are provided in the member's home. This is used only as a referral mechanism and is not a DMAS reimbursable service. The form may be located at Home Visiting Consortium website at www.homevisitingva.com.

BabyCare Case Management Services

Case management is a service to improve coordination of care, reduce barriers, and link members with appropriate services to ensure comprehensive, continuous health care. The specific activities allowed under case management are detailed in this section.

Service Authorization for BabyCare Case Management

A maternity care coordinator or BabyCare case manager is either a Registered Nurse or Social Worker employed by a qualified service provider to provide care coordination services to eligible individuals. The RN must be licensed in Virginia and should have a minimum of one year of experience in community health nursing and experience in working with pregnant women. The Social Worker (MSW/BSW) must have a minimum of one year of experience in health and human services, and have experience in working with pregnant women and their families.

DMAS requires that the BabyCare case manager complete the initial assessment and determine that the individual may benefit from ongoing BabyCare case management services. Note: DMAS requires use of the appropriate assessment form for the pregnant woman or infant (DMAS–50 Maternal (M) or DMAS-50 Infant (I)). The case management provider must submit a copy of the appropriate form to the fax number or email address listed below this section. The individual/individual's primary caregiver must agree to be open for BabyCare case management services in order for services to be authorized. The individual must agree to participate in the BabyCare case management program and document participation by completing a DMAS form titled "Letter of Agreement" (DMAS 55 or equivalent). The Letter of Agreement form is kept in the medical record for documentation purposes. DMAS does not require the BabyCare provider to submit the completed Letter of Agreement for authorization of BabyCare case management services but it must be available for reference if DMAS requests the document.

BabyCare case management service authorization requests must be submitted within 30 calendar days of completion by the BabyCare case manager to:

BabyCare at DMAS
Fax: 804-452-5451
*Email: BabyCare@dmas.virginia.gov
**Personal health information (PHI) can only be shared if using secure email. Please send a request to the email address above for secure email access prior to sending any PHI via email.*

Virginia Medicaid Management and Information System (MMIS) generate service authorization notifications and mails these notifications to the contact person identified on the Provider Enrollment Agreement as the contact for the BabyCare provider. If the BabyCare case management service authorization request is denied, the notification letter sent to the BabyCare provider will include information on appeals rights for the provider and the individual. BabyCare case management service authorization requests that are approved will include a written notification letter along with the BabyCare case management service authorization number and the number must be included when submitting the claim for payment of BabyCare case management services. This service authorization number must be included in Locater 23 of the CMS-1500 claim form.

Claims submitted without a service authorization number will be denied.

BabyCare case management services may not duplicate any other covered service provided under the Medicaid or FAMIS State Plans or other Medical Assistance programs. (For example: The BabyCare provider must not submit a BabyCare case management service authorization request for an individual that is residing in a specialized care nursing facility.)

If the BabyCare case manager is involved in the direct provision of medical or prenatal care services, the documentation must clearly differentiate the case management services from other service provisions.

Assessment

BabyCare case management services are determined by evaluating the high risk needs identified on the assessment form (DMAS-50 Maternal (M) or DMAS-50 Infant (I)). The high risk needs can be in any or all of the elements identified in the psychosocial, medical or nutritional areas. The case manager ensures that services are arranged and continuity of care is provided in reference to services delivered, education provided and the service plan followed.

During the initial face-to-face meeting, the case manager completes a comprehensive assessment to determine the need for any medical, educational, social, or other services. DMAS requires use of the appropriate assessment form (DMAS-50 Maternal (M) or DMAS-50 Infant (I)). The assessment must be identifiable and legible. Documentation for case management services must include identification of the individual on each entry by full name and Medicaid/FAMIS identification number. Case manager documentation must also include signatures and complete dates for all documentation or entries and must include at a minimum the first initial and last name and credentials. The assessment includes but is not limited to the following:

- Taking the member’s history and
- Identifying the needs of the member.

The case manager may utilize other sources, if necessary, to help complete the assessment, such as gathering information from family members, medical providers, social workers, and educators to develop a complete assessment.

Please note that the comprehensive assessments do not include performing medical or psychiatric screenings (such as the Edinburgh Postnatal Depression Scale or Ages and Stages Questionnaire Developmental Screen) but do include referrals for these screenings and time spent in preparing the referral.

BabyCare business rules can be found as an attachment at the end of Chapter IV and they provide guidance for BabyCare providers in completing the assessment for BabyCare case management service authorization requests (DMAS – 50 (M) or (I) forms) for obtaining the BabyCare case management service authorization covered service authorization number. DMAS provides authorization for BabyCare case management services for Virginia Medicaid FFS only.

Providers should adhere to the following process for FFS BabyCare case management service authorization requests submitted to DMAS using the BabyCare Fax number 804- 452-5451:

Eligibility Check:

- BabyCare providers must check eligibility prior to submitting the request to DMAS for authorization.
- It is the BabyCare provider's responsibility to verify eligibility to determine what program the individual is enrolled either FFS or MCO.
- Individuals often transition to a Virginia Medicaid MCO after enrollment for a brief period of time in FFS. For those individuals enrolled in a MCO, the BabyCare provider must have a contract with that MCO to receive authorization for covered services from the MCO.
- For those individuals enrolled in Medicaid FFS, the BabyCare provider submits the BabyCare case management service authorization request for covered services to DMAS.

Use Correct Forms:

- BabyCare providers must use the revised BabyCare case management service authorization request forms DMAS-50 Maternal (M) or DMAS-50 Infant (I).
- The forms can be found on the Virginia Medicaid web portal at www.dmas.virginia.gov or the BabyCare web page www.dmas.virginia.gov/Content_pgs/mch-home.aspx.
- The BabyCare case management service authorization requests forms must be fully completed. The form must include at a minimum: individual's name, Medicaid number, Agency name, Agency NPI number, for the pregnant woman the estimated date of delivery (EDD) or for the infant the date of birth (DOB), case management assessment date, case manager name, title and date assessment completed.

Submitting Forms:

- The BabyCare provider must submit the BabyCare case management service authorization request assessment form fully completed to DMAS for processing using the following Fax number (804-452-5451).
- BabyCare providers must submit BabyCare service authorization requests timelywithin 30 calendar days from the date the face-to-face assessment was completed and documented as the BabyCare case management date.
- There are exceptions to the 30 calendar day's timely filing and those exceptions are for those individuals that have retroactive eligibility. If the BabyCare provider has an individual that falls into this category, the provider must inform DMAS of the retroactive eligibility request prior to submitting the BabyCare case management service authorization request to DMAS for authorization. The 30 calendar day timely filing may be waived in these circumstances.

Access Authorization:

- The BabyCare provider can access BabyCare case management service authorization approvals to receive reimbursement for covered services.
- DMAS enters the BabyCare case management service authorization data into MMIS and a written notification is generated by the computer system and sent to the contact person identified in the Provider Enrollment Agreement to receive mail for the provider.
- The notification letter provides the authorization for BabyCare case management services along with the service authorization number. The BabyCare provider can obtain the service

authorization number from the Virginia Medicaid web portal www.dmas.virginia.gov or by calling Medicall.at 800-884-9730 or 800-772- 9996.

How to use the Medicall system:

Call Medicall and follow the prompts:

- Once dialed in, enter the provider's National Provider Identifier (NPI);
- Select prompt #4 for service authorization status;
- Enter the member's 12 digit Medicaid number;
- Enter the date that the member was assessed by the provider and identified as the BabyCare case management open date;
- Select pound (#) (skip end date request – do not enter date);
- Select star (*) (do not know service authorization number).

Submitting Claims:

- The BabyCare provider obtains the BabyCare case management service authorization number and enters the service authorization number on the claim form along with the BabyCare procedure code G9002.
- The BabyCare provider submits the claim including service authorization number and procedure code for reimbursement for covered services.

Authorization Period:

- BabyCare case management service will only be authorized for a period up to the date prior to managed care enrollment, if applicable
    - Example:
        - Case management requested for Mom on October 5,
        - However, Mom will transition to managed care on November 1,
        - FFS authorization period will end October 31st .
- If a managed care enrollment date is not present in the MMIS system at the time of the request, BabyCare case management will be authorized for a period not to exceed 60 days or until enrollment in a managed care health plan, whichever occurs first.
- If the member is enrolled in an MCO during the requested date of service, the service authorization requests will be returned to the provider because the member is not eligible for FFS BabyCare case management services.
- If the member meets the criteria to be excluded from managed care enrollment, the request will be authorized as follows:
    - Pregnant women are eligible for BabyCare during pregnancy and up to the end of the month following their 60th day post -partum,
    - Infants are eligible for BabyCare case management up to their second birthday.

Timely Requests:

DMAS BabyCare service authorization request for case management services must be submitted to DMAS within 30 calendar days from the date the face-to-face assessment was completed and documented on the assessment form as the case management open date (DMAS-50 M or I).

The BabyCare case management service authorization request form should include the provider requested begin date and DMAS will authorize the begin date as requested if eligible.

DMAS will not issue a service authorization number for BabyCare case management if:

1. The face-to-face assessment and service plan is not completed for the pregnant mom or the infant on the DMAS BabyCare service authorization request forms.
2. The case management open date is greater than 30 days from the date the form was submitted to DMAS (except for retrospective reviews).

Change in Eligibility:

For pregnant woman who receive a BabyCare case management service authorization under FFS, then moves to an MCO and returns to FFS in the same prenatal period, the provider shall submit the DMAS–50 Maternal (M) form and check the box for “Re-issue for same prenatal period.” DMAS shall, upon verification, reactivate the previous authorization number.

If the member loses Medicaid eligibility, including managed care eligibility, for a period of two (2) months or more, a new face-to-face assessment shall be required prior to submission of a new service authorization request. All timely submission requirements shall apply.

Service Plan

The case manager will develop a Service Plan based on the completed assessment. The case manager may utilize the DMAS 52 or equivalent. The Service Plan must include the following:

- Specific goals and actions to address the medical, psychosocial, educational, and other services needed by the eligible individual;
- Include activities such as ensuring the active participation of the eligible individual and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals; and
- Identifies a course of action to respond to the assessed needs of the eligible individual and a plan for follow-up.

Coordination and Referral

The case manager assists the individual in arranging appropriate services and ensuring continuity of care. The case manager helps the individual obtain needed services, including those medical, psychosocial, and educational services that address the needs and goals identified in the Service Plan. These services may include, but are not limited to, coordination and referral to the following: primary medical care, Early Intervention Services/Part C, Special Supplemental Nutrition Program for Women, Infants and Children (WIC), Early Periodic Screening Diagnosis and Treatment (EPSDT) services, expanded prenatal services, the State Tobacco Quit Line, DMAS Managed Care Organizations (MCOs) and family planning services.

Note: The case manager should discuss with the pregnant woman or caregiver of the infant the available services through Part C. If the infant appears to not be developing as expected, or has a medical condition that can delay normal development, the case manager should work with the family

to initiate a referral for evaluation and assessment through Part C. The case manager may assist the family in contacting the Infant & Toddler Connection for the city or county in which the family resides via the state toll free number: 1-800-234-1448, or through the Infant & Toddler Connection website at www.infantva.org. The case manager may work with the Part C Service Coordinator to help facilitate services as necessary.

Time spent making appointments for an individual is a covered case management activity. However, accompanying or transporting individuals to appointments is not covered under FFS BabyCare Case Management. BabyCare case management referrals and related activities may include scheduling appointments, assisting the individual in completing necessary forms, coordinating services and planning treatment with other agencies and providers, and collateral contacts with significant others to promote implementation of the service plan.

Monitoring and Follow-up

The case manager assesses ongoing progress and ensures services are delivered. The case manager maintains contact with other service providers to ensure the individual keeps appointments and the individual understands and has the ability to comply with the Service Plan and any other requirements of the service providers.

Activities may include contacts with the individual, the individual's caregiver, service providers, and/or family members as often as necessary to ensure that the Service Plan is effectively implemented and to determine if:

- Services are being furnished in accordance with the individual's Service Plan and includes activities and contacts that are necessary to ensure implementation and continued appropriateness of the service care plan;
- The plan and follow-up documented in the Service Plan are adequate to meet the member's identified needs/problems including collateral contacts, site visits and home visits; and
- There have been changes to the needs or status of the member and Service Plan requires updating.

Monitoring includes making necessary adjustments in the Service Plan and service arrangements with providers to ensure that the Service Plan adequately addresses the needs of the individual. BabyCare case management monitoring and follow-up activities includes at least one annual monitoring to ensure that:

- Services are being furnished in accordance to the service care plan;
- Services in the care plan are adequate;
- Service care plan is updated as needed.

BabyCare case management monitoring and follow-up includes the BabyCare provider monitoring and following up on the individual's needs based on the BabyCare providers professional judgement.

Education and Counseling

Education and counseling is a covered case management activity when the purpose is to guide the individual and develop a supportive relationship that promotes achieving goals in the Service Plan.

Counseling, in this context, is not psychological counseling, examination, or therapy. A case management activity is defined as problem-solving activities designed to promote community adjustment and to enhance an individual's functional capacity in the community.

Allowed educational activities include discussions describing the benefits of activities listed in the Service Plan to individuals. Educational activities must be individualized. Educational activities do not include group activities that provide general information. For example, group sessions on stress management, the nature of serious mental illness, or family coping skills are not covered BabyCare case management activities.

DMAS approved education providers include individuals employed by the Virginia Department of Health, Federally Qualified Health Centers (FQHCs) or Rural Health Clinics who are approved to provide health education in the clinic setting. BabyCare providers should maintain a copy of the employee's approved certification/training in the personnel file at the agency.

Individuals who have certification from programs other than the provider types listed above may forward their course content, a copy of the certificate and the BabyCare provider enrollment application to DMAS at the following address to be reviewed for approval:

DMAS

Attention: BabyCare, Request for Member Education Certification Approval

Division of Health Care Services

600 East Broad Street

Richmond, Virginia 23219

The BabyCare individual education instructor must complete a formalized course given by a recognized accredited health care organization or education related agency which may be community or hospital based. The BabyCare individual education instructor training must be a formal course of study based on an established written curriculum. The individual education instructor training must include principles of teaching, adult learning and group education as well as content specific to the type of certification (e.g., preparation for childbirth, preparation for parenting, tobacco dependence education), and mechanisms for practice teaching and/or observed teaching practicum should be included.

Service Units and Service Limitations

Code	Description	Unit	Limits
G9001	Case management assessment and development of service plan	per assessment and service plan - jointly	2 per provider per year
G9002	Case management	per day	Requires service authorization
S0215	Travel / mileage	per mile	Requires paid case management for same time period

Note: Billing for the service can only begin with the first face-to-face contact and can be submitted only for months in which at least one direct or collateral contact, activity or communication occurs and is documented. (Collateral contact is contact with the individual, primary care provider and/or the individual's significant others to promote implementation of services.) The level of involvement will vary among individuals due to the level of need, identified risks, availability of providers/services within the area, the support available to the individual and the individual's ability to follow the Service Plan.

There must be at least one documented contact, activity or communication as designated above, and relevant to the Service Plan, during any calendar month for which BabyCare case management services are billed. Written plan development, review, other written work is not considered a billable case management activity.

In the event that the case manager cannot complete a contact during a month after case management services have been authorized, an extension of one additional month will be granted to allow the case manager time to re-connect with the individual to resume services. The case manager must document the reason the contact with the individual did not occur within the given month as well as documentation of any contacts (attempted and/or successful). If the case manager is not able to complete a telephone, collateral or face-to-face contact during the one month extension, the individual's case must be closed. The provider must send a letter stating that the individual's- case is being closed, to the member and the member's primary care provider or referral source.

Initial Contact Requirements for Case Management

Upon referral or indication that a member may benefit from case management, the case manager must initiate contact to the member or member's caregiver to schedule a face-toface meeting. A telephone call or collateral contact must be made, at a minimum, within 15 calendar days from the date the referral was received. A collateral contact is defined as contact with the member, primary care provider and/or the member's significant others to promote implementation of services. The provider should maintain privacy requirements as set forth by Health Insurance Portability and Accountability Act (HIPAA)

The initial face-to-face contact must occur within 30 calendar days from the date the referral was received. If the case manager cannot make the face-to-face contact within 30 calendar days from the date the referral was received, an extension of 30 calendar days will be granted to allow the case manager to continue efforts to engage member in services. If the case manager is not able to complete the face-to-face contact during the 30 calendar day extension period, the case manager must close the case and notify the referring provider as applicable and the member's primary care provider.

Note: DMAS will only authorize case management at the time the face-to-face assessment and development of service plan is complete and the individual/individual's representative has agreed to be open for BabyCare case management services. If the face-to-face assessment and service plan is not completed, DMAS will not issue a service authorization number to use to bill for BabyCare case management services.

Home Visits

Face-to-face visits may take place in various settings such as the home, an office, and school, place of business, doctor's office or clinic. DMAS requires the case manager complete a minimum of one home visit to assess the member's home environment. DMAS requires that the case manager conduct a home visit with the member within 30 days from the date of referral to the program in order to complete an initial assessment of the home environment. If the case manager is unable to complete a home visit, there must be clear documentation why the home visit did not occur (i.e. the member or other member of the family refuses to allow the case manager in the home). The BabyCare case management service authorization request is only reimbursable if the DMAS-50 Maternal or Infant high risk assessment form is completed in full.

Closing a Case

An individual is closed to BabyCare case management services if the BabyCare provider is unable to establish a successful contact during a month and an extension of one month was granted. If the BabyCare provider is unable to establish a successful contact afer 60 days the BabyCare provider closes the individual's case.

Case management is covered for the maternal member to the end of the month following the sixtieth (60th) day post-partum and the infant up to their second birthday. If an individual is enrolled in an MCO, BabyCare case management is closed in FFS because the MCOs have high risk pregnant women and their infant programs. The case must be closed if one of the following occurs:

- The member's goals are met and the member is no longer in need of services;
- The maternal member reaches the end of the month following their 60th day postpartum;
- The child member reaches age two;
- The case manager is not able to establish contact with member for 60 consecutive days;
- The maternal member or infant's caregiver request to discontinue services;
- The individual is enrolled in an MCO;
- The individual no longer meets criteria;
- The individual moves out of the service area.

Prior to closing the individual to services, the BabyCare provider case manager needs to ensure a smooth discharge or transition by assisting the individual in locating community services which may be available to the individual and notify the other individual's providers , as appropriate, that services are being discontinued. The Service Plan must be updated and the termination reason must be included in the medical record.

If a member who was closed to case management services becomes eligible again, the provider must follow the guidelines for new enrollments. Note: DMAS no longer requires the BabyCare provider to send notification of the closure/transfer from FFS to an MCO.

Transfers to Managed Care Organizations (MCOs)

Members will often transfer between Fee-for-Service (FFS) and an MCO. Note: DMAS does not require the provider to send notification of the transfer from FFS to an MCO. Providers should contact the appropriate MCO about the requirements of the specific MCO's high risk maternity and infant program and request for continuation of service authorization.

It is the responsibility of the BabyCare provider to verify the individual's eligibility for BabyCare case management service authorization services to ensure they have the appropriate authorizations, approvals, and meet contract requirements in order to bill for services (either FFS or the MCO).

Service Requirements for Expanded Prenatal Services

The BabyCare program offers the following expanded prenatal services:

- Individual Patient Education Classes
- Nutrition Services
- Blood Glucose Meters
- Homemaker Services
- Substance Use Disorder Services

Referrals for expanded prenatal services may occur at any time during the pregnancy. In most instances, a pregnant woman who requires expanded prenatal services will also have been referred for BabyCare case management. In cases where there is more than one provider able to provide expanded prenatal services to the individual, the individual must be given a choice of providers and this choice must be documented in the individual's record.

DMAS no longer requires a primary care referral for eligible individual patient education classes, nutritional services or homemaker services. DMAS recommends that the individual's primary care provider is made aware of any referral for these services.

BabyCare providers of expanded prenatal services must be enrolled as a provider with DMAS and meet provider requirements as detailed in Chapter II of this manual to receive reimbursement for these services.

Individual Patient Education (S9442 and S9446)

Individual Patient Education includes six (6) classes of education for pregnant women in a planned, organized teaching environment including but not limited to topics such as body changes, danger signals, breastfeeding, signs and symptoms of preterm labor, alcohol/tobacco/substance use and cessation, labor and delivery information, courses such as planned parenthood, safety (such as Sudden Infant Death Syndrome {SIDS}), lead safety, safe sleeping (back-to-sleep), Lamaze, parenting, child safety and child rearing. There is a limit of six classes under Childbirth Education (S9442) and six classes under Parenting Education (S9446) per member (see list of classes in Appendix B in this manual).

The individual patient educator is responsible for offering group classes to the individual and documenting the individual's attendance and completion of the classes. In addition, the patient educator must notify the primary care provider and/or case manager of the dates on which the individual attended classes and any final recommendations for followup or additional services needed.

Tobacco Dependence Education (S9446)

Tobacco dependence education is a priority topic for individual education. All education sessions

may target tobacco dependence education. Research shows that tobacco use nearly doubles the rate of a woman having a low birthweight infant. Tobacco use also increases the risk of preterm delivery (before 37 weeks of gestation). Premature and low birthweight infants are at greater risk of serious health problems after birth, chronic lifelong disabilities and even death.

Research shows that if a woman stops smoking by 16 weeks gestation, she is at no more risk to have a low-birthweight infant than a woman who never smoked. Women who quit smoking by 30-36 weeks gestation have near normal birthweight infants.

The single most important step in addressing tobacco use and dependence is screening for tobacco use. The provider must first ask the member about their tobacco use and assess their willingness to quit. The provider can then determine the most appropriate intervention, either by assisting the member in quitting (the "5As") or by providing a motivational intervention (the "5Rs") (for more information on the 5As or 5Rs, see below).

Education and counseling by individual healthcare providers has been proven effective among certain groups, especially pregnant women. DMAS covers Tobacco Dependence Education through BabyCare Individual Education for pregnant members.

The purpose of DMAS covered tobacco dependence education is to offer education about the health benefits of quitting tobacco use and refer the individual to a provider for tobacco dependence treatment as well as the Virginia Quit Line for further intervention.

There is a limit of 6 sessions per member per provider (S9446). This may be combined with the nicotine replacement products which are covered through the pharmacy benefit for FFS members.

Tobacco Dependence Treatment Resources

Counseling services include evidenced-based screening and brief intervention services such as the 5As as well as the 5Rs. The 5As are intended for smokers who are willing to make a quit attempt. The 5Rs are directed for smokers who are unwilling to make a quit attempt at this time. For more information about 5As, visit Department of Behavioral Health and Developmental Services (DBHDS) website for screening tools and guidance for pregnant women or the Virginia Department of Health website. For more information about the 5Rs, please visit the United States Department of Health and Human Services website or the Virginia Department of Health website.

Providers should also refer members to the Quit Now Virginia program http://166.67.66.226/livewell/programs/tobacco/quitnow.html (1-800-QUIT NOW or 1-800-784-8669). Quit Now Virginia is a free service and has trained counselors to provide practical counseling via telephone, as well as support, materials, relapse prevention, follow-up and provider consults.

Providers should continue to monitor the website for DMAS to get up-to-date information of tobacco cessation coverage for pregnant members.

Nutrition Services

Nutrition Services include nutrition assessment of dietary habits, development of a nutrition care

plan, nutrition counseling and counseling follow-up. This information is provided in addition to the expected basic nutrition information pregnant women receive from their medical care providers or the WIC Program http://www.vdh.virginia.gov/livewell/programs/wic/ through the Virginia Department of Health. The information must be provided by a Registered Dietitian (R. D.) or a person with a master's degree in nutrition, maternal and child health, or clinical dietetics with experience in public health, maternal and child nutrition, or clinical dietetics.

Program criteria for referral to nutrition prenatal care services includes, but is not limited to, the following: pre-pregnancy underweight/overweight, inadequate or excessive weight gain, a teenager 18 years of age or younger, poor diet, pica, an obstetrical or medical condition requiring diet modification such as multiple gestation, delayed uterine growth, diabetes, hypertension and anemia.

The provider must complete an assessment within 30 days of the referral from the primary care provider or case manager and offer any follow-up nutrition counseling indicated. DMAS will reimburse a provider for the initial nutrition assessment and up to two (2) follow-up visits.

The initial orientation and periodic follow-up should include education concerning basic nutrition during pregnancy, appropriate weight gain during pregnancy and dietary intake. Nutrition assessment, development of a nutrition care plan, provision of nutrition counseling is provided, including appropriate referrals and linkage with WIC.

The provider must forward a copy of the nutrition assessment to the primary care provider. Upon completion of the nutrition counseling, the provider must provide the primary care provider with a report of the progress of the individual and final recommendations.

Please refer to the DMAS Durable Medical Equipment (DME) provider manual for requirements regarding nutritional counseling related to women who receive glucose monitors.

Glucose Monitors

Women with diabetes need to regularly check and control their blood glucose levels. If a woman has medical conditions caused by her diabetes, pregnancy can make these conditions worse. Miscarriage and stillbirth are more common in pregnant women with diabetes. The risks for problems of mother and baby are decreased if the woman maintains her blood glucose levels in the normal range before and during pregnancy.

DMAS will reimburse for blood glucose monitors and test strips for pregnant women suffering from diabetes for which the practitioner determines nutritional counseling alone will not be sufficient to assure a positive pregnancy outcome. As of July 1, 2010, the Maternity Risk Screen (DMAS-16) is no longer required under DME services. Please refer to the DMAS DME Provider Manual, Chapter IV – Covered Services, regarding additional requirements. The DMAS DME Provider manual is available online at http://dmasva.dmas.virginia.gov.

Note: 12VAC30-50-510 requires that women who receive a blood glucose meter covered by DMAS, must also be referred for nutrition counseling. Blood glucose meters shall be provided by Medicaid enrolled durable medical equipment providers.

Homemaker Services

Homemaker Services include those services necessary to maintain household routine for pregnant women, primarily in the third trimester, who need bed rest. Services include, but are not limited to, light housekeeping, child care, laundry, shopping, and meal preparation.

To qualify for homemaker services, the member must be referred by her primary care provider who has determined that it is medically necessary for the member to be on bed rest. The homemaker services must be rendered by Medicaid certified providers.

Duties may be performed by a companion, homemaker, nursing assistant or home health aide. A RN or Social Worker must provide supervision to the care providers.

The RN or Social Work supervisor must make an initial home assessment visit prior to the start of care and develop a written Service Plan with the member for the homemaker to follow. The supervisor is also responsible for introducing the assigned homemaker to the member and reviewing with the homemaker and the member the duties the homemaker will be performing. The homemaker may perform any household duties which follows the Service Plan and enables complete bed rest as ordered by the individual's primary care provider. The supervisor shall make supervisory visits as often as needed to ensure both the quality and appropriateness of services.

The homemaker may not transport the individual in the homemaker's personal car or perform any skilled nursing care procedures.

The homemaker agency and the member may decide the number of hours of care that are needed per day. There is a limit of 124 hours per 31 days.

If services are medically necessary beyond 31 days, extensions may be requested from DMAS. The member's primary care provider must write a letter of medical necessity that includes the following information: the member's name and current Medicaid/FAMIS/FAMIS Plus/FAMIS MOMS ID#; a brief justification for the continued need for bed rest (e.g., placenta previa, preterm labor); and, the expected amount of time the member will need bed rest. The estimated date of delivery should be included if bed rest is required through delivery.

To obtain approval for additional hours, a copy of the medical necessity letter should be forwarded to the BabyCare Program at DMAS:

BabyCare at DMAS

600 East Broad Street, Suite 1300

Richmond, Virginia 23219

Fax: 804-452-5451

Following review of the medical necessity letter, DMAS will send a letter authorizing further reimbursement for homemaker services to the case manager or primary care provider if the member is not receiving case management services. If the member is authorized by DMAS to receive more

than 31 days of homemaker services, the homemaker supervisor must make additional supervisory visits at a minimum frequency of every 30 days. The homemaker must be present during the supervisor's visit at least every other month. Flow sheets must be used by the homemaker/supervisor for documentation purposes. Each date of service must be documented and signed by the homemaker and the individual.

Substance Use Disorder Services

Please refer to the DMAS Community Mental Health Rehabilitative Services Manual for service definitions and requirements. A copy of this manual is available on the DMAS website at http://www.virginiamedicaid.dmas.virginia.gov

Related Programs for Pregnant Women and Children

The following information describes selected services that the case manager may use for service planning and referral.

Home Health Services

Home health services, while not specifically a prenatal care service, are also available when ordered by a physician for pregnant women whose medical complications require short-term, intermittent nursing care. Such services are provided by DMAS-enrolled home health agencies according to a written plan of care.

For more information, refer to the DMAS Home Health Manual. A copy of this manual is available on the DMAS website at http://www.virginiamedicaid.dmas.virginia.gov

Family Planning Services

Family planning services are covered by the Virginia Medical Assistance Program when rendered by DMAS-enrolled providers. These services include counseling, member education, examination, and treatment as prescribed by a physician for the purpose of family planning. For more information, refer to the DMAS Physician's Provider Manual. A copy of this manual is available on the DMAS website at http://www.virginiamedicaid.dmas.virginia.gov

Plan First Program

Plan First is DMAS' fee-for-service family planning services program. The purpose of this program is to cover services that help an individual prevent an unplanned pregnancy. Plan First reimburses health care providers for limited family planning services for men and women who meet the Plan First eligibility requirements.

For additional information, refer to the DMAS Plan First Manual. A copy of this manual is available on the DMAS website under 'Provider Services' at http://www.virginiamedicaid.dmas.virginia.gov. More information about Plan First Cover Virginia is also located at http://dmasva.dmas.virginia.gov/Content_atchs/mch/mchpln1_rcpnts_fcts.pdf.

Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT)

Early and Periodic Screening, Diagnosis, and Treatment Services (EPSDT) are a comprehensive and preventive child health program for individuals under the age of 21. EPSDT includes periodic screening, vision, dental and hearing services. In addition, under the Social Security Act Section 1905(r)(5), States are required to provide any medically necessary health care services listed at section 1905 (a) of the Social Security Act to correct and ameliorate physical and mental conditions even if the service is not included under the state's Medicaid plan. These services are referred to as EPSDT "Specialized Services." All EPSDT "Specialized Services" must be a service that is allowed by the Centers for Medicare and Medicaid Services (CMS). The allowable treatment services are defined in the United States Code in 42 U.S.C. sec 1396d (r) (5).

- The most frequently provided EPSDT specialized services are:
- Hearing Aids
- Assistive Technology
- Personal Care
- Private Duty Nursing
- Medical Formula and Medical Nutrition Supplements
- Specialized Behavioral Rehabilitation and Residential Treatment Services
- Substance Use Residential Treatment Services (effective April 1, 2017 - see ARTS Provider Manual)

For more information on EPSDT, refer to the DMAS EPSDT Manuals available on the DMAS website at http://www.virginiamedicaid.dmas.virginia.gov.

Smiles For Children

The Smiles For Children http://www.dmas.virginia.gov/content_pgs/dnt-home.aspx program provides coverage for diagnostic, preventive, restorative/surgical procedures, as well as orthodontia services for Medicaid, FAMIS and FAMIS Plus children. The program also provides limited coverage for medically necessary oral surgery services for adults (age 21 and older) – see below. DentaQuest http://www.dentaquestgov.com/ is the single dental benefits administrator that will coordinate the delivery of all Smiles For Children dental services.

Dental Services for Pregnant Women

Dental treatment for adults, including pregnant women enrolled in Medicaid and FAMIS MOMS, is covered under certain circumstances through Virginia's dental program, ***Smiles For Children***. Adult dental services are limited to medically necessary oral surgery and associated diagnostic services, such as X-rays and surgical extractions. Preventive, restorative, endodontics, and prosthetic services e.g. cleanings, fillings, root canals and dentures are not covered for adults. Dental conditions that may qualify for reimbursement are ones compromising a patient's general health and such conditions must be documented by the dentist or medical provider. Symptoms would include pain and/or infection.

Additional information about the Smiles For Children program is available at http://www.dmas.virginia.gov/content_pgs/dnt-home.aspx.

Women, Infants and Children's Supplemental Food Program (WIC)

WIC is a supplemental food and nutrition education program that provides assistance with the purchase of nutritious foods and dietary counseling to pregnant, postpartum or breastfeeding women and children under age five with special nutrition and financial needs. Any Medicaid/FAMIS/FAMIS Plus/FAMIS MOMS-eligible individual meeting the criteria must be referred to his or her local health department for additional information and eligibility determination. Additional information can be found the Virginia Department of Health http://www.vdh.virginia.gov/ website or by contacting the Virginia Department of Health at 1-888-942-3663.

Child Care Resources

Virginia Child Care Resource and Referral Network (VACCRRN) is a community-based network of early care and education specialists whose purpose is to deliver services to families, child care professionals and communities to increase the accessibility, availability, and quality of child care in Virginia. For more information about VACCRRN, please visit http://childcareaware.org/ (ChildCare Aware of Virginia) or call 1-866-KIDS-TLC.

Head Start

Head Start is a national child development program for children from birth to age 5. Head Start provides services to promote academic, social and emotional development for income-eligible families. Head Start provides comprehensive education, health, nutrition, dental, mental health, social services and parent involvement opportunities to low-income children and their families. In Virginia, the goals of Head Start are to enhance children's physical, social, emotional and cognitive development; enable parents to be better caregivers and teachers to their children; and, help parents meet their own goals, including economic independence. More information on Head Start in Virginia can be found on the Virginia Head Start Association, Inc. website at http://www.dss.virginia.gov/family/cc/headstart.html or by calling Head Start Virginia Department of Social Services by calling 804-726-7000 or 800-552-3431 toll free, located at 801 East Main Street, Richmond, VA. 23219

Early Intervention

Part C of the Individuals with Disabilities Education Act (IDEA) is a federal grant program that assists states in operating a comprehensive statewide program of early intervention services for infants and toddlers with disabilities, ages birth through age 2 years, and their families. In Virginia, Part C services are provided through the Infant & Toddler Connection of Virginia. Infant & Toddler Connection of Virginia provides early intervention supports and services to infants and toddlers from birth through age two who are not developing as expected or who have a medical condition that can delay normal development. Early intervention supports and services focus on increasing the child's participation in family and community activities that are important to the family. In addition, supports and services focus on assisting parents and other caregivers to find ways to help the child learn during everyday activities. These supports and services are available for all eligible children and their families regardless of the family's ability to pay.

Additional information on early intervention services in Virginia can be found on the Infant & Toddler Connection of Virginia website at www.infantva.org or by contacting the Virginia Department of Behavioral Health and Developmental Services (DBHDS).

Other Home Visiting Programs

Please visit the Virginia Home Visiting Consortium at www.homevisitingva.com for more information on home visiting programs in Virginia as well as trainings available for home visitors.

Client Medical Management Program (Baby Care)

As described in Chapters I, III and VI of this manual, the State may designate certain individuals to be restricted to specific physicians and pharmacies. When this occurs, it is noted on the member's Medicaid/FAMIS ID card. A DMAS-enrolled physician who is not the designated primary provider 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 primary health care provider using the Practitioner Referral Form (DMAS-70). This also applies to covering physicians.
- For other services covered by DMAS which are excluded from the Client Medical Management Program requirements.

The primary health care provider must complete a Practitioner Referral Form (DMAS70) when making a referral to another physician or clinic. The appropriate billing instructions for these situations are covered in Chapter V. Covered outpatient services excluded from this requirement include:

- Local education agency providers;
- Renal dialysis clinic services;
- Routine vision care services (routine diagnostic exams for members of all ages and eyeglasses for members under age 21) provided to restricted members; (NOTE: Medical treatment for diseases of the eye and its appendages still requires a written referral or may be provided in a medical emergency.)
- Baby Care services;
- Personal care services (respite care or adult day health care);
- Ventilator-dependent services; and
- Prosthetic services.

These services must be coordinated with the primary health care provider whose name appears on the individual’s eligibility card, but they are excluded from special billing instructions for the Client Medical Management Program. Other DMAS requirements for reimbursement, such as service authorization, still apply as indicated in each provider manual.

Claim Inquiries & Reconsideration

Inquires concerning covered benefits, specific billing procedures or questions regarding Virginia Medicaid policies and procedures should be directed to:

Customer Services

Department of Medical Assistance Services

600 East Broad Street, Suite 1300

Richmond, VA 23219

A review of additional documentation may sustain the original determination or result in an approval or denial.

Telephone Numbers

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

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

Fee-for-Service BabyCare Case Management Service Authorization (SA) Request Business Rules

Topic	Information
BabyCare Case Management	Case management is a service to improve coordination of care, reduce barriers, and link members with appropriate services to ensure comprehensive, continuous health care.
Regulation	12VAC30-50-410 Case Management Services for High Risk Pregnant Women and Children http://law.lis.virginia.gov/admincode/title12/agency30/chapter50/section410/
BabyCare Provider Manual	Provider Requirements, Covered Services, and Documentation Requirements https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual
Eligibility Criteria	• Pregnant women up to end of the month following the 60th day postpartum • Infants from birth up to the age of 2 years To be eligible for BabyCare services, pregnant women and infants up to age two must be at risk for poor birth/health outcomes.
SA Request Forms	BabyCare Service Authorization Requests DMAS 50-I: Infant High Risk Case Management DMAS 50-M: Maternal High Risk Case Management https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderFormsSearch
Eligibility Verification and FFS Service Authorization Numbers	Medicall: 800-884-9730 or 800-772-9996 Automated Response System (ARS) Web Portal www.virginiamedicaid.dmas.virginia.gov
BabyCare FAX	NEW FAX # 804-452-5451

MCO Contact Information for Managed Care Members	Managed Care High Risk Maternity and Infant programs information: http://dmasva.dmas.virginia.gov/Content_atchs/mc/mc-guide_p2.pdf. Aetna Better Health: • Baby Matters (1-800-279-1878) Anthem HealthKeepers Plus: • Future Moms (1-800-828-5891) INTotal Health: • Starring Baby and Me (1-855-323-5588) Kaiser Permanente: • Healthy Mom Healthy Baby (1-866-223-2347) Optima Family Care: • Partners in Pregnancy (1-866-239-0618) Virginia Premier: • Healthy Heartbeats (1-800-727-7536)
More Information	More information about BabyCare may be found at http://www.dmas.virginia.gov/Content_pgs/mch-home.aspx

BabyCare Case Management Service Authorization (SA) Requests

Business Rules Process for Virginia Medicaid Fee-for-Service (FFS) Members

1. **Enrolled Providers**

Any provider of case management services for fee-for-service members must be an enrolled provider with DMAS prior to billing for any services provided to Medicaid, FAMIS, FAMIS Plus, or FAMIS MOMS members.

BabyCare Case Management services may be provided by a

- Registered Nurse (RN) who has an unrestricted license by the Virginia Department of Health Professions, Virginia Board of Nursing with a minimum of one year of experience in community health nursing and experience in working with pregnant women; or
- Social Worker who has either a master's or bachelor's degree in social work from a school of social work accredited or approved by the Council on Social Work Education with a minimum of one year of experience in health and human services and experience in working with pregnant women and their families.

Refer to Chapter II of the BabyCare Provider Manual for

provider qualification requirements.

2. Eligibility

Pregnant women are eligible for BabyCare case management during pregnancy and up to the end of the month following the 60th day post-partum. Infants are eligible for BabyCare case management from birth up to their second birthday. BabyCare case management program is for FFS members only. The Virginia Medicaid/FAMIS managed care organization have high risk maternity and infant case management programs.

The pregnant woman, or caregiver/parent of the infant, must agree to be open for case management and sign the Letter of Agreement (DMAS-55 or equivalent) that becomes part of the medical record. The Letter of Agreement does not need to be submitted to DMAS to process the service authorization request.

Providers **must** verify Medicaid/FAMIS/FAMIS MOMS eligibility prior to completing and submitting the BabyCare case management service authorization requests to DMAS. Verification can occur through a verification vendor, the Automated Response System (ARS) Web Portal www.virginiamedicaid.dmas.virginia.gov or Medicall at 800-884- 9730 or 800-772-9996. The eligibility verification process will provide information on which program the recipient is participating (Medallion 3.0, Medicaid Fee-For-Service, or FAMIS).

Most individuals are covered under a Virginia Medicaid/FAMIS contracted managed care organization (MCO). If the member is enrolled in an MCO at the time of the request, the BabyCare case management service authorization request will be rejected and the provider must contact the appropriate MCO about the requirements of the specific MCO's maternity and infant program and for transition of care. Providers must be contracted with the MCO in order to bill for services.

Refer to Chapter IV of the BabyCare Provider Manual for information on eligibility.

3. Case Management Assessment

DMAS requires that the BabyCare case manager complete the initial assessment and forward a copy of the DMAS-50 (M) or(I) to BabyCare at DMAS (Fax: 804-452-5451 or email to BabyCare@dmas.virginia.gov**). Authorization begins only when the first face- to-face visit is completed. ** **Personal health information (PHI) can only be shared if using secure email. Please send a request to the email address above for secure email access prior to sending any PHI via email.**

4. Timely Submissions of Service Authorization Requests

A service authorization must be obtained for FFS Medicaid/FAMIS members that are eligible for BabyCare case management services. Providers may submit BabyCare case management service authorization requests only after the completion of the face-to-face assessment, development of service plan and the member/member representative has agreed to receive BabyCare case management services.

The DMAS BabyCare Service Authorization request for case management services must be submitted to DMAS **within 30 calendar days from the date the face-to-face assessment was completed and documented on the DMAS-50 (M) or (I) as the case management open date**. Providers will need this date to obtain the service authorization numbers as detailed in Section 9 of this document.

DMAS will not issue a service authorization for BabyCare case management

a. If the face-to-face assessment and service plan is not completed for the pregnant mom or the infant on the DMAS BabyCare Service Authorization Request forms
b. If the case management open date is greater than 30 days

from the date the form was submitted to DMAS (except as detailed in Section 5 of this document).

The BabyCare case management service authorization request form should include the provider requested begin date and DMAS will provide the authorized date. A system generated letter with the decision determination and approved dates in reference to the service authorization will be mailed to BabyCare providers including the procedure code as requested by the provider.

5. Exceptions to Timely Submission Requirements

Retrospective Reviews:

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.

Retrospective review will be performed when a provider is notified of a patient’s retroactive eligibility for Virginia Medicaid coverage. Providers must request a retrospective service authorization within 30 days of the member becoming retroactively enrolled in Medicaid and prior to billing for services.

6. Incomplete Service Authorization Requests

All BabyCare case management service authorization requests must be submitted to DMAS on the DMAS-50 maternal (M) or infant (I) form with all of the required information. Forms may be found under the Maternal and Child Health/BabyCare

section on the DMAS website at http://dmasva.dmas.dmas.virginia.gov or at the Medicaid Portal:

https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderFormsSearch.

The DMAS-50 assessments must contain information that is identifiable and legible. The required information includes providing the correct:

- Member name
- Medicaid/FAMIS identification number
- Member date of birth for infants or expected delivery date for pregnant women
- Date assessment completed
- Provider case management begin date
- Agency name
- National Provider Identifier (NPI #)
- Check all risks identified, minimum of one to authorize case management
- Signature and title of case manager completing assessment

The BabyCare service authorization request will only be reimbursable if the DMAS-50

(M) or DMAS-50 (I) is completed in full. All incomplete service authorization requests will be pended and returned to the provider for correct information.

DMAS will return pended requests to providers via fax within three (3) business days of the original receipt of the request by DMAS. Providers will have three (3) business days from the DMAS return date to submit a completed form. If the form is not returned by the provider within this timeframe, the original request will be rejected and DMAS will process the service authorization and the case management begin date will be the date the completed form was received at DMAS.

7. Incorrect Signature Protocol

Signatures and complete dates are required for all

documentation and must include, at a minimum, the first initial and last name and credentials of the provider.

The service authorization request will be pended and returned to the provider if the signature protocol is not followed.

8. Authorization Period

It is the responsibility of the provider to **verify the member's eligibility prior to submitting case management service authorization requests** as members often transfer between fee-for-service and managed care. Service authorizations requests will be rejected and returned to the provider if the member is enrolled in an MCO during the requested date of service.

DMAS will only authorize case management services through the date prior to managed care enrollment. If a managed care enrollment date is not present in the MMIS system at the time of the request, case management shall be authorized for a period not to exceed

60 days or until enrollment in a managed care health plan, whichever occurs first. If the member meets the criteria to be excluded from managed care enrollment, the request will be authorized as follows:

a. Pregnant women are eligible for BabyCare during pregnancy and up to the end of the month following their 60th day post-partum; or
b. Infants are eligible for case management up to their second birthday.

9. Service Authorization Numbers

Providers should not contact DMAS BabyCare staff requesting the authorization number or to generate a

duplicate authorization number. It is the responsibility of the provider to obtain the authorization number via the DMAS web portal or call MediCall at 1-800-884-9730 or 800-772-9996. The provider will need the BabyCare case management open date to obtain the service authorization number. The case management open date is the first begin date for BabyCare case management services.

How to use Medicall:

1. Once dialed in, enter National Provider Identifier
2. Select #4 for Service Authorization status
3. Enter Member ID (12 digits)
4. Enter the BabyCare case management open date
5. Select pound # (skip end date request – do not enter date)
6. Select star * (do not know service authorization number)

The Virginia Medicaid Web Portal will not have authorization numbers for those recipients enrolled in managed care.

Virginia Medicaid Management and Information System (MMIS) generates service authorization notifications and mails those within one (1) business day of authorization of services. If the service authorization is rejected, the notification letter will include the reason for the rejection. Requests that are approved include a service authorization number. This service authorization number must be included in Locator 23 of the CMS - 1500 claim form. Claims submitted without a service authorization number will be denied.

10. Transfers to Managed Care Organizations (MCOs)

Members will often transfer between FFS and an MCO. Providers should contact the appropriate MCO about the requirements of the specific MCOs maternity and infant program and the transition of care. It is the responsibility of the provider to verify the member's eligibility each time services are rendered to ensure they have the appropriate authorizations, approvals, and contract requirements in order to bill for services (either FFS or the MCO).

For pregnant women who receive a service authorization under FFS, then move to an MCO, and return to FFS in the same prenatal period, the provider shall submit the DMAS-50 maternal (M) and check the box for “Re-issue for same prenatal period.” DMAS shall, upon verification, reactivate the previous authorization number.

11. Changes in Eligibility

If the member loses Medicaid eligibility, including managed care eligibility, for a period of two (2) months or more, a new face-to-face assessment shall be required prior to submission of a new service authorization requests. All timely submission requirements as outlined in Section 4 of this document shall apply.

Billing Instructions (BabyCare)

Updated: 5/2/2017

The purpose of this chapter is to explain the procedures for filing claims to the Virginia

Medicaid Program for
services rendered.
Three major areas are
covered in this chapter:

- **General Information** - This section contains information about the timely filing of claims, claim inquiries, and the procurement of forms.
- **General Billing Procedures** - Instructions are provided on the completion of claim forms and the submission of adjustment requests.
- **Specific Information and Billing Procedures for BabyCare** – This section contains specific information about approved codes and filing claims for services for BabyCare 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:

EDI Coordinator

Virginia Medicaid Fiscal Agent

P.O. Box 26228

Richmond, Virginia 23260-6228

Phone: (866) 352-0766

Fax number: (888) 335-8460

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

Billing Instructions: Direct Data Entry

As part of the 2011 General Assembly Appropriation Act - 300H which requires that all new providers bill claims electronically and receive reimbursement via Electronic Funds Transfer (EFT) no later than October 1, 2011 and existing Medicaid providers to transition to electronic billing and receive reimbursement via EFT no later than July 1, 2012, DMAS has implemented the Direct Data Entry (DDE) system. Providers can submit claims quickly and easily via the Direct Data Entry (DDE) system. DDE will allow providers to submit Professional (CMS-1500), Institutional (UB-04) and Medicare Crossover claims directly to DMAS via the Virginia Medicaid Web Portal. Registration thru the Virginia Medicaid Web Portal is required to access and use DDE. The DDE User Guide, tutorial and FAQs can be accessed from our web portal at: www.virginiamedicaid.dmas.virginia.gov. To access the DDE system, select the Provider Resources tab and then select Claims Direct Data Entry (DDE). Providers have the ability to create a new initial claim, as well as an adjustment or a void through the DDE process. The status of the claim(s) submitted can be checked the next business day if claims were submitted by 5pm. DDE is provided at no cost to the provider.

Timely Filing

Federal regulations [42 CFR § 447.45(d)] require the initial submission of all Medicaid claims (including accident cases) within 12 months from the date of service. Only claims that are submitted within 12 months from the date of service are eligible for Federal financial participation. To request a waiver of timely filing requirements, providers billing electronically must submit a Claim Attachment Form (DMAS-3) with the appropriate attachments.

DMAS is not authorized to make payment on claims that are submitted late, except under

the following conditions:

Retroactive Eligibility - Medicaid eligibility can begin as early as the first day of the third month prior to the month in which the individual makes application for benefits. All eligibility requirements must be met within that period for retroactive eligibility to be granted. In these instances, unpaid bills for that period may be submitted to DMAS as Medicaid claims.

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

It is the provider's obligation to verify the individual's Medicaid eligibility. The individual's local department of social services will notify providers who have rendered care during a period of delayed eligibility. The notification will indicate notification of the delayed eligibility and include the Medicaid ID number, and the time span for which eligibility has been granted. The provider must submit a claim within 12 months from the date of the notification of the delayed eligibility. A copy of the "signed and dated" letter from the local department of social services indicating the delayed claim information must be attached to the claim.

Denied claims - Denied claims must be submitted and processed on or before 13 months from the date of the initial claim denial where the initial claim was filed according to the timely filing requirements. The procedures for resubmission are:

- Complete invoice as explained in this billing chapter.
- **Attach** written documentation to justify/verify the explanation. If billing electronically and waiver of timely filing is being requested, submit the claim with the appropriate attachments. (The DMAS-3 form is to be used by electronic billers for attachments. See exhibits).

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

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

Other Insurance - The member can keep private health insurance and still be covered by Medicaid. The other insurance plan pays first. Having other health insurance does not change the co-payment amount that providers may collect from a Medicaid member. For

members with a Medicare supplemental policy, the policy can be suspended with Medicaid coverage for up to 24 months while the member has Medicaid without penalty from their insurance company. The member must notify the insurance company within 90 days of the end of Medicaid coverage to reinstate the supplemental insurance.

Billing Instructions: Billing Invoices

The requirements for submission of billing information and the use of the appropriate claim form or billing invoice are dependent upon the type of service being rendered by the provider and/or the billing transaction being completed. Listed below is the billing invoice to be used:

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

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

DMAS follows the National Uniform Billing Committee (NUBC) and the National Uniform Claims Committee (NUCC) standards and specifications for format, fonts (10- pitch Pica type, 6 lines per inch vertical and 10 characters per inch horizontal) margins for claims.

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).

Billing Instructions: Automated Crossover Claims Processing

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

DMAS reimburses providers for the coinsurance and deductible amounts on Medicare claims for Medicaid or FAMIS Plus students who are dually eligible for Medicare and Medicaid or FAMIS Plus. However, the amount paid by DMAS in combination with the Medicare payment will not exceed the amount DMAS would pay for the service if it were billed solely to DMAS.

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

Billing for Copayments When Enrolled in a Medicare Advantage Plan

In order for Virginia Medicaid to appropriately process allowable cost sharing amounts, Medicaid providers should enter the copayment amount in the coinsurance locator field (field 21), the coinsurance amount in the coinsurance locator field (field 22) and the deductible in the deductible locator field (field 20) on the claim form. Should a Medicare Advantage Plan include a copayment

and coinsurance amount on their explanation of benefits, providers will need to combine the dollar amount in the coinsurance locator field. The deductible is always to be billed in the appropriate locator field (20) and should not be combined with the copayment or coinsurance amount(s). Please be advised that Virginia Medicaid will provide reimbursement up to the Medicaid allowable amount for each service. IN addition, Medicaid providers cannot balance bill dual eligibles for charges in excess of the allowable amounts.

Requests for Billing Materials

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

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

U.S. Government Print Office
Superintendent of Documents
Washington, DC 20402

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

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

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

Commonwealth Mailing
1700 Venable St.,

Richmond, VA 23223

Calling the DMAS order desk at Commonwealth Martin 804-780-0076 or, by faxing the DMAS order desk at Commonwealth Martin 804-780-0198

All orders must include the following information:

- Provider Identification Number
- Company Name and Contact Person
- Street Mailing Address (No Post Office Numbers are accepted)
- Telephone Number and Extension of the Contact Person
- The form number and name of the form
- The quantity needed for each form

Please DO NOT order excessive quantities.

Direct any requests for information or questions concerning the ordering of forms to the address above or call: (804) 780-0076.

Billing Instructions: Inquiries Through Web Portal

Virginia Medicaid Web Portal

The new Virginia Medicaid Web Portal is the gateway for providers to transact all Medicaid and FAMIS business via one central location on the Internet. The web portal will provide access to Medicaid Memos, Provider Manuals, provider search capabilities, provider enrollment applications, training and education. Providers must register through the Virginia Medicaid Web Portal in order to access and complete those secured transactions listed below. The new Virginia Medicaid Web Portal can be accessed by going to: www.virginiamedicaid.dmas.virginia.gov.

The new Virginia Medicaid Web Portal will contain similar functionality and content as the current web portal except that some functionality may not be available as the transition occurs. Exceptions include alternate search criteria for member eligibility inquiries and service authorization requests and claims status inquiries with servicing provider visibility.

The following transactions are available to registered users:

1. Check Medicaid and FAMIS Member Eligibility (up to ten at a time).
2. Check Medicaid and FAMIS Member Service Limits.
3. Check the Status of a Submitted Claim.
4. Check a Weekly Medicaid and FAMIS Payment Amount.
5. Check on a Member Service Authorization.

First Time Registrations to the new Virginia Medicaid Web Portal

First time users must navigate to the new Virginia Medicaid Web Portal at

www.virginiamedicaid.dmas.virginia.gov and establish a user ID and password. By registering, individuals are acknowledging that they are the staff member who will have administrative rights for their organization. Answers to any questions regarding the registration process may be located on the Web registration reference materials available on the Web Portal. If further assistance is required, please contact the Xerox Web Registration Support Call Center, toll free at 1-866-352-0496, from 8:00 A.M. to 5:00 P.M. Monday through Friday, except holidays.

Billing Instructions: Electronic Filing Requirements

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

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

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

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

277 - Unsolicited Response (5010)

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

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

835 - Health Care Claim Payment/ Remittance (5010)

837 - Dental Health Care Claim or Encounter (5010)

837 - Institutional Health Care Claim or Encounter (5010)

837 - Professional Health Care Claim or Encounter (5010)

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

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

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

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

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

Billing Instructions: Web Portal

Using the Provider Services navigation tab, click on Provider Manuals and choose the Service Center User Manual. Details on sending electronic claims to Virginia Medicaid are contained in the manual with provider forms included in the appendix. If you have questions about electronic billing, contact the Xerox EDI Helpdesk toll-free at 1-866-352- 0766.

Virginia Medicaid is requiring all entities (clearinghouses, intermediaries and software vendors) that submit X12 transactions to Xerox to test and meet requirements through Level 2. Once they have met this requirement, any provider can submit transactions through one of these entities. More information about EDI is available online through the Web Portal at https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/EDISupport.

Service Centers Changes Related to the EDI Batch Process

Xerox will use email as its primary means for communicating with existing Service Center contacts already on file. Providers should receive an email from DMAS or Xerox for existing Service Center contacts. For further information, please send an email message to https://www.virginiamedicaid.dmas.virginia.gov and include the following information:

1. In the subject line of the email, type the following: EDI New Contact Information – [insert Service Center contact name here]
2. In the body of the email, copy and paste the information below, then provide the respective Service Center contact information:
   First and Last Name
   Email address
   Phone number

The Xerox EDI Helpdesk will be accessible toll-free at 1-866-352-0766 to assist with EDI needs. The email address above may also be used.

Billing Instructions: ClaimCheck

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

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

and HCPCS code will be subject to both the NCCI and ClaimCheck edits. Upon review of the denial, the provider can re-submit a corrected claim. Any system edits related to timely filing, etc. are still applicable.

- PTP Edits:

CMS has combined the Medicare Incidental and Mutually Exclusive edits into a new PTP category. The PTP edits define pairs of CPT/HCPCS codes that should not be reported together. The PTP codes utilize a column one listing of codes to a column two listing of codes. In the event a column one code is billed with a column two code, the column one code will pay, the column two code will deny. The only exception to the PTP is the application of an accepted Medicaid NCCI modifier. **Note**: Prior to this implementation, DMAS modified the CCI Mutually Exclusive edit to pay the procedure with the higher billed charge. This is no longer occurring, since CMS has indicated that the code in column one is to be paid regardless of charge.

- MUE Edits:

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

- Exempt Provider Types:

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

- Service Authorizations:

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

- Modifiers:

Prior to this implementation, DMAS allowed claim lines with modifiers 24, 25, 57, 59 to bypass the CCI/ClaimCheck editing process. With this implementation, DMAS now only allows the Medicaid NCCI associated modifiers as identified by CMS for the Medicaid NCCI. The modifier indicator currently applies to the PTP edits. The application of this modifier is determined by the modifier indicator of “1”or “0” in the listing of the NCCI PTP column code. If the column one, column two code combination has a modifier indicator of “1”, a modifier is allowed and both codes will pay. If the modifier indicator is “0”, the modifier is not allowed and the column two code will be denied. The MUE edits do not contain a modifier indicator table on the edit

table. Per CMS, modifiers may only be applied if the clinical circumstances justify the use of the modifier. A provider cannot use the modifier just to bypass the edit. The recipient's medical record **must** contain documentation to support the use of the modifier by clearly identifying the significant, identifiable service that allowed the use of the modifier. DMAS or its agent will monitor and audit the use of these modifiers to assure compliance. These audits may result in recovery of overpayment(s) if the medical record does not appropriately demonstrate the use of the modifiers.

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

Reconsideration

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

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

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

Billing Instructions: Basis of Payment

A request for payment must be made under the Medicaid eligibility number of the person receiving the services and whose Medicaid eligibility number appears on the billing invoice.

Federal regulation 42 CFR 447.15 requires providers to accept Medicaid payment as payment in full for the service rendered. The provider may not bill DMAS or the member for the difference (if any) between the allowed charge and the provider's actual charge.

The provider must bill any other possibly liable third party prior to billing DMAS. Provider must submit a bill and it must be processed by DMAS within 12 months from date of service. DMAS will pay the difference between the Program's allowable fee and any payment made by another third party if that payment is less than the allowable fee.

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 services if it were billed solely to Medicaid.

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

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

Locator 22 **Medicaid Resubmission**

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

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

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

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

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

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

Billing Instructions: Group Practice Billing Functionality

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

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

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

Billing Instructions: Negative Balance Information

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

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

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

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

Billing Instructions: Place of Service Codes

CMS - 1500 CODE

00-10	Unassigned
11	Office location
12	Patient's home
13-20	Unassigned
21	Inpatient hospital

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

Billing Instructions: Special Billing Instructions: BabyCare Program

Locator	Special Instructions

24A	Dates of Service. When billing for BabyCare Services, the from and to dates should reflect the days services were provided within a given calendar month. When the from and to dates are the same, enter that date in both sections.

24D

Procedures, Services or Supplies
CPT/HCPCS. The following procedure codes must be used.

96160	Behavioral health screening (administration and interpretation) Maternal – Administration of patient-focused health risk assessment (e.g. health hazard appraisal) with scoring and documentation per standardized instrument and procedure code (formerly 99420 that ended 12/31/16); or,
96161	Infant – Administration of care-giver focused health risk assessment instrument (e.g. depression inventory) for the benefit of the patient, with scoring and documentation per standardized instrument. Service Limitations:

Pregnant members up to end of month following 60 day postpartum.	4/12 months (for individual provider)
Infant members up to age 2.	4/12 months (for individual provider)

G9001	Case management assessment and development of service plan. Service Limitations: Two per provider, per member, every 12 months
G9002	Case management services. Requires services authorization. 1 unit = 1 day
S0215	Mileage; 1 unit = 1 mile; Must be billed with case management.

Expanded Prenatal Care Services

S9442	Preparation for Childbirth Classes
S9446	Tobacco Dependence Education and Preparation for Parenting Classes

Service Limitations (per code)
A limit of 6 units per provider per member may be billed.

Nutrition Services

97802	Nutrition assessment
97803	Nutrition follow-up visits. Indicate the number of visits in Block 24G

Service Limitations
Limited to one assessment and no more than two follow-up visits.

Homemaker Services

S5131	Homemaker Services

Service Limitations
Not to exceed four hours (units) per day. May not exceed 31 days (or 124 units). Services greater than 31 days must have medical justification sent to DMAS-BabyCare for authorization.

Billing Instructions: Invoice Processing

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

- **Remittance Voucher (Payment Voucher)** - DMAS sends a Remittance Voucher with each payment. This voucher lists the approved, pended, 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;
  - **Pended** - These claims are being reviewed. The final adjudication of this claim will be a later Remittance Voucher;
  - **Denied** - These claims are denied and are not reimbursable by DMAS as submitted (e.g., the submission of a duplicate claim of a previously submitted claim);
  - **Debit** - This section lists any formerly paid claims which have been adjusted, thereby creating a positive balance;
  - **Credit** - This section lists any formerly paid claims which have been either adjusted or voided and have created a negative balance; and
  - **Provider Number** - The nine-digit API or NPI identification number assigned to the individual provider. Include this number in all correspondence with DMAS.
- **No Response** - If one of the above responses has not been received within 30 days, the provider should assume non-delivery and rebill using a new invoice form.

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

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 (BabyCare)

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 knows 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 and the specific documentation requirements for BabyCare services 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.

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.

BabyCare Requirements

Eligibility

Recipients must be eligible for Fee-for-Service (FFS) or Primary Care Case Management, Medicaid, FAMIS, FAMIS Plus or FAMIS MOMS on the date of service. Maternal members must be either pregnant or up to the end of the month following their sixtieth day post-partum. Infant members are eligible for BabyCare case management up to their second birthday.

Member's Consent for BabyCare Services

Individuals cannot be forced to receive BabyCare services for which they might be eligible. The member/member's primary caregiver must agree to be open for services and refusal of services will not negatively impact the member's benefits.

Note: DMAS requires the completion of the Letter of Agreement (DMAS-55) or equivalent to support the member's or member's primary caregiver willingness to be open for BabyCare services. The documentation should be kept in the member's medical record.

Member Choice and Involvement in the Planning Process

- Documentation must indicate that the member was given a choice of available BabyCare Service providers.
- Documentation must indicate that the member or member's caregiver was involved in the assessment, Service Plan development and any changes to the Service Plan.

Screening Requirements

DMAS will reimburse providers, as defined in Chapter II of this manual, for administering the *Behavioral Health Risks Screening Tool* {DMAS 16-P (Provider) and DMAS 16-S (Self-Instrument)} . The completed screening tool and outcome including referrals must be documented in the member's medical record. This tool replaces the BabyCare Maternity Risk Screen (DMAS 16) and the BabyCare Infant Risk Screen (DMAS 17).

Note: Practitioner's may document in the infant's medical record for completion of a screening of the infant's mother, that a "risk assessment" has been performed. To maintain the confidentiality of the mother's screen, keep the screening tool and results in a separate file.

Universal Referral Form

DMAS has approved the use of the *Virginia Home Visiting Consortium's Universal Referral Form* as a template for use as a referral mechanism to BabyCare. BabyCare providers may adapt the form and change it to meet their community's needs. Note: Referrals to BabyCare are not a reimbursable service. DMAS has removed the requirement for a "Risk Screen" to be completed to initiate a referral to BabyCare. This change was made to reduce any potential barriers for an at-risk pregnant or infant enrollee to be referred for BabyCare services.

Case Management Documentation Requirements

BabyCare providers must maintain records for each member which includes, at a minimum, the following information:

- Evidence that the member or member's primary caregiver has agreed to be open to services (via Letter of Agreement DMAS 55 or equivalent)
- Identification of the member on each entry by full name and Medicaid/FAMIS ID number;
- Documentation must be clear and legible;
- Signatures and complete dates are required for all documentation or entries and must include, at a minimum, the first initial and last name and credentials;

- Written documentation verifying the qualifications of the nurse or social worker providing the services must be maintained and available for review;
- All contacts and attempted contacts (face-to-face, telephonic and collateral) signed and dated by the individual providing the service;
- Evidence of coordinating care with the member's primary care provider (PCP);
- A timeline for obtaining needed services as well as a timeline for reevaluation of the Service Plan (via DMAS 52 or equivalent);
- All interventions to include the nature and content of services received and which goals the intervention is addressing;
- Documentation of the need for, and occurrences of, coordination with other case managers;
- Copies of all required forms, or equivalents, as specified within this chapter;
- If the nurse or social worker was not able to complete the initial face-to-face assessment (via DMAS 50 (M)aternal or (I)nfant) within the first 30 calendar days from date of referall, there must be specific documentation to the reason the face-to-face contact did not occur;
- Documentation must be evident that the member is receiving services as detained in the Service Plan during any month in which billing for services occurs; and
- The Service Plan must address needs identified in the case manager's assessment and be reviewed and updated as necessary to reflect changes in the member's service needs.

Services may not duplicate any other covered service provided under the Medicaid or FAMIS State Plans or other Medical Assistance programs. If the BabyCare case manager is involved in the direct provision of medical or prenatal care services, the documentation must clearly differentiate the case management services from other service provisions.

High Risk Case Management Service authorization Request Form (DMAS 50 M/I)

During the initial face-to-face meeting, the nurse or social worker completes a comprehensive assessment and documents this on the BabyCare Service authorization Request form (DMAS 50 [M]aternal or [I]nfant) and notes this as entry in member's medical record.

The following documentation is required to be completed on the assessment for service authorization of case management services:

- Member's name;
- Medicaid/FAMIS ID number;
- Member's date of birth;
- Pregnant member's obstetric history (Gravida, para, AB elective, AB Spontaneous);
- Pregnant member's estimated date of delivery;
- Date that case management services began;
- Provider's National Provider Identifier (NPI);
- Provider's Agency Name;
- At lease one risk must be checked to indicate at risk pregnancy or infant;

- Signature and date of case manager completing the assessment.

Service Plan

The nurse or social worker uses the information obtained from the assessment to create a Service Plan with the member or member's caregiver. The Service Plan is an individualized description of what services and resources are needed to meet the service needs of the member and a plan to access those resources. The Service Plan includes active participation of the member or member's caregiver in developing and working towards specified goals. The provider may use the DMAS 52 or equivalent documentation that include the following:

1. The member's identifying information;
2. A list of identified needs/problems identified during the assessment process including medical, social, and educational needs. Resolved problems and/or issues the member does not wish to address may be documented in the member's record;
3. A plan for interventions addressing the identified problems. This includes all necessary referrals; and
4. A plan for follow-up.

After the member is enrolled in case management services, the nurse or social worker conducts periodic reassessments as needed and must update the service plan as necessary.

Closing to Case Management Services

The provider must send a letter stating that the member's case is being closed to the member and the member's primary care provider or referring provider.

DMAS no longer requires the provider to submit notification of the closure of member's case. Upon closure of case to BabyCare case management, DMAS requires that the provider document the following in the member's medical record, including the following:

- Documentation of Part C referral if infant appears to not be developing as expected or who have a medical condition that can delay normal development.
- Documentation of the *Behavioral Health Risks Screening for Women of Childbearing Age* administration and outcome, as applicable.
- The referrals that were initiated upon closure to case management for purposes of discharge planning.
- Signature of case manager and date completed.

Expanded Parental Services

Member Education Classes

A written record must be kept for each member which includes:

- The member's name and Medicaid/FAMIS ID number;
- The course being provided;
- The instructor teaching the course; and
- Verification through the member's signature of the dates of each course session attended.

Nutrition Services

The provider of nutrition services must develop a written dietary assessment for each member which includes, at a minimum, the following information: height and weight measurements (including pregravid weight), laboratory values, dietary habits, socioeconomic status, complications of pregnancy involving a nutrition component, a nutrition care plan for follow-up and referral based on individual needs, and provide nutrition counseling based on the assessment and care plan. Documentation of participation in food assistance programs such as WIC or the Supplemental Nutrition Assistance Program (SNAP) should also be included. It is also acceptable to maintain laboratory values in the laboratory section of the member's record.

Documentation for the nutrition follow-up visits must include progress notes which document how the concerns found in the initial assessment have been addressed.

Blood Glucose Monitors

The physician must follow the guidelines for ordering blook glucose monitors which is detailed in the DMAS Durable Medical Equipment (DME) Provider manual available online at www.dmas.virginia.gov. When a physician determines that a pregnant enrollee is at risk due to her diabetes and authorizes the use of a blood glucose monitor, Virginia Administrative Code requires that the a referral to a nutritionist be completed. The ordering physician must indicate in the member's medical record that a referral for nutrition counseling was initiated.

Homemaker Services

A written record must be kept which includes the following:

- A referral from the primary care provider supervising the member's prenatal and/or postpartum care which states that the member is confined to bed for a specific period of time;
- An assessment performed by the supervisor of the homemaker service that states what services are required for the normal functioning of the bed-bound member's household. The assessment should reflect inquiries into such elements as: the number and age of persons in the household, availability of assistance by relatives/friends, needs as perceived by the bed-bound member, etc.;
- A Service Plan developed based on the needs assessment that states specific services needed and the frequency of services;
- All documentation for the extension of services, if necessary;
- Services rendered and length of the visit by the homemaker; and
- Signatures by the homemaker and the member verifying services received for each date of service.

Homemaker services rendered must be reviewed monthly by the supervisor and documented in the record. Flow sheets may be utilized by the homemaker and/or the supervisor for documentation purposes.

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 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

Appendix A: Definition of Terms

Updated: 12/5/2008

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Supplement B: EPSDT

Qualified EPSDT Screening Providers

Qualified providers of EPSDT screening services include:

- A physician licensed by the Board of Medicine;
- A physician assistant licensed by the Board of Medicine under supervision as required by their license;
- A nurse practitioner licensed by the Board of Nursing under supervision by a licensed physician;
- Federally Qualified Health Centers (FQHCs);
- Rural Health Clinics (RHCs);
- Local health departments;
- School based health clinics; and
- Other DMAS approved clinics

EPSDT providers must be Medicaid enrolled providers and must meet all applicable Medicaid provider and specific EPSDT screening requirements. There are no additional enrollment requirements for qualified providers to participate in EPSDT.

The Primary Care Physician's Role in Screening

PCPs for children in MCO's must directly provide EPSDT services for all children assigned to them. Those children who are not enrolled in managed care may obtain these services from any Medicaid enrolled physician or clinic qualified to provide EPSDT services and also offers these services. These qualified Medicaid enrolled fee-for-service EPSDT providers must follow the same requirements indicated in this manual. The Managed Care Help Line maintains a list of these providers. There are no special enrollment procedures for recipients to access EPSDT services.

The PCP or EPSDT screening provider (both MCO and FFS), must perform the following activities related to screening services:

- Advise families of the importance of regular preventive health care for their children and explain EPSDT services.
- Provide or arrange for initial and periodic EPSDT preventive health screenings according to the DMAS periodicity schedule and screening requirements.
- Assure that the initial screening is scheduled within thirty (30) days of notification of managed care assignment and immediately upon notification of newly assigned newborns unless the services are declined.
- Notify families when the next screening is due including those families who have previously declined screening services and encourage them to keep all screening appointments.
- Schedule the next screening appointment and maintain periodicity and tracking system on screenings.
- Follow up on missed or incomplete screenings including contacting families and rescheduling the screenings promptly.
- Coordinate care for children referred to other qualified providers for screening services and specialty care and obtain results of the screenings and other health care services.
- Maintain a comprehensive and integrated medical record of all health care the child receives including complete documentation of all EPSDT screening components and immunizations given.

MCOs may assume responsibility for some of the informing, tracking and notifying functions of PCPs. One of the primary goals of DMAS' managed care programs is to promote a "medical home" for children so that recipients under the age of 21 receive both sick and well care from their PCP rather than seek episodic care from an emergency room. A PCP who chooses not to directly provide screening services must enter into a formal written agreement with a local health department, FQHC, or other qualified EPSDT provider to provide screening services to children in his panel. The referral duration will be at the discretion of the provider, and must be fully documented in the patient's medical record. "Exhibits" at the end of this chapter contains an optional referral form for this purpose. Regardless of the screening arrangements, the PCP must continue to be responsible for the informing, tracking, follow-up and documentation requirements of EPSDT.

The EPSDT Screening Periodicity Schedule

EPSDT screenings are Medicaid's well child visits and should occur according to the "American Academy of Pediatrics Recommendations for Preventive Pediatric Health Care". The DMAS periodicity schedule is included as Appendix 1 under "Exhibits" at the end of this chapter. Providers must obtain a medical history that is inclusive of mental health risk factors and documents the family's history of mental health conditions.

EPSDT screenings, inter-periodic screenings and the required components of the screenings do not require service authorization requirements. However, screenings not performed by the child's PCP require a referral from the PCP. Children not enrolled in managed care are not subject to this referral requirement.

EPSDT Screening Components

This Section describes the required components of EPSDT screenings for members enrolled in Fee for Service and Managed Care Organizations. The EPSDT comprehensive health screening/well child

visit content should be in line with the most current recommendations of the **"American Academy of Pediatrics (AAP), Guidelines for Health Supervision"**. Another resource for preventive health guidelines is the AAP compatible **"Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents"**. All components of EPSDT screenings, including specimen collection, must be provided during the same screening visit.

The following is a description of each of the required age appropriate screening components:

Comprehensive Health and Developmental/Behavioral History

At the initial screening, the screening provider must obtain a comprehensive health, developmental/behavioral, mental health and nutritional history from the child's parents or a responsible adult familiar with the child, or directly from an adolescent, when appropriate. This history should be gathered through an interview or questionnaire. A comprehensive initial history includes a review of the:

- Family medical history (health of parents and current family members, identification of family members with chronic, communicable or hereditary diseases);
- Patient medical history (prenatal problems, neonatal problems, developmental milestones, serious illnesses, surgeries, hospitalizations, allergies and current health problems and medications);
- Nutritional history;
- Immunization history;
- Environmental risk (living conditions, water supply, lead, sewage, pets, smokers in home);
- Family background of emotional problems, problems with drinking or drugs or history of violence or abuse; and
- Patient History of behavioral and/or emotional problems (educational environment and performance, family and social relationships, hobbies, sports).

In addition, for all adolescent children, the initial history must include:

- History of sexual activity, if appropriate
- Menstrual history for females
- Obstetrical history, if appropriate

The history must be updated at each subsequent screening visit to allow serial evaluation.
Developmental Surveillance, Assessment, and Screening

DEVELOPMENTAL SURVEILLANCE

Developmental surveillance should be conducted at each well-child visit. Developmental surveillance is the process of recognizing children who may be at risk of developmental delays. Surveillance is longitudinal, continuous, and cumulative and is comprised of the following components: parental concerns; developmental history; observation of the child; identification of risk and protective factors; and accurately documenting the process and findings. The following are examples of conducting surveillance:

- Parental concerns: Simple questions to parents such as "do you have any concerns about your

child's development? Behavior? Learning? Asking about behavior can help identify issues, as parents may not be able to differentiate between development and behavior.

- Developmental history: Ask parents about changes since the last visit, and questions about age-specific developmental milestones such as walking, pointing, etc.
- Observation: The health care provider can often see evidence of age-specific developmental milestones, and may be able to confirm parental concerns. It is also important to monitor the parent's response to the infant, and vice versa.
- Risk and protective factors: Infants born prematurely, at low or very low birth weight, or with prenatal exposure to alcohol, drugs, or other toxins are at risk for developmental delay. Protective factors to support infants at risk, such as participation in home visitation program, or strong connections within a loving and supportive family, should also be considered in determining the overall degree of risk.

Surveillance services are always a subjective observation by the practitioner. Reimbursement for well child visits includes surveillance activities because developmental, hearing and vision surveillance occurs during the course of each EPSDT visit. When a child has an issue that warrants further investigation by the practitioner, then the child may receive a screening to document the need for further assessment or evaluation.

DEVELOPMENTAL SCREENING TOOLS

If at any time developmental surveillance demonstrates a risk for developmental delay, a standardized screening tool should be administered to further assess the child. As recommended by the AAP, developmental screening using a standardized screening tool should occur at 9, 18, 24 and 30 months of age or at any time when surveillance indicates a risk for developmental delay. An autism specific screening is recommended at the 18 and 24 month visit. Children should be screened for developmental concerns at least 5 times while they are younger than three years of age.

Developmental assessment and screening differs from surveillance because the activity of assessment and screening includes the use of a standardized developmental screening tool. The tools used may vary according to the type of screening or assessment that is provided. All of the examples listed below can be performed by a parent or other office staff and interpreted by the physician during the "face to face" portion of the child's visit. These tools are designed to be used easily as part of the typical office work flow and the tools are very sensitive and specific with proven statistical validity.

Recommended Developmental Screening Tool

Parents' Evaluation of Developmental Status (PEDS),	Parent-report instrument used to identify general developmental delay in the general primary care population
Ages and Stages Questionnaire (ASQ),	Parent-report instrument used to identify general developmental delay in the general primary care population and/or broad highrisk population
Bayley Infant Neurodevelopmental Screen (BINS),	Practitioner-administered instrument used to identify general developmental delay in the high-risk population

Cognitive Adaptive Test/Clinical Linguistic Auditory Milestone Scale Expressive and Receptive Language Scale (CAT/CLAMS),	practitioner-administered instrument used to identify general developmental delay in the high-risk population
Language Development Survey (LDS),	parent-report instrument used to identify language delay in the general primary care population
Clinical Linguistic Auditory Milestone Scale Expressive and Receptive Language Scale (CLAMS),	practitioner-administered instrument used to identify language delay in the high-risk population
Modified Checklist for Autism in Toddlers (M-CHAT)	parent-administered instrument used to screen for autism and developmental delay in the general primary care population

Recommended Tools for Focused Screening for suspected health conditions:

Cognitive Adaptive Test/Clinical Linguistic Auditory Milestone Scale Expressive and Receptive Language Scale (CAT/CLAMS),	practitioner-administered instrument used to identify general developmental delay in the high-risk population
Language Development Survey (LDS),	a parent-report instrument used to identify language delay in the general primary care population
Clinical Linguistic Auditory Milestone Scale Expressive and Receptive Language Scale (CLAMS),	practitioner-administered instrument used to identify language delay in the high-risk population
Modified Checklist for Autism in Toddlers (M-CHAT)	parent-administered instrument used to screen for autism and developmental delay in the general primary care population

Hearing and Vision Screening and Surveillance

Subjective

The subjective screening for hearing and vision is part of the comprehensive history and physical examination. Children's hearing is assessed according to the AAP policy for "Hearing Assessment in Infants and Children: Recommendations Beyond Neonatal Screening". Children's vision assessment should be provided according to the AAP policy for "Eye Examination in Infants, Children, and Young Adults by Pediatricians". Hearing and Vision screenings follow the most current AAP periodicity schedule as stated in the AAP "Recommendations for Preventive Pediatric Health Care".

The Virginia Early Hearing Detection and Intervention (EHDI) program, the AAP, and the American Speech-Language-Hearing Association provide information on objective hearing screening methods for infants and toddlers.

The EHDI program has a resource, Protocols for Medical Management, that defines best practices for caring for infants and young children who are in need of follow-up from universal newborn hearing screening programs and for children who are found to have hearing loss. The Early Hearing Detection and Intervention protocols can be accessed the Virginia EHDI Program Web site,

http://www.vahealth.org/hearing/. Early and consistent intervention specific to hearing loss is essential to achieving normal language development.

Information on vision assessment and surveillance may be found in The American Association for Pediatric Ophthalmology and Strabismus, the American Academy of Ophthalmology, and the American Academy of Pediatrics Section on Ophthalmology.

Screening and Testing Using Standardized Methods

The provision of hearing or vision testing using a standardized instrument during the well child visit is billable on that service day as a distinct service. Hearing and vision testing using a standardized instrument is eligible for reimbursement when performed according to the DMAS periodicity schedule or when required to monitor the progression of hearing or vision loss related to the presence of identified risk factors.

Virginia Law Regarding Hearing Screening at Birth

Virginia law requires that effective July 1, 2000, all infants will be given a hearing screening before discharge from the hospital after birth. Those children who did not pass the newborn hearing screening, those who were missed, and those who are at risk for potential hearing loss should be scheduled for evaluation by a licensed audiologist.

Comprehensive Unclothed Physical Examination

A complete unclothed physical examination must be performed at each screening visit. The examination must be conducted using observation, palpation, auscultation and other appropriate techniques using the criteria for specific age groups described in the latest edition of the *AAP Guidelines for Health Care Supervision*. The examination must include all body parts (or areas) and systems listed below:

- Cranium and face
- Hair and scalp
- Ears
- Eyes
- Nose
- Throat
- Mouth and teeth
- Neck
- Skin and lymph nodes
- Chest and back (using a stethoscope) to check for heart and lung disorders
- Abdomen
- Genitalia
- Musculoskeletal system
- Extremities
- Nervous system

The examination must include screening for congenital abnormalities and for responses to voices and other external auditory stimuli. Evaluation of the Tanner stage and scoliosis screening must be

included as part of the complete physical examination at each screening visit beginning at age ten.

In addition, the height (or length) and weight of the child must be measured. When examining a child two (2) years of age and younger, the provider must measure the child's occipital-frontal circumference. All measurements must be plotted on age-appropriate, standardized growth grids and evaluated.

Evaluation of growth and laboratory measures is useful for assessing nutritional status. Assessing eating habits in relationship to developmental stage is also important. If dietary or nutritional problems are identified, a referral to the appropriate professional should be made.

For children three and above, the physical examination must include blood pressure measurement.

As part of the physical examination, excessive injuries or bruising that may indicate inadequate supervision or possible abuse must be noted in the child's medical record. If there is suspicion or evidence that the child has been abused or neglected, State law requires medical professionals to promptly report it to the Department of Social Services' Hotline 1-800-552-7096 (Code of Virginia Section-63-248.3).

Immunizations and Laboratory Tests

Age appropriate immunizations should be provided according to the Advisory Committee on Immunization Practices (ACIP) guidelines. All "catch up" schedules for missed vaccines should follow ACIP guidelines. The child's immunization status must be reviewed from the child's medical record and interview with the parent at each screening visit. If the immunization history is based on the verbal report of the parents or other responsible adult, the information must be confirmed and properly documented, indicating the source.

Age-appropriate immunizations that are due must be administered during the screening visit. Immunizations given to a child during a screening visit may be billed separately. PCPs and other medical screening providers are required to participate in the Virginia Vaccines for Children (VFC) Program and provide necessary immunizations and information about the benefits and risks of immunizations as part of EPSDT screenings. The PCP and screening provider must ensure that every child is immunized according to the current Childhood Immunization Schedule approved by ACIP and AAP. A parent's refusal to allow immunizations must be documented by a statement in the child's medical record that is signed and dated by the parent. If a condition is identified during the screening that warrants deferral of necessary immunizations to a later date, the progress notes in the medical record must so indicate. The provider must follow up to reschedule the child to catch up on immunizations at the earliest possible opportunity.

VACCINES FOR CHILDREN PROGRAM

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

To be eligible for free vaccine from the VFC Program, children must be under the age of 19.

VFC eligible must also meet one of the following criteria:

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

Requirement to Enroll in VFC

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

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

Billing Codes for the Administration Fee

Providers must use Medicaid-specific billing codes when billing Medicaid for the administration fee for free vaccines under VFC. These codes identify the VFC vaccine provided and will assist VDH with its accountability plan which the Health Care Financing Administration (CMS) requires. The billing codes are provided in the Current Procedural Terminology (CPT-4) books.

Billing Medicaid as Primary Insurance

For immunizations, Medicaid should be billed first for the vaccine administration. This is regardless of any other coverage that the child may have, even if the other coverage would reimburse the vaccine administration costs. Medicaid will then seek reimbursement from other appropriate payers. When a child has other insurance, check “YES” in Block 11-D (Is there another health benefit plan?) on the CMS-1500 (08-05)claim form. See the Physician/Practitioner Manual for further instructions.

Reimbursement for Children Ages 19 and 20

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

Vaccines Not Available Under VFC

The Virginia Department of Health has no contracts with the Centers for Disease Control (CDC) for the VFC distributor to provide Diphtheria Tetanus and Pertussis (DTP) and Hepatitis B for dialysis patients. Therefore, Medicaid will reimburse for the acquisition cost for these vaccines under CPT

codes 90701 and 90747, respectively. No administration fee will be reimbursed under code since this vaccine is not available under VFC.

Single Antigen Vaccines

Single antigen vaccines (such as measles, mumps, and rubella) are available from the VFC contractor but must be ordered by the provider with special justification since the combined antigen vaccine (MMR) is available. This is consistent with Medicaid policy to require medical justification for single antigen vaccines.

Pneumococcal and Influenza Vaccines for Adults Aged 19 and Older

Medicaid will provide reimbursement for these vaccines only if they are reasonable and necessary for the prevention of illness. Medical justification needs to be attached to the claim. The physician's treatment plan on file in the patient's medical record must indicate that the vaccine was provided to prevent the occurrence of more serious illness in an individual "at risk."

Situations Where Vaccines Are Not Covered Under VFC

There may be some situations where a child is attempting to "catch-up" on vaccines that have been missed. In some cases, the VFC program will not provide coverage for these "catch-up" vaccines, and the provider will have to purchase them from his or her normal vaccine distributor. If this occurs, Medicaid will continue to reimburse the provider for the acquisition cost of these vaccines as long as there is information attached to the claim indicating the reason for billing Medicaid for the acquisition cost. In addition to the attachment to the claim, use modifier 22 in Block 24-D of the CMS-1500 (08-05) claim form.

Vaccines Provided Outside of the EPSDT Periodicity Schedule

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

Billing for Childhood Immunizations

The Federal Vaccines for Children (VFC) Program provides routine childhood immunizations free of charge to Medicaid-eligible children up to age 19. These vaccines are provided to VFC enrolled providers by the Virginia Department of Health (VDH). DMAS requires that PCPs serving children and EPSDT screening providers participate in the VFC program. Providers may enroll in the VFC Program by contacting VDH at 1-800-568-1929. DMAS and the DMAS contracted MCO's will not reimburse providers for the acquisition cost of vaccines that are covered under the VFC Program.

DMAS reimburses providers for the administration fee for routine childhood vaccines that are available under VFC (up to the age of 19). DMAS will reimburse the provider an $11.00 administration fee per injection. MCOs are responsible for provider payments of immunizations furnished to children enrolled in MCOs. Therefore, providers cannot be reimbursed by DMAS for immunizations provided to MCO enrolled children.

Reimbursement for Children Ages 19 and 20

Since EPSDT Federal regulations require states to provide coverage for vaccines for children up to the age of 21, and VFC provides coverage only up to the age of 19, there may be instances where the provider will provide immunizations to children who are ages 19 and 20. In these instances, the provider must use the appropriate CPT procedure code. DMAS will reimburse the acquisition cost for these vaccines. The charges in locator 24F of the HCFA 1500 (12-90) claim form must reflect the actual acquisition cost per dose. Providers should refer to Chapter V of the DMAS Physician Manual for further billing guidance.

VFC Coverage of Other Vaccines

The VFC program covers other vaccines not included in the ACIP immunization schedule including single antigen vaccines. If the provider chooses to provide a single antigen vaccine, such as measles, mumps, or rubella, medical justification, which documents the medical necessity of providing a single antigen vaccine when the combined-antigen vaccine is available, must be attached to the claim. Claims for measles, mumps, or rubella vaccines will automatically pend for review by DMAS staff. The VFC Program also provides coverage for the pneumococcal and influenza vaccines for high-risk patients only. When ordering these vaccines through VFC, the provider must provide medical justification. DMAS will provide reimbursement for these vaccines only if they are reasonable and necessary for the prevention of illness. Medical justification does not need to be attached to the claim, but the physician’s treatment plan on file in the patient’s medical record must indicate that the vaccine was provided to prevent the occurrence of more serious illness in an individual “at risk”.

Age appropriate immunizations are a federally required screening component. The provider must not submit a claim for a complete screening unless all required components that are due are administered and documented including appropriate immunizations according to age and history (unless medically contraindicated or the parents refuse at the time). Failure to comply with or properly document this screening requirement must constitute an incomplete screening and may result in denial of payments.

Laboratory Procedures

EPSDT REQUIREMENTS FOR LEAD TESTING

As part of the definition of EPSDT services, the Medical Statute requires coverage for children to include both screening and blood lead tests as appropriate, based on age and risk factors. The Centers for Medicare and Medicaid Services (CMS) requires all Medicaid enrolled children receive a blood lead test at 12 months and 24 months of age. In addition, any child between 24 and 72 months with no record of a previous blood lead screening test must receive one. The medical record will be deemed insufficient if the child has not been previously screened. Completion of a risk assessment

questionnaire does not meet the Medicaid requirement. The Medicaid requirement is met only when the two blood lead screening tests identified above (or a catch-up blood lead screening test) are conducted (https://www.medicaid.gov/federal-policy-guidance/downloads/cib113016.pdf).

Confirmation of blood lead levels

Blood Lead level testing shall be performed on venipuncture or capillary blood; however, additional testing may be required, as described below. Filter paper methods are also acceptable and can be performed at the provider's office. The use of handheld testing machines must be approved through the Lead-Safe Virginia Program to assure proper quality assurance and reporting of data.

Tests of venous blood performed by a laboratory certified by the federal Centers for Medicare & Medicaid Services in accordance with 42 USC § 263a, the Clinical Laboratory Improvement Amendment of 1988 (CLIA-certified), are considered confirmatory. Tests of venous blood performed by any other laboratory and tests of capillary blood shall be confirmed by a repeat blood test, preferably venous, performed by a CLIA-certified laboratory. Such confirmatory testing shall be performed in accordance with the following schedule (requirements of 12VAC5- 90-215):

If result of screening test (µg/dL) is:	Perform diagnostic test on venous blood within:
5-9	1-3 months
10-44	1 week - 1 month
45-59	48 hours
60-69	24 hours
70 or higher	Immediately as an emergency lab test

For consultation and assistance on the treatment of children with elevated venous blood levels 70 or higher contact Emergency Lead Healthcare through their free medical hotline at 1-866-767- 5323 (1-866-SOS-LEAD).

LEAD TESTING PROCEDURE CODES

If blood lead screening tests are conducted in the providers' offices, the code 83655 for Lead blood testing is used with one of the following: 36416 or 36415, depending on whether the sample is from a capillary or venous site, as shown below.

Service Description	Procedure Code
Lead Lab Test (paid to Lab or EPSDT screener)	CPT 83655
Capillary Sample (finger, heel, ear, stick)	CPT 36416
Venous Sample (recommended)	CPT 36415

When blood lead testing is provided to a client enrolled in a Virginia Medicaid Managed Care Organization (MCO), please follow the MCOs specific billing instructions.

Remember to always verify Medicaid eligibility before services are rendered.

VIRGINIA REGULATIONS FOR DISEASE REPORTING AND CONTROL

The Virginia Regulations for Disease Reporting and Control require physicians and the directors of laboratories to report any “detectable” blood lead levels in children ages 0-15 years to the Local Health Department within 3 days.

In October 2016, these regulations were updated and “Lead, elevated blood levels” was renamed “Lead, reportable levels”. “Lead, reportable levels” now means any detectable blood lead level in children 15 years of age and younger and levels greater than or equal to 5 µg/dL in a person older than 15 years of age (12VAC5-90-10). This requirement applies to test results confirmed by a CLIA-certified laboratory. Results of office-based screening tests do not need to be reported.

Many laboratories submit disease reports by means of secure electronic transmission. Reports may also be submitted by using the Epi-1 form that can be found on the Virginia Department of Health (VDH) web site at: http://www.vdh.virginia.gov/content/uploads/sites/13/2016/03/Epi1.pdf

For more information, please visit the VDH web site: http://www.vdh.virginia.gov/surveillance-and-investigation/commonwealth-of-virginiastateboard-of-health/

MEDICAID FUNDED ENVIRONMENTAL INVESTIGATIONS

Environmental investigations are a service offered by Medicaid through Lead-Safe Virginia and local health departments. Environmental investigations are reimbursed to local health departments enrolled with DMAS or contracted with a Virginia Medicaid MCO. Medicaid funds are not available for the testing of environmental substances such as water, paint, or soil. Environmental investigations are conducted when certain criteria are met and may be carried out by private entities or environmental health specialists in local health departments who are licensed risk assessors. For information about what triggers an environmental lead investigation and what it includes, go to http://www.vdh.virginia.gov/environmental-health/childhood-leadpoisoning-prevention.

For additional questions about environmental lead testing, contact Lead-Safe Virginia toll-free at 1-877-668-7987. You may also email Lead-Safe Virginia at leadsafe@vdh.virginia.gov.

Resources for more information about blood lead testing and lead exposure

Lead-Safe Virginia

https://www.cdc.gov/nceh/lead/programs/va.htm

The National Lead Information Center (NLIC)

Environmental Protection Agency (EPA)

https://www.epa.gov/lead

CDC Childhood Lead Poisoning Prevention Program

https://www.cdc.gov/nceh/lead/

Coalition To End Childhood Lead Poisoning

http://www.greenandhealthyhomes.org/StrategicPlanforEndingLeadPoisoning

Additional Laboratory Procedures

In addition to the lead toxicity screening, the following procedures on laboratory tests are required:

Neonatal Screening

The screening provider must review the results of the newborn metabolic screening for phenylketonuria, hypothyroidism, galactosemia and other disorders performed prior to hospital discharge.

Sickle Cell Screening

The screening provider must review the results of the sickle cell screening performed prior to hospital discharge on the appropriate population. A sickle cell preparation must be done at the six (6) month old visit if indicated in accordance with AAP guidelines.

Anemia Screening

Iron deficiency anemia screening involving taking hematocrit or hemoglobin values through a finger prick or venous blood sample must be performed at screening visits in accordance with AAP guidelines.

Anemia screening, is a Medicaid reimbursable service, and should be administered more frequently if medically indicated. The results can be shared with the patient's written consent if the certification is needed for the Supplemental Nutrition Program for Women, Infants and Children (WIC).

EPSDT Optional Screening Procedures

The following is a description of **optional** screening procedures to be performed on children and adolescents at risk:

Tuberculin Test (Optional)

Tuberculin testing using the Purified Protein Derivative (PPD) skin test should be performed in accordance with AAP guidelines. The PPD test has replaced the Tyne method.

Cholesterol Screening (Optional)

Cholesterol and hyperlipidemia screening should be performed at each screening visit beginning at age two in accordance with AAP guidelines.

Sexually Transmitted Disease (STD) Screening (Optional)

All sexually active adolescents should be screened for sexually transmitted diseases such as

chlamydia, gonococci, and syphilis at each screening visit beginning at age 11 through age 20. HIV testing should be performed if requested or if the adolescent is at high risk.

Cancer Screening (Optional)

A Papanicolaou (Pap) smear should be performed on all sexually active females at each screening visit.

Pelvic Examination (Optional)

All sexually active females should have a pelvic examination. A pelvic examination and a Pap smear must be offered as part of preventive health maintenance between the ages of 18 and 21.

Anticipatory Guidance

Health Education, also called “Anticipatory Guidance”, and problem focused guidance and counseling are provided at each well child visit according to developmental needs and with respect to patient cultural backgrounds and literacy levels.

The **Bright Futures** program has family friendly materials that provide useful anticipatory guidance information and age appropriate safety and parenting tips. For more information on Bright Futures, go to the web based training module at http://www.vdh.virginia.gov/brightfutures/ DMAS endorses **Bright Futures** and **Bright Futures Virginia**.

Referral to Dental Screening

Federal EPSDT regulations require a direct referral to a dentist beginning at age three. An oral inspection must be performed by the EPSDT screening provider as part of each physical examination for a child screened at any age. Tooth eruption, caries, bottle tooth decay, developmental anomalies, malocclusion, pathological conditions or dental injuries must be noted. The oral inspection is not a substitute for a complete dental screening examination provided through direct referral to a dentist.

The PCP or other screening provider must make an initial direct referral to a dentist when the child receives his or her three-year screening. The initial dental referral must be provided at the initial medical screening regardless of the periodicity schedule on any child age three or older unless it is known and documented that the child is already receiving regular dental care. The importance of regular dental care must be discussed with the family (and child as appropriate) on each screening visit for children three (3) years and older. When any screening, even as early as the neonatal examination, indicates a need for dental services at an earlier age, referral must be made for needed dental services.

Client Education Course Contents

Preparation for Childbirth (S9442)

- Breastfeeding
- Car safety during pregnancy (safety belts, air bags)
- Signs and Symptoms of pre-term labor
- Anatomy and physiology of reproduction
- Fetal development
- Physical changes during pregnancy and postpartum
- Emotional changes during pregnancy and postpartum
- Teratogens/smoking/alcohol
- Prescriptions and over-the-counter medications
- Maternal nutrition
- Coping mechanisms/comfort measures (exercises relaxation and breathing)
- Prenatal diagnostic procedures, screening, medical interventions
- Common abnormalities during pregnancy and labor
- Medical procedures during labor
- Obstetrical anesthesia/analgesia
- Newborn characteristics
- Infant nutrition
- Birthing options
- Consumer advocacy/rights of clients
- Family-centered care
- History/philosophy of childbirth education/prepared childbirth
- Birth control options following delivery

Preparation for Parenting (S9446)

- Breastfeeding
- Tobacco Dependence
- Growth and development
    - Physical
    - Mental/cognitive/personality
    - Developmental tasks (child, parents, siblings)
    - Infant stimulation needs
- Health and nutrition

    - Age-related nutrition
    - Preventive health care
    - Immunizations
    - Common illnesses
- Safety
    - Home (include toy safety)
    - Car, car seat
- Lead safety
- Sudden Infant Death Syndrome (SIDS)
- Safe Sleeping
- Safe Bathing Practices
- Behavior/discipline
    - Temperament
    - Parental coping skills
    - Non-physical means of discipline
    - Consistency in discipline
- Support
    - Emotional needs/support systems
    - Resources (readings, groups)