Durable Medical Equipment and Supplies

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General Information

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

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

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

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

Program Background

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

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 Originally enacted by the Social Security amendments of 1965 (Public Law 89-97), Title XIX was approved on July 30, 1965.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

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

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

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

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

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

General Scope of the Program

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

Covered Services

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

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

- Blood glucose monitors and test strips for pregnant women

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

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

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

    - Health education

- Home health services

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

- Hearing services

- Inpatient psychiatric services for members under age 21

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

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

- Skilled nursing facilities for persons under 21 years of age

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

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

criteria for non-State Plan services under EPSDT.

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

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

- Emergency hospital services

- Emergency services for aliens

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

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

- Eye refractions

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

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

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

- Laboratory and radiograph services

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

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

- Mental Health:

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

- Substance Use Disorder:

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

- Outpatient Treatment

- Community Living Waiver:

- Nurse-midwife services
- Nursing facility services

- Occupational therapy

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

- Optometry services

- Outpatient hospital services

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

- Papanicolaou smear (Pap) test

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

- Podiatry services

- Prostate specific antigen (PSA) test (1998)

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

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

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

- Reconstructive surgery - post-mastectomy (1998)

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

- Renal dialysis clinic services

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

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

Adult (Medicaid Expansion) covered group.

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

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

- Transportation services related to medical care

- Treatment Foster Care Case Management

General Exclusions

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

Examples of such non-covered services are as follows:

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

- Acupuncture

- Artificial insemination or in vitro fertilization

- Autopsy examinations

- Cosmetic surgery

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

services which are unrelated to patient care

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

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

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

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

- Unkept or broken appointments

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

- Weight loss programs

MEMBER COPAYS

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

Managed Care Programs

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

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

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

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

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

Managed Care Enrollment Broker (Maximus)

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

- **Medallion 4.0**

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

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

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

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

- **CCC Plus**

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

MCO Provider Reimbursement

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

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

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

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

Eligibility and MCO Enrollment Verification

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

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

Continuity of Care

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

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

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

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

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

Family Access to Medical Insurance Security (FAMIS) Plan

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

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

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

FAMIS Covered Services

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

The following services are covered for FAMIS enrollees:

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

  - Assistive technology

  - Blood lead testing

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

  - Intensive in-home services

  - Therapeutic day treatment

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

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

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

Member Copays

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

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

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

*Other co-payments may apply to other services.

EMERGENCY MEDICAID SERVICES FOR ALIENS

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

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

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

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

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

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

Client Medical Management (CMM)

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

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

Providers may refer Medicaid patients suspected of inappropriately using or abusing

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

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

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

Written referrals should be mailed to:

Lead Analyst, Recipient Monitoring Unit

Division of Program Integrity

Department of Medical Assistance Services

600 East Broad Street, Suite 1300

Richmond, Virginia 23219

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

Sources of Information

MediCall Automated Voice Response System

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

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

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

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

Automated Response System (ARS)

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

HELPLINE

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

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

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

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

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

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

ELECTRONIC FILING REQUIREMENTS

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

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

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

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

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

Provider Manual Updates

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

Notice of Provider Responsibility

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

THE VIRGINIA MEDICAL ASSISTANCE MEDICALL SYSTEM

GENERAL INFORMATION

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

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

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

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

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

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

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

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

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

The telephone numbers are:

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

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

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

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

HOW TO USE THE SYSTEM

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

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

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

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

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

- Press “1” for member eligibility verification.

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

MEMBER ELIGIBILITY VERIFICATION

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

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

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

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

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

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

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

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

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

PROVIDER CHECK LOG

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

CLAIMS STATUS

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

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

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

SERVICE AUTHORIZATION INFORMATION

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

SERVICE LIMITS INFORMATION

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

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

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

PRESCRIBING PROVIDER ID

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

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

The Automated Response System (ARS)

GENERAL INFORMATION

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

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

CITY/COUNTY CODES

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

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

COUNTIES

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

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

CITIES

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

976 Central Processing Unit for FAMIS

STATE MENTAL HEALTH FACILITIES

983 Southern Virginia Mental Health Institute

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

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

996. Hiram Davis Hospital
997. Catawba State Hospital

CLIENT MEDICAL MANAGEMENT INTRODUCTION

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

MEMBER RESTRICTION

Utilization Review and Case Management

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

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

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

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

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

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

Member Enrollment Procedures

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

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

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

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

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

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

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

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

Designated Primary Care Physicians (PCP)

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

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

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

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

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

Designated Pharmacies

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

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

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

Changing Designated CMM Providers

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

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

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

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

A PCP No Longer in Practice

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

Covered Services and Limitations

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

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

Physician Services

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

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

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

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

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

Services Excluded from PCP Referral

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

Covered services that do not need a referral include:

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

- Immunizations (member under age 21);

- Family planning services;

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

- Dental services (members under age 21);

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

- School-based services.

CMM Provider Affiliation Groups

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

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

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

Emergency Room Services

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

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

CMM also requires a PCP referral form for:

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

Emergency Pharmacy Services

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

Provider Reimbursement and Billing Instructions

Management Fees

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

PCP and Designated Pharmacy Providers

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

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

Affiliated Providers

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

Referral Providers

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

Physicians Billing Emergency Room Services

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

Facilities Billing Emergency Room Services with a Referral

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

Non-designated Pharmacy Providers

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

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

REFERRALS TO THE CLIENT MEDICAL MANAGEMENT PROGRAM

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

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

Lead Analyst, Recipient Monitoring Unit

Division of Program Integrity

Department of Medical Assistance Services

600 East Broad Street, Suite 1300

Richmond, Virginia 23219

Telephone: (804) 786-6548

CMM Helpline: 1-888-323-0589

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

PROVIDER RESTRICTION

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

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

Provider Participation Requirements

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.

Provider Identification Number (DME)

Upon receipt of the signed agreement and upon approval and signature by DMAS, the ten-digit National Provider Identifier (NPI) number that was provided with the enrollment application will be assigned as the provider identification number. This number must be used on all billing invoices and correspondence submitted to DMAS. All physical locations must obtain their own separate provider identification number. This number must be used on all claims and correspondence submitted to Medicaid. DMAS will not reimburse the provider for any services rendered prior to the assignment of this provider identification number (ID).

Participation Requirements

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

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

payment from the state. The provider may not seek to collect from an eligible individual, or any financially responsible relative or representative of that individual, any amount that exceeds the established Medicaid allowance for the service rendered. A provider may not charge DMAS or an eligible individual for missed or broken appointments.

- Accept assignment of Medicare benefits for eligible individuals.
- Use DMAS-designated billing forms for submission of charges.
- Maintain and retain business and professional records sufficient to document fully and accurately the nature, scope, and details of the health care provided. In general, such records must be retained for a period of not less than six years from the date of service or as provided by applicable state laws, whichever period is longer. However, if an audit is initiated within the required retention period, the records must be retained until the audit is completed and every exception resolved. (Refer to the section titled "Documentation of Records," page 4.)
- Furnish to authorized state and federal personnel, in the form and manner requested, access to records and facilities.
- Disclose, as requested by DMAS, all financial, beneficial, ownership, equity, surety, or other interests in any and all firms, corporations, partnerships, associations, business enterprises, joint ventures, agencies, institutions, or other legal entities providing any form of health care services to eligible individuals.
- Hold confidential and use for authorized DMAS purposes only all medical assistance information regarding eligible individuals. A provider shall disclose information in his or her possession only when the information is used in conjunction with a claim for health benefits or the data are necessary for the functioning of DMAS. DMAS shall not disclose medical information to the public.

Participation Requirements for Equipment and Supplies Related to Ventilators

A medical equipment and supply provider must meet the following requirements for the provision of any durable medical equipment and supplies related to the care of a ventilator maintained in the home of an individual.

- The provider must employ or contract with a registered or certified respiratory therapist who will be available on a 24-hour-a-day basis for emergency care. The respiratory therapist should be stationed within two (2) hours of the patient’s home to facilitate an immediate response.
- The provider must employ or contract with technicians to make regularly scheduled maintenance visits.
- The provider must perform replacement or repair of the equipment and supplies as required.
- The provider must submit a copy of a current business license or a copy of a current license through the Virginia Board of Pharmacy if invasive products are distributed.
- The provider must provide instruction and training to caregivers.

Respiratory therapists must be either certified or registered by the National Board for Respiratory Care (NBRC).

The respiratory therapist must provide a monthly home visit for all individuals receiving equipment and supplies related to the care of the ventilator. This visit must be documented to include all of the following information:

- A respiratory assessment;
- A note of any instructions given to the caregiver;
- The ventilator model identification, settings, and schedule; and
- A note that the equipment has been checked, and the required information has been posted in the home.

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.

Documentation of Records (Podiatry)

The provider agreement requires that medical records fully disclose the extent of services provided to Medicaid recipients. Medical records must clearly document the medical necessity for covered services. This documentation is to be written at the time service is rendered, and be legible and clear in the description of the services rendered.

Pre-existing written protocols with contemporaneous medical record documentation may be considered in addition to the medical record to satisfy the documentation requirements. Sufficient information must be present in the medical record to support the medical necessity for the billed service. The protocol is not acceptable as a replacement for appropriate medical record documentation. A copy of the written protocol must be present in the patient's chart to be considered in any audit.

Specific points to be recorded in the medical records to meet documentation requirements include the following:

- The present complaint.
- A history of the present complaint, past medical history applicable to the complaint, and the family history applicable to the complaint.
- The positive and negative physical examination findings pertinent to the present complaint.
- Diagnostic tests ordered, if any, and the positive and negative results.
- Diagnosis(es).
- Any systemic condition that results in severe circulatory embarrassment or areas of desensitization in the legs or feet which justifies the palliative trimming of toenails or other foot lesions. See Podiatry Manual, Ch. IV, page 10, "Covered Services and Limitations," subsection entitled "NON-COVERED SERVICES AND LIMITATIONS."
- Treatment, if any, including referrals. Any drugs prescribed as part of the treatment must have the quantities and the dosage entered in the medical record.
- The record must indicate the progress at each visit, any change in diagnosis or treatment, and the response to treatment. Progress notes must be written and signed for every office, clinic, or hospital visit billed to Medicaid.
- The record must identify the patient on each page.
- Entries must be signed and dated by the responsible licensed participating provider. The documentation for the care rendered by personnel under the direct, personal supervision of the provider, which is in accordance with Medicaid policy, must be countersigned by the responsible licensed participating provider.

Examples of medical record documentation:

Initial Office Visit With Follow-Up (Please note that routine, uncomplicated post-operative care is included in the global surgical procedure and may not be billed separately.)

Jan. 20, 1989 C/O of knuckle on rt. big toe sticking out and pain on walking. Referred by family physician.

Gradual onset over 4 months with increasing pain. Unable to wear closed shoe. No drug allergies.

No current meds.

No illnesses.

First MTPJ (rt) pain on ROM. Can't stand on ball of foot without pain. X-rays show

rt. hallux with phalangeal deformity, displaced met. head.
Painful hallux valgus deformity rt. foot.

Patient informed of risks of surgery and alternative treatments.
Schedule for modified Austin bunionectomy rt.

Feb. 20 1989 2 wks. S/P mod. Austin bunionectomy rt.
Min. swelling around op. site. Incision clean and healing.

Pain controlled with Ibuprofen 200 mg. q4-6 hours

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

Quantitative:

Glucose - 85 mg/dl WBC -
7,000/mm3

Qualitative:

Antistreptolysin screen - negative

Descriptive tests:

Urine microscopic - clear, yellow-brown, few WBC, rare renal epithelial cell
X-ray (left foot) - no abnormal findings

CLARIFICATION OF CURRENT PROCEDURAL TERMINOLOGY DEFINITIONS (Podiatry)

Brief Level of Service - A documented abbreviated system evaluation. A brief office visit may indicate a recheck of a complaint for one system with previous treatment continued or discontinued if the problem is resolved.

Limited Level of Service - A documented limited or interval one system evaluation. Tests to support the diagnosis may be ordered with the results documented.

Intermediate Level of Service - A documented multiple systems review. One or more conditions may be new complaints or there may be one new complaint with a follow-up for a previously identified condition.

Extended Level of Service - History, diagnosis and treatment for two or more systems are documented. There may be new or existing problems. The past medical history as well as history of the present medical complaint is done.

Comprehensive Level of Service - A complete history, diagnosis and treatment plan provided are documented. A comprehensive level of service may include a family history, past medical history, a personal history and a history of the chief complaint, or a complete systems review and physical exam.

Termination of Provider Participation

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

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

DMAS Provider Enrollment Services

PO Box 26803

Richmond, Virginia 23261-6803

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

customers subsequent to the date specified in the termination notice.

1.325(D." DMAS

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

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

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

Appeals of Adverse Actions

Definitions:

Administrative Dismissal – means:

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

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

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

Adverse Benefit Determination – Pursuant to 42 C.F. R. § 438.400, means, in the case of an MCO, any of the following: (i) The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit; (ii) The reduction, suspension, or termination of a previously authorized service; (iii) The denial, in whole or in part, of payment for a service; (iv) The failure to provide services in a timely manner, as defined by the State; (v) The failure of an MCO to act within the timeframes provided in §438.408(b)(1) and (2) regarding the standard resolution of grievances an appeals; (vi) For a resident of a rural area with only one MCO, the denial of a member's request to exercise his or her right, under §438.52(b)(2)(ii), to obtain services outside the network; (vii) The denial of a member's request to dispute a financial liability, including cost sharing,

copayments, premiums, deductibles, coinsurance, and other member financial liabilities. The denial, in whole or in part, of payment for a service solely because the claim does not meet the definition of a "clean claim" at § 447.45(b) is not an adverse benefit determination.

Appeal – means:

1) A member appeal is:

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

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

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

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

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

Internal Appeal – means a request to the MCO or other DMAS Contractor by a member, a member's authorized representative or provider, acting on behalf of the member and with the member's written consent, for review of the MCO's adverse benefit determination or DMAS Contractor's adverse action. The internal appeal is the only level of appeal with the MCO or other DMAS Contractor and must be

exhausted by a member or deemed exhausted according to 42 C.F.R. § 438.408(c)(3) before the member may initiate a State fair hearing.

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

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

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

MEMBER APPEALS

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

PROVIDER APPEALS

Non-State Operated Provider

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

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

Program Operations Division

Department of Medical Assistance Services

600 East Broad Street,

Richmond, Virginia 23219

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

Internal appeal rights with a managed care organization ("MCO") must also be exhausted prior to

appealing to DMAS if the individual is enrolled with DMAS through a Virginia Medicaid MCO.

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

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

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

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

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

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

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

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

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

Repayment of Identified Overpayments

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

State-Operated Provider

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

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

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

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

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

The third step, where the preceding steps do not resolve the dispute to the satisfaction of the state-

operated provider, permits the provider to request, within 30 days after receipt of the DMAS Agency Director's Decision, that the DMAS Agency Director refer the matter to the Secretary of Health and Human Resources and any other Cabinet Secretary, as appropriate. Any determination by such Secretary or Secretaries shall be final.

Client Appeals

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

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.

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

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

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 (DME)

Updated: 7/13/2022

This chapter describes the Durable Medical Equipment (DME) and Supplies available under the Commonwealth of Virginia's *State Plan for Medical Assistance* (Medicaid). DME services are provided in accordance with the requirements of 42 CFR §§ 440.70 and 441.15 and are available to all categorically and medically needy individuals determined to be eligible for assistance. DME services under Virginia Medicaid must not be of any less or greater duration, scope, or quality than that provided individuals not receiving state and/or federal assistance for those DME services covered by Virginia Medicaid. All items and supplies must meet the DME coverage criteria and the Virginia Administrative Code (VAC).

For the purpose of the Virginia Medical Assistance Program, a DME provider is a Medicaid enrolled provider that is primarily engaged in durable medical equipment and supplies outside of an institutional setting.

Virginia Medicaid Web Portal

The Virginia Medicaid Web Portal is the gateway for providers to transact all Medicaid and FAMIS (Family Access to Medical Insurance Security Plan) business via one central location on the Internet. The web portal provides access to Medicaid Memos, Provider Manuals, providers search capabilities, provider enrollment applications, training and education. Providers must register through the Virginia Medicaid Web Portal in order to access and complete secured transactions such as verifying Medicaid eligibility, service limits and service authorization or by submitting a claim. The Virginia Medicaid Web Portal can be accessed at: www.virginiamedicaid.dmas.virginia.gov.

Freedom of Choice (DME)

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

NOTE: If a provider accepts a Medicaid individual as a client, the provider must provide all of the DME services that are provided to the general population.

Managed Care Enrolled Members (DME)

Managed Care Enrolled Individuals

Most individuals enrolled in the Medicaid program for Medicaid and FAMIS have their services furnished through contracted Managed Care Organizations (MCOs) and their network of providers. All providers should check eligibility (Refer to Chapter 3) prior to rendering services to confirm which MCO the individual is enrolled in. The MCO may require a referral or prior authorization for the individual to receive services. All providers are responsible for adhering to this manual, their provider contract with the MCOs, and state and federal regulations.

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

Ø Medallion 4.0:

http://www.dmas.virginia.gov/#/med4

Ø Commonwealth Coordinated Care Plus (CCC Plus):

http://www.dmas.virginia.gov/#/cccplus

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

http://www.dmas.virginia.gov/#/longtermprograms

Covered Services (DME)

DME and supplies are a covered service available to the entire Medicaid population including both Fee for Service and Managed Care enrollees *as described in this manual*. In addition, the Department of Medical Assistance Services (DMAS) may cover DME services when the individual is under age 21 and the item or supply could be covered under the Virginia *State Plan for Medical Assistance* (the *State Plan*) through the Early and Periodic Screening, Diagnostic, and Treatment benefit (EPSDT).

All medically necessary medical equipment and supplies under the *Virginia Administrative Code* (12VAC30-50-165) may be covered only if they are necessary to carry out a treatment prescribed by a practitioner (MD, Doctor of Osteopathy (DO), physician assistant (PA) or nurse practitioner (NP). Unusual amounts, types, and duration of usage must be authorized by DMAS, or its contractor in accordance with published policies and procedures. When determined to be cost-effective by DMAS, or its contractor, payment may be made for rental of the equipment in lieu of purchase. Individuals shall be notified of their right to appeal any denial determinations.

DME providers shall adhere to all applicable DMAS policies, laws, and Federal and State regulations for durable medical equipment and supplies, including the face-to-face requirements in 42 CFR 410.38. DME providers shall comply with all other applicable Virginia laws and regulations requiring licensing, registration, or permits. Failure to comply with such laws and regulations shall result in denial of reimbursement or retraction of payments made, for durable medical equipment and supplies that are regulated by licensing agency or agencies. (12 VAC 30-50-165)

No provider shall have a claim of ownership on DME reimbursed by Virginia Medicaid once it has been delivered to the Medicaid individual. Providers shall only be permitted to recover DME, for example, when DMAS determines that it does not fulfill the required medically necessary purpose as set out in the Certificate of Medical Necessity (CMN), when there is an error in the ordering practitioner's CMN, or when the equipment was rented.

NOTE: The provider must accept Medicaid payment as payment in full and may not bill the individual, including shipping and handling charges. Costs incurred for shipping and handling, except when otherwise noted, are considered to be a part of the DME provider’s overhead/business expenses.

The provider and all employees shall adhere to the DMAS policies and regulations. The provider must also ensure that all requirements for services are met in order to receive payment from DMAS. If it is found during a post-payment audit that the DME provider has not met all of the requirements, the provider may be required to refund the payment to DMAS.

DME COVERED THROUGH EARLY AND PERIODIC SCREENING, DIAGNOSTIC, AND TREATMENT (EPSDT)

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a federally mandated benefit that provides screening and treatment for Medicaid individuals who are under the age of 21. Some DME not otherwise available to Medicaid individuals may be available for this age group through the EPSDT benefit, if medically necessary. **NOTE**: Children who are eligible for Medicaid/FAMIS Plus may be eligible for DME.

EPSDT is not a separate Medicaid program. EPSDT is distinguished only by the scope of treatment services available to children who are under the age of 21. Because EPSDT criteria must be applied to each service that is available to EPSDT eligible children, EPSDT criteria must be applied to all requests requiring service authorization for Medicaid services. The criteria requires that the service/item is practitioner ordered and is medically necessary to correct, ameliorate (“make better”) or maintain the individual’s condition. For example, coverage under EPSDT may be requested when a child needs a device that is not covered under the DME and supplies benefit or the child needs a device that exceeds the frequency limitations defined in the DME program then the devices may be

requested for coverage through the EPSDT benefit.

When the DME service needs of an individual fall outside of coverage rules described in this manual, providers should send the service authorization request directly to the DMAS service authorization contractor for consideration under the EPSDT benefit. Additional information on the EPSDT benefit can be accessed by submitting any questions via e-mail to EPSDT@dmas.virginia.gov.

Medical Necessity (DME)

Only supplies, equipment, and appliances that are determined medically necessary may be covered for reimbursement by DMAS. (12VAC30-50-165**)** The following criteria must be satisfied through the submission of adequate and verifiable documentation satisfactory to DMAS, or its contractor. Medically necessary DME and supplies shall be:

1. Ordered by the practitioner on the CMN/DMAS-352;
2. A reasonable and medically necessary part of the individual's treatment plan;
3. Consistent with the individual's diagnosis and medical condition, particularly the functional limitations and symptoms exhibited by the individual;
4. Not furnished for the safety or restraint of the individual, or solely for the convenience of the family, attending practitioner, or other practitioner or supplier;
5. Consistent with generally accepted professional medical standards (i.e., not experimental or investigational);
6. Furnished at a safe, effective, and cost-effective level; and
7. Suitable for use, and consistent with 42 CFR 440.70(b)(3), that treats a diagnosed condition or assists the individual with functional limitations.

Generally Non-Covered DME and Supplies (DME)

As described above, for individuals under age 21, coverage must be explored under EPSDT.

Supplies, equipment and appliances that are generally not covered include, but are not limited to, all of the following: **(**12VAC30-50-165)

1. Space conditioning equipment, such as room humidifiers, air cleaners, and air conditioners;
2. DME and supplies for any hospital patient or nursing facility resident, except ventilators and the associated supplies that are approved by DMAS, or its contractor, and provided to nursing facility residents (see Nursing Facility Manual for DME covered for nursing facility residents);
3. Furniture or appliances not defined as medical equipment (such as blenders, bedside tables, mattresses other than for a hospital bed, pillows, blankets or other bedding, special reading lamps, chairs with special lift seats, hand-held shower devices, exercise bicycles, geri-chairs, and bathroom scales);
4. Items that are only for the individual's comfort and convenience or for the convenience of those caring for the individual (e.g., a hospital bed or mattress because the individual does not have an adequate bed, a wheelchair tray used as a desk surface); and mobility items used in addition to the primary assistive mobility aid for the

convenience of the individual or his caregiver (e.g., an electric wheelchair plus a manual chair); underpads (such as chux) in addition to incontinence briefs, unless there is a specific medical need for using both; and cleansing wipes;

5. Items and services that are not reasonable and necessary for the diagnosis or treatment of illness or injury or for improving the functioning of a malformed body extremity (for example, over-the-counter drugs, dentifrices, toilet articles, shampoos which do not require a practitioner's prescription, dental adhesives, electric toothbrushes, cosmetic items, soaps, and lotions which do not require a practitioner's prescription; sugar and salt substitutes; non-compression type support stockings; and non-legend drugs);
6. Home or vehicle modifications;
7. Equipment for which the primary function is vocationally or educationally related (e.g., computers, environmental control devices, speech devices, etc.).

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NOTE: For orthotics refer to coverage addressed later in this chapter. Refer to Prosthetics manual for coverage criteria.

Certificate of Medical Necessity (CMN)/DMAS-352 (DME)

CERTIFICATE OF MEDICAL NECESSITY (CMN)/DMAS-352

All DME and supplies must be ordered by a practitioner on the CMN/DMAS-352 (revised 2017) and must be medically necessary to treat a health condition. The CMN/DMAS-352 may be completed by the practitioner, DME provider, or other health care professionals, but the practitioner must sign and date the completed CMN. (12VAC30-60-75) The CMN and any supporting verifiable documentation must be completed (signed and dated by the practitioner) within 60 days from the time the ordered DME and supplies are initially furnished to the individual by the DME provider. DMAS will not reimburse the DME provider for services provided prior to the date of the practitioner's signature when the signature is not obtained within 60 days of the first day the DME supplies are furnished to the individual**.** (12 VAC 30-50-165)

NOTE: Initially furnished is defined as begin service date.

There are some supplies and/or equipment that can be provided at the time of request while other supplies and/or equipment may take several days or up to several weeks to be delivered to the individual. For example, a custom wheelchair may take up to six (6) months to be delivered to the individual but the begin service date starts when the service is initiated. For additional clarification regarding the completion of the CMN, refer to the instructions on how to complete the CMN.

A CMN shall contain a practitioner's diagnosis of an individual's medical condition and an order for the durable medical equipment and supplies that are medically necessary to treat the diagnosed condition and the individual's functional limitation(s). The order for DME or supplies must be justified in the written documentation either on the CMN or on an attachment to the CMN.

A complete order on the CMN consists of the description of the item, quantity ordered, frequency of use (for expendable supplies), practitioner signature and complete date. If any of these components are missing the CMN will be considered invalid and a new CMN should be obtained additional documentation to justify the DME or supplies must coincide with the date of service for the item(s) ordered and the name and title must identify the practitioner. The CMN must also be completed for equipment repairs. (12 VAC 30-50-165)

NOTE: In order to obtain Medicaid reimbursement, specific fields of the DMAS-352 form shall be completed as specified in 12VAC30-60-75. (See Ch. VI of this manual for instructions to complete a DMAS-352)

DME and supplies must be furnished exactly as ordered by the attending practitioner on the CMN (12 VAC 30-50-165). The practitioner must specifically order each component of the DME on the CMN. The CMN shall not be changed, altered, or amended after the attending practitioner has signed it. If changes are necessary for the ordered DME or supplies, as indicated by the individual's condition, the DME provider must obtain a new CMN. The attending practitioner must sign and date the new CMNs within 60 days from the time the ordered supplies are furnished by the DME provider. Supporting documentation, signed and dated by the practitioner, may be attached to the CMN, but the attending practitioner's entire order must be on the CMN. (12 VAC 30-50-165)

NOTE: If technical information changes on the CMN, a new CMN is not required because it does not affect the practitioner's order or delivery of services. Technical information includes changes to an individual's address, phone number, or provider's address, phone number or provider enrollment number. The next CMN renewal must include this updated technical information. Faxed copies of the CMN are acceptable.

All practitioners' documentation must be completely signed with title and dated (with the month, day, and year). A required practitioner signature for Medicaid purposes may include signatures, computer entry, or rubber stamp initialed by the practitioner. These methods do not preclude other requirements that are not for Medicaid purposes. If a practitioner chooses to use a rubber stamp on documentation requiring his or her signature, the practitioner whose signature the stamp represents must provide the agency with a signed statement to the effect that he or she is the only person who has the stamp and is the only person who will use it. The practitioner must initial and completely date (with day, month, and year) all rubber-stamped signatures. The DME provider shall retain a copy of the CMN and all supporting verifiable documentation on file for DMAS' purposes of the DMAS post payment audit review. (12 VAC 30-50-165)

The practitioner shall never back date a CMN or supporting documentation in order for the CMN or supporting documentation to comply with the requirements. The date the practitioner actually signs the CMN or supporting documentation is the valid date for services.

The CMN/DMAS-352 can be found on the Medicaid web portal

(www.virginiamedicaid.dmas.virginia.gov) link identified as "Provider Forms Search."

Length of Certification on the CMN/DMAS-352 (DME)

LENGTH OF CERTIFICATION ON THE CMN/DMAS-352

The CMN shall be valid for a maximum period of six (6) months for Medicaid individuals under 21 years of age. The maximum validity time for Medicaid individuals 21 years and older is twelve (12) months. DMAS has the authority to determine an alternative length of time different from the required time frames (stated above) that a CMN may be valid based on medical documentation submitted on the CMN. The validity of the CMN shall terminate when the individual's medical need for the prescribed DME or supplies is no longer needed or expires. (12 VAC 30-50-165)

Retroactive Eligibility (DME)

DMAS may make an exception to the 60-day practitioner signature requirement if retroactive eligibility is determined. All remaining criteria (e.g., fully completed CMN, documentation requirements, and specific coverage criteria) must be satisfied in accordance with the State Plan and DMAS policy guidelines.

CMN Exceptions (DME)

A CMN is not required for individuals for whom Medicare is the primary insurance carrier and Medicaid is the secondary carrier. In those instances, if Medicare approves the DME item(s), the provider must bill on the DMAS-30 invoice. Medicaid will pay the appropriate deductible and/or co-insurance, and no CMN is needed for this Medicare crossover coverage. If the item(s) is not covered by Medicare and is covered by Medicaid, the fully completed CMN is required in order for Medicaid to pay as the primary carrier.

For private primary insurance where Medicaid is secondary payer, or payer of last resort, the CMN is required, even if it only applies to a co-payment. Medicare is the only exception where a CMN and service authorization would not be required (e.g., crossover claim).

Face-to-Face Requirements for DME - Fee-for-Service

This only applies to FFS members and not those enrolled in one of DMAS' managed care plans.

Beginning July 1, 2017, no payment shall be made for new DME (as defined in 12VAC30-50-165) unless a face-to-face encounter has been performed by an approved practitioner (outlined below) no more than six (6) months prior to the begin service date. The face-to-face encounter shall be related to the primary reason the individual enrolled in Medicaid requires DME.

The face-to-face encounter for DME must be conducted by one of the following four (4) practitioners:
- A physician licensed to practice medicine;
- A licensed nurse practitioner or licensed clinical nurse specialist acting within the scope of their practice under state law;
- A licensed physician assistant within the scope of their practice under state law and working under the supervision of the physician who orders the individual's services; or
- For individuals requiring DME immediately after an acute or post-acute stay, the attending acute or post-acute physician.

The practitioner performing the face-to-face encounter must document the clinical findings in the individual's medical record and communicate the clinical findings of the encounter to the ordering physician.

The face-to-face encounter may occur through telehealth, which is defined as the real-time or near real-time two-way transfer of medical data and information using an interactive audio/video connection for the purposes of medical diagnosis and treatment (DMAS Medicaid Memo dated May 20, 2014). Telehealth shall not include by telephone or email.

Providers must use the revised CMN form (found on the portal) to document the new requirements. Completion of all elements related to the face-to-face requirements on the CMN will satisfy the face-to-face encounter documentation requirements. For DME items that require service authorization as indicated in the table below, providers must, during the service authorization process, "attest" that the face-to-face encounter requirement has been met. For those items that do not require a service authorization, the CMN with the face-to-face encounter documentation should be maintained in the individual's medical record.

NOTE: A face-to-face encounter is only required for Medicaid DME items that also require a face-to-face encounter under the Medicare program. If a face-to-face encounter is not required for a specific DME item under the Medicare program, then it is not required for the Medicaid program. Below are the list of HCPCS codes that require a face-to-face encounter for the initiation of Medicaid DME:

CODE	DESCRIPTION	SERVICE AUTH
E0185	Gel or gel-like pressure mattress pad	No
E0194	Air fluidized bed	Yes
E0197	Air pressure pad for mattress standard length and width	No
E0198	Water pressure pad for mattress standard length and width	No
E0199	Dry pressure pad for mattress standard length and width	No
E0250	Hospital bed fixed height with any type of side rails, mattress	
E0255	Hospital bed variable height with any type side rails with mattress	No
E0256	Hospital bed variable height with any type side rails without mattress	Yes
E0260	Hospital bed semi-electric (head and foot adjustment) with any type side rails with mattress	Yes
E0261	Hospital bed semi-electric (head and foot adjustment) with any type side rails without mattress	No
E0265	Hospital bed total electric (head, foot and height adjustments) with any type side rails with mattress	Yes
E0266	Hospital bed total electric (head, foot and height adjustments) with any type side rails without mattress	Yes

CODE	DESCRIPTION	SERVICE AUTH
E0300	Pediatric crib, hospital grade, fully enclosed	Yes
E0301	Hospital bed heavy duty extra wide, with weight capacity 350-600lbs with any type of rail, without mattress	Yes
E0302	Hospital bed heavy duty extra wide, with weight capacity greater than 600 lbs with any type of rail, without mattress	Yes
E0303	Hospital bed heavy duty extra wide, with weight capacity 350-600bls with any type of rail, with mattress	Yes
E0304	Hospital bed heavy duty extra wide, with weight capacity greater than 600lbs with any type of rail, with mattress	Yes
E0424	Stationary compressed gas oxygen system rental; includes contents, regulator, nebulizer, cannula or mask and tubing	No
E0431	Portable gaseous oxygen system rental includes portable container, regulator, flowmeter, humidifier, cannula or mask, and tubing	No
E0433	Portable liquid oxygen system	Yes
E0434	Portable liquid oxygen system, rental; includes portable container, regulator, flowmeter, humidifier, cannula or mask, and tubing	No
E0439	Stationary liquid oxygen system rental, includes container, contents, regulator, flowmeter, humidifier, flowmeter, refill adaptor, content gauge, cannula or mask and tubing	No
E0441	Oxygen contents, gaseous (1 month supply)	Yes
E0442	Oxygen contents, liquid (1 months supply)	No
E0443	Portable oxygen contents, gas (1 months supply)	No
E0444	Portable oxygen contents, liquid (1 month supply)	Yes

CODE	DESCRIPTION	SERVICE AUTH
E0465	Home ventilator, any type, used with invasive interface (e.g., tracheostomy tube)	Yes
E0466	Home ventilator, any type, used with non-invasive interface (e.g., mask, chest shell)	Yes
E0470	Respiratory assist device, bi-level pressure capability, without backup rate used non-invasive interface	Yes
E0471	Respiratory assist device, bi-level pressure capability, with backup rate for a non-invasive interface	Yes
E0472	Respiratory assist device, bi-level pressure capability, with backup rate invasive interface	Yes
E0480	Percussor electric/pneumatic home model	Yes
E0482	Cough stimulating device, alternating positive and negative airway pressure	Yes
E0483	High frequency chest wall oscillation air pulse generator system	Yes
E0570	Nebulizer with compressor	No
E0575	Nebulizer, ultrasonic, large volume	Yes
E0580	Nebulizer, durable, glass or autoclavable plastic, bottle type for use with regulator or flowmeter	No
E0585	Nebulizer with compressor and heater	No
E0601	Continuous airway pressure device	Yes
E0607	Home blood glucose monitor	No
E0650	Pneumatic compressor non-segmental home model	Yes
E0651	Pneumatic compressor segmental home model without calibrated gradient pressure	Yes
E0652	Pneumatic compressor segmental home model with calibrated gradient pressure	Yes
E0655	Non-segmental pneumatic appliance for use with pneumatic compressor on half arm	Yes

CODE	DESCRIPTION	SERVICE AUTH
E0656	Non-segmental pneumatic appliance for use with pneumatic compressor on trunk	Yes
E0657	Non-segmental pneumatic appliance for use with pneumatic compressor, chest	Yes
E0660	Non-segmental pneumatic appliance for use with pneumatic compressor on full leg	Yes
E0665	Non-segmental pneumatic appliance for use with pneumatic compressor on full arm	Yes
E0666	Non-segmental pneumatic appliance for use with pneumatic compressor on half leg	Yes
E0667	Segmental pneumatic appliance for use with pneumatic compressor on full leg	Yes
E0668	Segmental pneumatic appliance for use with pneumatic compressor on full arm	Yes
E0669	Segmental pneumatic appliance for use with pneumatic compressor on half leg	Yes
E0671	Segmental gradient pressure pneumatic appliance full leg	Yes
E0672	Segmental gradient pressure pneumatic appliance full arm	Yes
E0673	Segmental gradient pressure pneumatic appliance half leg	Yes
E0675	Pneumatic compression device, high pressure, rapid inflation/deflation cycle, for arterial insufficiency	Yes
E0720	Transcutaneous electrical nerve stimulation, two lead, local stimulation	Yes
E0730	Transcutaneous electrical nerve stimulation, four or more leads, for multiple nerve stimulation	Yes
E0745	Neuromuscular stimulator electric shock unit	Yes
E0784	External ambulatory infusion pump	Yes

CODE	DESCRIPTION	SERVICE AUTH
E0840	Tract frame attached to headboard, cervical traction	No
E0849	Traction equipment cervical, free standing stand/frame, pneumatic, applying traction force to other than mandible	Yes
E0850	Traction stand, free standing, cervical traction	No
E0855	Cervical traction equipment not requiring additional stand or frame	No
E0856	Cervical traction device, cervical collar with inflatable air bladder	Yes
E0958	Manual wheelchair accessory, one-arm drive attachment	No
E0959	Manual wheelchair accessory-adapter for Amputee	No
E0960	Manual wheelchair accessory, shoulder harness/strap	No
E0961	Manual wheelchair accessory wheel lock brake extension handle	No
E0966	Manual wheelchair accessory, headrest extension	No
E0967	Manual wheelchair accessory, hand rim with projections	No
E0969	Narrowing device wheelchair	No
E0971	Manual wheelchair accessory anti-tipping device	No
E0973	Manual wheelchair accessory, adjustable height, detachable armrest	No
E0974	Manual wheelchair accessory anti-rollback device	No
E0978	Manual wheelchair accessory positioning belt/safety, belt/pelvic strap	No
E0980	Manual wheelchair accessory safety vest	No
E0981	Manual wheelchair accessory, Seat upholstery, replacement only	No
E0982	Manual wheelchair accessory, back upholstery, replacement only	No

CODE	DESCRIPTION	SERVICE AUTH
E0983	Manual wheelchair accessory power add on to convert manual wheelchair to motorized wheelchair, joystick	Yes
E0984	Manual wheelchair accessory power add on to convert manual wheelchair to motorized wheelchair, Tiller control	Yes
E0985	Wheelchair accessory, seat lift mechanism	Yes
E0986	Manual wheelchair accessory, push activated power assist	Yes
E0990	Manual wheelchair accessory, elevating leg rest	No
E0992	Manual wheelchair accessory, elevating leg rest solid seat insert	No
E0994	Arm rest	No
E1014	Reclining back, addition to pediatric size wheelchair	Yes
E1015	Shock absorber for manual wheelchair	No
E1020	Residual limb support system for wheelchair	No
E1028	Wheelchair accessory, manual swing away, retractable or removable mounting hardware for joystick, other control interface or positioning accessory	Yes
E1029	Wheelchair accessory, ventilator tray	Yes
E1030	Wheelchair accessory, ventilator tray, gimbaled	Yes
E1161	Manual adult size wheelchair includes tilt in space	Yes
E1232	Wheelchair, pediatric size, tilt-in-space, folding, adjustable with seating system	Yes
E1233	Wheelchair, pediatric size, tilt-in-space, rigid, adjustable without seating system	Yes
E1234	Wheelchair, pediatric size, tilt-in-space, folding, adjustable without seating system	Yes

CODE	DESCRIPTION	SERVICE AUTH
E1235	Wheelchair, pediatric size, rigid, adjustable, with seating system	Yes
E1236	Wheelchair, pediatric size, folding, adjustable, with seating system	Yes
E1237	Wheelchair, pediatric size, rigid, adjustable, without seating system	Yes
E1238	Wheelchair, pediatric size, folding, adjustable, without seating system	Yes
E1296	Special sized wheelchair seat height	No
E1297	Special sized wheelchair seat depth by upholstery	No
E1298	Special sized wheelchair seat depth and/or width by construction	No
E2502	Speech generating device prerecorded messages between 8 and 20 minutes	Yes
E2506	Speech generating device prerecorded messages over 40 minutes	Yes
E2508	Speech generating device message through spelling, manual type	Yes
E2510	Speech generating device synthesized with multiple message methods	Yes
E2227	Rigid pediatric wheelchair adjustable	Yes
K0001	Standard wheelchair	Yes
K0002	Standard hemi (low seat) wheelchair	Yes
K0003	Lightweight wheelchair	Yes
K0004	High strength lightweight wheelchair	Yes
K0005	Ultra-lightweight wheelchair	Yes
K0006	Heavy duty wheelchair	Yes
K0007	Extra heavy duty wheelchair	Yes
K0009	Other manual wheelchair/base	Yes

The list of HCPCS codes that require a face-to-face encounter under the Medicare program may also be found here: https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Medical-

Review/Downloads/DME_List_of_Specified_Covered_Items_updated_March_26_2015.pdf.

DME and Supplies Listing - Appendix B

The Appendix B is a listing of Healthcare Common Procedure Coding System (HCPCS) which describe equipment and supplies, coverage limitations, and service authorization (SA) requirements. The HCPCS codes listed in Appendix B of this manual must be used for all Medicaid claims, regardless of whether Medicare uses the same HCPCS code for the item.

NOTE: Service authorization by Medicaid is not required when Medicare is the primary payer. Reimbursement for Medicare crossover claims will be made in accordance with established Medicare HCPCS codes and guidelines.

In Appendix B, codes marked with an 'N' in the SA column do not require service authorization unless they exceed the service limit in Appendix B. The service limit informs the provider at what point service authorization is required. If a code is marked with a 'Y' in the SA column, SA is always required, so the service limit is a guideline for normal use. The service limit may be exceeded or equipment purchased prior to the service limit expiring. In situations when the request is over the service limit or prior to the service limit, SA is required and the determination will be made based on documentation submitted by the provider.

Instructions regarding service authorization (SA) may be found in the Appendix D of the DME and Supplies Manual. DMAS does not use all available HCPCS codes. Items not identified in the listing require SA and may be submitted for SA under the appropriate miscellaneous HCPCS code. Lack of a specific HCPCS code for an item does not impact coverage. The appropriate miscellaneous code may be used and submitted for SA for items that are not included in this manual.

Providers must maintain documentation in accordance with the coverage criteria, documentation requirements, and CMN requirements regardless of whether or not service authorization is required. Issuance of a service authorization does not exempt a claim from post payment audit. Documentation requirements are located in Chapter VI of this manual.

Payment Methodologies (DME)

For HCPCS codes that do not have a Medicare Competitive Bid Rate, the reimbursement rate shall be the DMERC rate minus 10%. The rates have been incorporated into the Appendix B of this Manual. This listing will be updated periodically and is found on the Medicaid web portal located at www.virginiamedicaid.dmas.virginia.gov. If a national code becomes available for an item, the miscellaneous code can no longer be used for those items. The following table outlines the applicable payment methodology for various DME items.

DME ITEM	RATE
1. DME items that have a national code and a DMERC rate	Rate will be Medicare Competitive Bid Rate if available or the DMERC rate minus 10%.

2. DME items that have a July 1, 2010 rate, but do not have a national code	Bill the E1399 code (miscellaneous). The rate will be the July 1, 2010 rate. The rate will be posted in Appendix B of this manual.
3. DME items that have a national code, but do not have a DMERC or a July 1, 2010 rate	Rate will be Individual Consideration (IC). Manufacturer's charge to the provider, less shipping and handling, plus 30%,
4. DME items that do not have a national code, and do not have a July 1, 2010 rate	Bill the E1399 code (miscellaneous). Rate will be IC. The manufacturer's charge to the provider, less shipping and handling, plus 30%
5. DME items that have a national code and a July 1, 2010 rate from the previous local code crossover.	The rate will be the July 1, 2010 rate. The rate will be posted in Appendix B of this manual.

MISCELLANEOUS HCPCS AND CODES PRICED AS INDIVIDUAL CONSIDERATION (IC)

Miscellaneous codes will not be recognized for the sole purpose of cost variances. If a HCPCS code is not listed in the Appendix B, the provider can use an appropriate miscellaneous code for coverage consideration. In order for the service authorization contractor and the post payment auditing contractor(s) to determine the appropriate reimbursement for miscellaneous items and HCPCS codes priced as IC, all of the following must be provided and kept on file in the individual's record:

- A complete description of the item(s) being supplied;
- A copy of the supplier's invoice or the dealer cost information to document the cost of the item(s), this must include MSRP in order for the service authorization contractor and the post payment auditors to be able to determine the provider's cost; and
- Any discount received must be indicated.

The manufacturer's invoice, the dealer's price list showing the dealer's cost of the item, or a statement from the manufacturer detailing estimates of cost for specially designed items, are all acceptable documentation. The documentation must include the manufacturer's cost, any discounts provided to the provider, and the provider's ancillary cost of providing the DME and or supplies to the individual. The reimbursement amount is determined by adding 30% to the providers cost for the item, unless this amount exceeds MSRP. **DMAS will not reimburse over MSRP**.

Providers should not bill any claim for a miscellaneous code or HCPCS codes prices as IC prior to verifying invoice cost. Claims with cost less than that submitted on the service authorization should have billed amounts adjusted to comply with DMAS guidelines (i.e. net cost + 30%). If an estimate is used for specially constructed items, upon receipt of the manufacturer's invoice, if the cost is less than reported on service authorization, the provider must only bill 30% over the cost of that item. Likewise, if the cost is more than the original estimates, the provider may submit a change request to the service authorization contractor for consideration (See Appendix D for more service

authorization information). Documentation of the actual cost of the item billed must be in the individual's record.

BILLING E1399 – MISCELLANEOUS HCPCS CODE

HCPCS code E1399 will generate a summary line that includes the total number of E1399 units and the total fees associated with those lines. The service authorization (SA) file in VAMMIS combines all like miscellaneous DME codes into one 'summary' line, which carries the status of AC (approved combined). Providers can view the AC line on their SA notification report and in order to bill for miscellaneous DME lines, providers will need to total the authorized amounts as well as the authorized units for each of the miscellaneous codes and submit this total or 'summary line' amount as one line item on the claim.

The provider should bill the total number of units and the total authorized fee once all supplies are delivered. If the provider does not deliver all units at one time, the provider can follow the instructions below:

1. Submit a change request to the service authorization contractor. The provider will request a change to the line item that was not delivered by either decreasing the number of units or voiding the line item for the DME/supplies that was not delivered and if necessary create a new service authorization for item not delivered; *or*
2. Wait until all DME/supplies are delivered to submit the claim for reimbursement; *or*
3. If the provider has already billed for all DME/supplies but has not delivered all units, the provider will need to adjust the claim. If it is found on post payment audit that the provider has billed all units but did not deliver all units, the provider may have funds retracted.

For monthly supplies the provider will need to divide the total units amount by the total authorized dollar amount to get the unit price. If there are several items with different dollar amounts the roll up line unit price will not match. If the provider does not bill for all units in the roll up line, the provider will need to adjust the final claim(s).

NOTE: There is a power point training presentation on the DMAS website at www.virginiamedicaid.dmas.virginia.gov that gives additional information on the roll up line with several examples.

Providers may contact the DMAS helpline for questions related to claims adjustment. Refer to Chapter I of this manual for contact information.

MISCELLANEOUS CODES – CATEGORY SPECIFIC

DMAS added five (5) additional miscellaneous codes to the Appendix B that are more category specific and will allow for better understanding of usage by category. Providers will be required to use these miscellaneous codes instead of E1399. E1399 will still be accepted; however providers should only use E1399 if the item supplied does not fall under one of the new miscellaneous codes. See additional information below.

- **B9998 Enteral Miscellaneous** – This code should be used for any item that falls under the

Feeding Pumps, Nutritional Supplements, Feeding Kits and Tubes section that has not been assigned a HCPCS code.
- **A4421 Ostomy Supply Miscellaneous** – This code should be used for any item that falls under the Ostomy and Colostomy Pouches and Accessory Supplies section that has not been assigned a HCPCS code.
- **K0108 Wheelchair Accessory NOS –** This code should be used for any item that falls under the Wheelchairs and Accessories section that has not been assigned a HCPCS code.
- **S8189 Tracheostomy Supplies NOS –** This code should be used for any item that falls under the Apnea Monitors, Respiratory, Oxygen and Ventilators section that has not been assigned a HCPCS code.
- **A4335** Incontinence Miscellaneous - This code should be used for any items other than incontinence supplies, that are not covered under an established HCPC code, such as bedpans, urinals, catheters and irrigation equipment and supplies, vendors should use the appropriate miscellaneous code.

These new miscellaneous codes listed above will work just like the E1399 code in the VAMMIS system. The service authorization file in VAMMIS combines all like miscellaneous DME codes into one 'summary' line, which carries the status of AC (approved combined). Providers will see the AC line on their service authorization notification report and in order to bill for miscellaneous DME lines, providers will need to total the authorized amounts as well as the authorized units for each of the miscellaneous codes and submit this total or 'summary' line amount as one line item on the claim.

Provider Responsibilities for Provision of DME and Supplies

The Durable Medical Equipment and Supplies provider may not bill for items or services that have not been provided to the member and documented as received by the individual.

To receive reimbursement, the DME provider must:

- Verify the individual's Medicaid eligibility, on a monthly basis;
- Determine whether the item is covered and if so, does it require service authorization;
- Deliver only the item(s) ordered by the physician and approved by DMAS or its contractor;
- Deliver only the quantities ordered by the physician on the CMN and approved by DMAS or its contractor;
- Deliver only the item(s) for the periods of service covered by the physician's order and approved by DMAS or its contractor.

Interqual Requirements for All DME

All items and supplies must meet the coverage criteria outlined in this manual and the Virginia Administrative Code. DMAS requires specific categories of items to meet Interqual criteria. These categories are: adaptive strollers, nebulizers (including compressors), augmentative communication devices (AAC and speech generating devices), continuous passive motion devices, cranial molding orthosis, oxygen, hospital beds, insulin pumps, lower extremity orthosis (knee braces and immobilizers), lymphedema compression devices,

manual wheelchairs, negative pressure wound therapy devices, non-invasive airway assistive devices, CPAP and BiPAP devices, power wheelchairs and scooters, seat lift mechanisms (not lift chairs), secretion clearance devices, standing frames, support surfaces, TENS, wheelchair cushions and seating systems.

The above list is subject to change with Interqual® updates and at the discretion of DMAS. Interqual criteria information may be obtained through:

Change Healthcare

Website: https://www.changehealthcare.com/

There must be a practitioner-generated diagnosis and treatment order which demonstrates the need for the recommended item(s). Additional supporting documentation above the current requirements may be necessary, especially for expendables which are beyond the established guidelines for use.

If the amount requested exceeds the limit specified in the Appendix B, the provider must request service authorization for those items exceeding the limit. The provider may supply the individual with the amount of items up to the limit prior to obtaining service authorization from DMAS, or its contractor, for the overages. If the practitioner orders items or quantities that are not consistent with the standard in medical or nursing practice, additional supporting documentation (above the current requirements) must be provided to justify the order.

NOTE: DMAS and its contractors have a responsibility to verify that the individual is receiving adequate and medically justified services, that services are provided with fiscal responsibility and to monitor for possible fraud. Without adequate documentation neither DMAS nor its contractors can meet these responsibilities.

Specialized DME, such as specialized wheelchairs, augmentative communication devices, adaptive equipment, and rehabilitative therapy equipment, must be accompanied by an individual assessment performed by a qualified therapist who details the individual's functional abilities and disabilities, therapy goals, rehabilitation potential, suitability for use in the home environment, and how the equipment will be used in the individual's home. (See Chapter VI of this manual for specific documentation requirements). If in-home rehabilitative therapy equipment is ordered, the in-home therapy plan must be included.

For items that may be either used for the convenience of the caregiver or individual or to treat or manage a medical condition (e.g., hospital beds), supporting documentation of the medical need and use of the equipment must be included. Medicaid does not cover items for restraint of the individual or for the convenience or safety of the individual, the family, the attending practitioner, other practitioners, or the supplier. (12 VAC 30-50-165)

Specific DME Coverage Criteria

In addition to the Medical Necessity guidelines described in this chapter, and the described documentation requirements for all DME, additional specific medical justification and/or documentation requirements are in place for the following DME and supplies. Specific documentation requirements can be found in Chapter VI.

Patient Lifts

A patient lift and sling is an assistive device that will help transfer an individual, with limited mobility, from the bed to a chair or wheelchair and back to the bed. Patient lifts are operated by hydraulic-manual pumping or an electric motor.

A total electric lift and/or multi-positional patient transfer system may be covered in limited circumstances and will be reviewed based on medical necessity, on a case by case bases.
The sling is the key component when using a lift. The sling is what holds the individual and connects to the lift. Slings come in many shapes and fabrics and are designed for different support levels and uses. When choosing a sling the provider should consider the support needs of the individual and the activity of the individual, be it for transferring only or using the bathroom or for bathing.

Wheelchairs and Components (DME)

DMAS will reimburse DME providers for wheelchairs and components when the follow criteria are met:

- The practitioner must prescribe the equipment as medically necessary;
- Document that the individual's condition is such that without the use of a wheelchair the individual would be essentially bed or chair confined;
- The wheelchair is expected to increase mobility and independence.

A standard wheelchair must be requested unless documentation supports the need for any variation from the standard wheelchair. All customized manual wheelchairs are required to have had a comprehensive "hands on" evaluation completed by a healthcare professional with experience in fitting wheelchairs and making recommendations based on the individual's needs (specifically, a practitioner, physical therapist, occupational therapist, or a rehab engineer in coordination with a physical or occupational therapist). The evaluation must be performed prior to ordering the final equipment and should be signed and dated by the ordering practitioner. DMAS requires the evaluation to be performed by a physical or occupational therapist especially for wheelchairs with specialized seating and positioning components and features. The physical or occupational therapy wheelchair evaluation is a covered rehabilitation program service that may be billed to DMAS.

Specialized or customized wheelchairs may include HCPCS codes in the Appendix B which do not require service authorization, but that may require a specialty hands on evaluation. *Customized*

equipment is defined as equipment that is uniquely constructed or substantially modified by the provider from the standard product for a specific individual according to the description and orders of a practitioner, and in such a way that the equipment can only be used by the specific individual. See the power wheelchair section for evaluation requirements.

DMAS will not pay for repairs or replace a damaged wheelchair if the damage done to a wheelchair or component is considered intentional individual abuse or misuse of the equipment.

Power Wheelchairs

DMAS will cover most power (motorized) wheelchairs. All power wheelchairs and scooters must be preauthorized by the service authorization contractor. All conditions listed below must be met as follows:

- The individual has a mobility limitation that impairs his or her ability to perform one or more mobility related activities of daily living (MRADLs); and
- The limitation cannot be resolved with a cane or walker; and
- The individual does not have sufficient upper extremity strength to functionally operate an optimally configured manual wheelchair in the home; and
- The individual has the mental and physical capabilities to safely operate a power wheelchair or has a caregiver who is unable to propel an optimally configured manual wheelchair but is available, willing and able to safely operate the power wheelchair; and
- The individual's weight is less than or equal to the weight capacity of the power chair to be provided; and,
- The individual's home has adequate access, maneuvering space and surfaces for the operation of the power wheelchair to be provided.

Power Operated Vehicle (POV)/Scooter

The following criteria should be used to rule out POV/Scooter as follows:

- The individual cannot transfer to and from a POV, operate the tiller on a POV *or* maintain stability, balance and position while operating a POV; *or*
- The individual's mental and physical capabilities are insufficient to operate a POV in the home; *or*
- Does not meet weight requirements per manufactures specifications; *or*
- The individual's home does not provide adequate access, space or surface to operate a POV in the home.

Below are the descriptions for Groups 1 through 5 power wheelchairs:

- Group 1 power wheelchairs are designed for light duty and are generally for intermittent use indoors, typically used two hours or less per day. Group 1 power chairs do not accommodate seating and positioning items.
- Group 2 power wheelchairs are for daily indoor basic mobility, typically 8 hours per day or longer. Wheelchairs in this group are capable of accommodating seating and positioning items. Some examples of diagnoses that may qualify under a group 2 power wheelchair include but are not limited to, COPD, congestive heart failure, diabetes, osteoarthritis,

amputation, weakness, and fatigue.

- Group 3 power wheelchairs are for complex rehab and are designed for indoor use by individuals with complex disabilities (neurological condition, myopathy, or congenital skeletal deformity). Some examples of diagnosis that may qualify under a group 3 include but are not limited to: Multiple Sclerosis (MS), Amyotrophic Lateral Sclerosis (ALS), spinal cord injury, spinal muscular atrophy, osteogensis imperfecta and Cardiovascular Accident (CVA). The Appendix B includes HCPCS codes, with the "U1" modifier, that will be reimbursed at a higher rate if included as an accessory to a Group 3 and above power wheelchair. Providers will need to document the wheelchair type/group when submitting a request for these accessories using a "U1" modifier.
- Group 4 power wheelchairs have added capabilities that are not typically considered for use in the home. **Please note these wheelchairs will be considered on a case by case basis.** Remove - and only if the wheelchair will be primarily used indoors.
- Group 5 power wheelchairs are for pediatric use when the individual is expected to grow in height.

All Single-Power Option Wheelchairs

The following criteria must be met for all single-power wheelchairs as follows:

- The individual requires a drive control interface other than a hand or chin-operated standard proportional joystick; *and* the individual has had a speciality "hands on" evaluation performed *and* the documentation states the medical necessity for the wheelchair and its special features *or*;
- The individual meets coverage criteria for a power tilt or recline-seating system *and* the system is being used on the wheelchair; *and* the individual has had a specialty "hands on" evaluation performed *and* the documentation states the medical necessity for the wheelchair and its special features.

All Multiple-Power Option Wheelchairs

The following criteria must be met for all multiple-power option wheelchairs as follows:

- The individual meets criteria for a power tilt and recline-seating system and the system is being used on the wheelchair; *and* the individual has had a specialty hands on evaluation performed and the documentation states the medical necessity for the wheelchair and its special features; *or*
- The individual uses a ventilator mounted on the wheelchair; *and* the individual has had a specialty hands on evaluation performed and the documentation states the medical necessity for the wheelchair and its special features.

Power Seating

A power tilt, recline or tilt and recline system, with or without power elevating leg rests, is covered if the following criteria is met:

- The individual meets all the criteria for a power wheelchair; *and*
- A specialty evaluation has been completed by a licensed/certified healthcare professional such

as a physical or occupational therapist or practitioner, who can access the individual's specific seating and positioning needs; plus at least one of the following criteria points are met.

1. The individual is at high risk for development of a pressure ulcer and is unable to perform a functional weight shift for pressure relief; *or,*
2. The individual utilizes intermittent catheterization for bladder management and is unable to independently transfer from wheelchair to bed; *or*,
3. The power seating system is needed to manage increased tone or spasticity.

Push-Rim Activated Power Assist Device

All of the following criteria must be met for all push-rim activated power assist devices:

- The individual meets the criteria for a power wheelchair; *and*
- The individual has been self-propelling in a manual wheelchair for at least one year; *and*
- The individual has had a specialty "hands on" evaluation performed and documentation states the medical necessity.

The following wheelchair related items are not covered: mobility devices used in addition to the primary means of mobility; mobility devices not required for use primarily within the home environment, i.e., strollers, scooters, or wheelchairs for community use; wheelchairs for restraint purposes; and home or vehicle modifications, i.e., wheelchair ramps. (12 VAC 30-50-165)

MEDICAL CAR SEATS

Medical Car seats for use in vehicles may be covered with prior authorization for individuals with special orthopedic or medical needs related to positioning that cannot be met using conventional car seats or with needs that make conventional car seats medically inappropriate. A positioning seat may be medically necessary for a recipient with an inability to maintain an unsupported sitting position independently which is caused by a medical condition such as the following (list is not all-inclusive):

- Severe head and trunk instability;
- Severe hypotonicity, hypertonicity, spasticity or muscle spasms which result in uncontrollable movement and position changes;
- Severe seizure activity that results in uncontrollable movement and position changes
- Orthopedic disease processes resulting in significant bony fragility;
- Significant contractures that would result in an inability to perform postural corrections due to vehicle motion;
- Orthopedic condition, such as a curvature of the spine, which interferes with proper positioning;
- Long term, neurological, developmental, or other chronic health conditions which makes the use of standard, commercially available child restraints or vehicle seat belts impossible.

The individual must be within the manufacturer guidelines for height and weight.

Documentation for the authorization request for a positioning seat for use in vehicles must include an evaluation by a physical therapist or occupational therapist, the medical condition that causes the need for the positioning seat, other interventions that have been tried to meet the recipient's needs,

and less costly positioning seats that have been considered and rejected. Document the recipient's current height and weight, and the weight capacity and growth potential for the requested seat.

WHEELCHAIR TIEDOWNS

Tiedowns, also known as transit options and transport brackets, are required for individuals and their wheeled mobility to be safely transported in a vehicle withinwith the community.

Tiedowns may be covered if the following are met:

1. The wheelchair or stroller has passed ANSI/RESNA WC19 or ISO 7176-19.[1] [2]
2. The wheelchair needs to be effectively secured to the vehicle using a 4 point strap-type tiedown or docking system that complies with SAE J2249[3] or ISO 10542[4] [5].

Tiedowns reduce the potential for injury while the individual or equipment is being transported in a vehicle or public transportation. Tiedowns may be covered for wheelchairs and strollers, occupied or unoccupied. Prior authorization will be required for tie downs and documentation must include a statement from a physical or occupational therapist that include the medical need to be used in conjunction with the mobility device.

Easy lock systems for conversion vans are **not** covered.

PORTABLE RAMPS

Portable ramps are placed over inclines, steps, and other uneven surfaces to provide passage for individuals who use assistive mobility devices. A portable ramp may be covered for an individual with an order from a practitioner and prior authorization when it is required to support transfer and performance of activities of daily living in the home and community.

Two types of portable ramps may be covered, portable ramps and threshold ramps, with prior authorization and an evaluation from physical therapist, occupational therapist or certified Assistive Technology Professional (ATP) must document the medical need for the ramp.

1. Portable ramps – For use in the home or for vehicle transportation. Typically constructed of metal or fiberglass.
2. Removable threshold ramps – For use in the home to cross over interior or exterior thresholds. Must be removable (not permanently affixed). Typically constructed of rubber or aluminum.

Portable ramps will not be covered if the individual already has a permanent ramp at the individual's residence or the individual's vehicle is already wheelchair accessible. Permanent and modular ramps are not covered under the DME benefit.

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[1] ANSI/RESNA, *ANSI/RESNA WC19: Wheelchairs Used as Seats in Motor Vehicles*. 2000, American National Standards Institute (ANSI)/Rehabilitation Engineering and Assistive Technology Society of North America (RESNA).

[2] ISO, *ISO 7176/19: Wheelchairs Used as Seats in Motor Vehicles*. 2000, International Organization for Standardization: Geneva, Switzerland.

[3] Society of Automotive Engineers, *SAE J2249: Wheelchair Tiedowns and Occupant Restraint Systems - Surface Vehicle Recommended Practice*. 1999, Society of Automotive Engineers: Warrendale, PA.

[4]ISO, *ISO 10542-2: Technical systems and aids for disabled or handicapped persons - Wheelchair tiedown and occupant-restraint systems - Part 2: Four point strap type tiedown systems*. 1999, International Organization for Standardization: Geneva, Switzerland.

[5] ISO, *ISO 10542-3: Technical systems and aids for disabled or handicapped persons - Wheelchair tiedown and occupant-restraint systems - Part:3: Docking type tiedown systems*. 2005, International Organization for Standardization: Geneva, Switzerland.

Augmentative Communication Devices

DMAS will consider reimbursement for electronic or manual augmentative communication devices when evidence of medical necessity has been submitted by the provider for service authorization (SA) to the DMAS SA contractor for review. Communication devices to improve educational and/or vocational abilities are not covered services by Medicaid. (12 VAC 30-50-165)

One of the following criteria must be met before an augmentative communication device can be considered for approval:

- The individual cannot functionally communicate basic needs verbally or through gestures due to medical conditions, and expressive language is not expected to be restored. Basic needs include eating, drinking, toileting, and indicating discomfort or pain; *or*
- The individual cannot verbally or through gestures participate in medical care, i.e., indicate decisions regarding medical care or indicate medical needs; *or*
- The individual cannot verbally or through gestures functionally communicate informed consent on medical decisions. (12 VAC 30-50-165)

In accordance with the Virginia State Plan for Medical Assistance, all of the following must be met before an augmentative communication device can be considered for approval. The communication device must be:

- Ordered by the practitioner on the CMN/DMAS-352;
- A reasonable and medically necessary part of the individual's treatment plan;
- Consistent with the individual's diagnosis and medical condition, particularly the functional limitations and symptoms exhibited by the individual;
- Not furnished solely for the convenience of the individual, the family, the attending practitioner, or other practitioner or supplier;
- Consistent with generally accepted professional medical standards (i.e., not

experimental or investigational); *and*
- Furnished at a safe, effective, and cost effective level, primarily for use in the individual's home environment.

Requests for augmentative communication devices must be submitted on a DMAS-363 Outpatient Service Authorization Request Form as described in Appendix D of this manual. Requests must be accompanied by documentation of a systematic and comprehensive speech/language evaluation, completed by a speech-language pathologist licensed by the Department of Health Professions and signed and dated by the individual's practitioner.

The speech-language pathologist may not be a provider of augmentative communication systems nor have a financial relationship with a provider/manufacturer.

A 30 to 60-day trial rental period must be considered for all electronic devices to assure that the chosen device is the one most appropriate to meet the individual's medical needs. (Note: For those individuals whose needs can be clearly defined by the comprehensive speech-language pathologist's evaluation, a trial rental period is not necessary.) At the end of the trial rental period, if purchase of the device is recommended, documentation by the speech-language pathologist of the individual's ability to use the communication device must be provided.

If the communication device(s) supplied for the required two-month rental period is new upon delivery, DMAS will consider paying the full purchase price listed in the DME Listing in addition to the initial two-month rental period for these items.

Collaborative Funding for Communication Devices

Based on House Joint Resolution 697 (1995), an effort should be made to promote the removal of identified barriers and seek to broaden and improve access to assistive technology devices and services to persons with disabilities, within the guidelines established in the Virginia Administrative Code (VAC). When the requested device is needed partially for medical purposes and partly for educational, vocational, or social needs, the communication assessment team must pursue the possibility of a collaboration of funding sources. In addition to DMAS, these funding sources may include a local school division, the Department of Aging and Rehabilitative Services, private foundations, the individual's family/friends, and charities or other non-profit groups.

If the individual/family requests to act as a funding source for portions of the device found to be "not medically necessary" and therefore, not covered by Medicaid, the DME provider must maintain documentation that the individual/family was charged, per their request, for Medicaid non-covered services. However, the individual/family may not be charged for services that are medically necessary and covered by Medicaid. The DME provider must accept Medicaid's payment as payment in full for services that are medically necessary and covered by Medicaid.

Once another funding source is identified, DMAS must be contacted to negotiate a collaborative funding formula. When pursuing collaborative funding of a communication device, the speech/language pathologist must include previously described documentation and must delineate which components are felt to be medically necessary and which are educational, vocational, etc. If a device is determined to be medically necessary, DMAS, or its contractor, will approve the level of funding for a device that meets the individual's medical needs. If a more complex device is required to meet the educational/social/vocational needs as well as the medical needs of the individual, the remainder of the funding must be provided by an alternative funding source.

Each request for collaborative funding will be reviewed or authorized on an individual basis. The assessment team must notify DMAS, or its contractor, as soon as possible of a situation that might require collaborative funding so that acquisition of the device by the individual will not be delayed.

Payments toward funding of the device must be made directly to the provider and not to the individual. Payments to the individual may be viewed as "income" and could potentially affect the individual's eligibility for Medicaid.

Note: Although collaborative funding is primarily utilized for communication devices, there may be other DME for which collaborate funding is appropriate and will be reviewed on a case by case basis.

ADAPTIVE EQUIPMENT

Adaptive equipment includes, but is not limited to, adaptive utensils, wall-mounted insulin delivery devices, and automatic feeder systems. All adaptive equipment must be medically necessary and essential for the treatment of illness or injury. Adaptive equipment does not include home modifications (e.g., devices that are permanently affixed to the walls of the home such as grab bars, ramps, barrier free lifts, and widening of doorways); furniture and appliances not defined as medical equipment such as bathroom scales and hand-held shower devices; items that are not for the diagnosis and treatment of illness or injury or to improve the functioning of a malformed body part; and equipment when the primary function is vocationally or educationally related (e.g., computers and environmental control devices). (12 VAC 30-50-165)

The following conditions must be met for DMAS to approve reimbursement of adaptive equipment. These conditions are applicable whether the equipment is for initial use or replacement. Approval may occur under one of the following categories:

1. Individual-Based Outcomes (one of the following must be met):
    - An identified, realistic goal exists that makes necessary the use of the adaptive equipment for the treatment of the medical condition; *or*

- Anticipated stabilization of the medical condition or progress toward goal achievement is clearly related to the use of the equipment.

2. Supportive Activities to Accomplish Outcomes (all of the following must be met):

- Goal(s) must be a part of an active, rehabilitative, therapeutic plan of care in place at the initiation of the use of the equipment. The goal(s) must be realistic in that it is consistent with the individual's cognitive, environmental, and physical status;
- The individual or caregiver demonstrates the ability cognitively, motivationally, and physically to effectively utilize the equipment toward goal achievement. Someone is available to regularly assist the individual as necessary in the use of the equipment to facilitate progress toward the goal ;
- Within the plan of care, documentation exists that other equipment and/or health care alternatives have been considered and rejected as not appropriate for the treatment of the medical condition;
- The individual does not have a deficient level of "energy" or other systemic condition (e.g., CHF, COPD) that adversely impacts the ability to participate in the use of the equipment; *and*
- The equipment must reduce the need for other reimbursed health care (such as personal care, private duty nursing, rehabilitation services, and/or home health services).

Blood Glucose Monitors

DMAS will reimburse for blood glucose monitors and associated supplies for individuals eligible for the DME program or EPSDT when all of the following criteria are met:

- The individual has a condition that requires adjustment of insulin dosage based on at least daily blood glucose findings, or the individual has clinically demonstrated unstable glucose readings and must report frequent findings to a practitioner for adjustment of hypoglycemic medications; *and*
- There must be written verification that the individual and/or caregiver have participated in diabetic training (diet, medication, monitoring, etc.) and that the individual and/or caregiver have demonstrated the ability to appropriately use the prescribed blood glucose monitor. (This requirement is applicable for initial blood glucose monitors and is not required for future monitors unless the practitioner feels additional education is necessary).

DMAS has implemented the Medicare established competitive rates for select diabetic supplies. The select HCPCS codes will be marked in blue in the Appendix B section. As part of this implementation, **providers are now permitted to ship a 90 day supply for the following diabetic supplies:**

A4206, A4245, A4250, A4233, A4234, A4235, A4236, A4253, A4256, A4258 and A4259

Continuous Glucose Monitors (CGM)

A CGM reveals short-term trends in the blood sugar as they happen. The monitor reads a constant stream of glucose data every 1 to 5 minutes. CGMs have 3 basic components: a sensor (A9276), a transmitter (A9277) and a receiver (A9278). The receiver and transmitter are durable devices that are reused each time the sensor is changed. Sensors are disposable and approved for 3 to 7 days of use depending on the manufacturer.

Coverage will be limited to members with:

1. Type 1 Diabetes , no age limitations
2. Type II Diabetes > 16 years of age
3. Pregnant women with Type 1 or Type 2 diabetes, who are injecting insulin

A resident physician, endocrinology fellow, nurse practitioner acting within the scope of their practice under state law, or physician's assistant supervised by an endocrinologist can write the order as long as the supervising endocrinologist signs the CMN.

The DMAS Medical Support Unit (MSU) will review all service authorizations. The authorizations are to be faxed to the MSU unit at 804-452-5450. An approved service authorization allows the DME provider to receive reimbursement from DMAS for members enrolled in the Medicaid, FAMIS, or FAMIS MOMS Fee-for-Service programs.

The following criteria will be used for all CGM devices:

Type I diabetes, no age limitations, **ALL** of the following are met:

- Inadequate glycemic control despite self-monitoring at least 4 x/day, with fasting glucose >150; **and**
- Recurring episodes of severe hypoglycemia <50 mg/dl **or** hypoglycemic unawareness; **and**
- Insulin injections are required 3 or more times per day or an insulin pump is used for maintenance of blood sugar control.

Authorization is for purchase of DME.

Type 2 diabetes, age >16, **ALL** of the following are met:

- Inadequate glycemic control despite self-monitoring at least 4 x/day, with fasting glucose >150; **and**

- Recurring episodes of severe hypoglycemia <50 mg/dl **or** hypoglycemic unawareness; **and**
- Insulin injections are required 3 or more times per day or an insulin pump is used for maintenance of blood sugar control.

Authorization is for purchase of DME.

Pregnant individuals with Type 1 or Type 2 diabetes who are injecting insulin, **ALL** of the following are met:

- Inadequate glycemic control despite self-monitoring at least 4 x/day, with fasting glucose >150; **and**
- Recurring episodes of severe hypoglycemia <50 mg/dl **or** hypoglycemic unawareness; **and**
- Insulin injections are required 3 or more times per day or an insulin pump is used for maintenance of blood sugar control.

Authorization is for rental of DME for up to 12 months

For Pregnant Women

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.

The Certificate of Medical Necessity (CMN-352) is required. The maternity risk screen is no longer required; however, 12VAC 30-50-510 requires that pregnant women who receive a blood glucose meter covered by DMAS must be referred for nutritional counseling.

Breast Pumps for Pregnant and Postpartum Women (DME)

Coverage of lactation counseling services and breast pumps, for pregnant and postpartum women enrolled in the fee-for-service Medicaid/FAMIS/FAMIS MOMS benefits is effective January 1, 2016. (Refer to DMAS Memo dated December 2015.) Effective July 1, 2022, continuous coverage for Medicaid and FAMIS MOMS is provided during pregnancy and for a 12-month postpartum period beginning on the last day of the pregnancy and including any remaining days of the calendar month in which the 12-month period ends. See Appendix B of this manual for HCPCS codes.

DMAS will cover a manual or standard electric breast pump as medically necessary for the initiation or continuation of breastfeeding (up to the child's first birthday). These breast pump codes are available as of January 1, 2016:

- E0602 Manual breast pump, purchase – does **not** require service authorization;
- E0603 Single user electric breast pump, purchase – requires service authorization;
- E0604 Multi-user (Hospital grade) electric pump, rental – requires service authorization;

- E1399 Additional collection kit for use with the single and multi-user electric breast pumps - requires service authorization.

E0603 - Single user electric breast pumps - purchase

A personal use electric breast pump is designed for mothers who are breastfeeding without problems. A personal use electric breast pump is defined as a double electric (AC and/or DC) pump, intended for a single user and is capable of being used multiple times per day. Payment includes supplies necessary for operation of the pump (pump, adapter/charger, breast shields, bottles, lids, tubing, locking ring, connectors, valves, filters and membranes). DMAS medical necessity criteria is as follows:

- Mother must express the desire to breastfeed;
- The pump must be FDA registered;
- The pump has a minimum one year manufacturer's warranty; and
    - The pump must have a mechanism to prevent suction beyond 250 mm Hg to prevent nipple trauma.

Limits: One purchase every 3 years. Request must be medically justified. Request duration is 30 days (for pick up/delivery). DMAS allows for one additional purchase every three years with medical justification.

E0604 – Multi-user (Hospital grade) electric pumps - rental

Multi-user/Hospital grade electric pumps are designed to initiate and maintain a milk supply when a baby is not feeding well. The pump must be FDA registered and have a mechanism to prevent suction beyond 250 mm Hg to prevent nipple trauma.

DMAS coverage of hospital grade rental pumps must meet one of the medical necessity criteria listed below:

- When the infant is premature at 24-34 weeks of gestation, and the mother is pumping breast milk, awaiting the baby's ability to nurse directly from the breast, *or*
- When the infant is premature at 35-37 weeks of gestation and continues to experience difficulty coordinating suck and swallow, and the mother is pumping breast milk, awaiting the baby's ability to nurse directly from the breast*, or*
- For infants with cleft lip and/or palate or ankyloglossia who are not able to nurse directly from the breast*, or*
- For infants with cardiac anomalies or any medical condition that makes them unable to sustain breast feeding due to poor coordination of suck and swallow or fatigue, or
- For multiples (including twins), until breast-feeding at the breast is established consistently, *or*
- When the mother has an anatomical breast problem, which may resolve with the use of

breast pump, such as insufficient glandular tissue, *or*
- For any infants for medical reasons who are temporarily unable to nurse directly from the breast, such as NICU babies, or during any hospitalization of the mother or baby which will interrupt nursing, *or*
- When the infant has poor weight gain related to milk production and pumping breast milk is an intervention in the provider's plan of care and infant has a documented weight loss of 7% or greater despite use of conventional breast pump.

A hospital grade breast pump is not medically necessary when one of the above criteria are not met or when it is requested solely to allow for the mother's return to work or mother's or family convenience.

Limits: Up to 6-month initial rental period based on medical necessity; 12-month **maximum** rental period per member with medical justification. Requests for additional months after the initial 6 months must include why purchase of a single user electric pump (E0603) will not meet member's needs.

E1399 – Collection kits for use with the single and multi-user electric breast pumps

One collection kit for electric breast pumps includes necessary supplies and collection containers. The service limit is one additional kit per single or multi-user electric breast pump authorization. Providers must include medical justification when requesting an additional kit. Each breast pump includes an initial collection kit. Providers must bill their Usual and Customary Charge (UCC). Additional collection kits have a maximum reimbursement rate; 1 unit equals 1 kit. **There is no 30% mark up for additional collection kits.**

Limits: One (1) per service limit period for single-use and multi-use electric pumps. Request must be medically justified; provider must indicate pump is owned or rental and that the additional collection kit is appropriate for member owned (or rental) pump. Request duration: 30 days (for pick up/delivery).

DME providers must submit medical justification to DMAS or its contractor when requesting these codes. Providers must have a completed CMN (DMAS 352) on file. NOTE: Please note that Medicaid and FAMIS MOMS is effective for the duration of the pregnancy and for 12-months postpartum period beginning on the last day of the pregnancy and including any remaining days of the calendar month in which the 12-month period ends. If they need additional coverage of a hospital grade pump, refer the individual to their local Women, Infants and Children (WIC) office in their county for assistance. If a hospital grade breast pump is no longer needed but the mother has the desire to continue breast feeding, DMAS may consider the purchase of a manual or standard electric pump prior to coverage ending.

Disposables to Carry Out Infection Control Procedures

The following recommendations regarding disposable items are based on current guidelines from the Centers for Disease Control (CDC). Disposable items, including, but not limited to, gloves, gowns, and masks, will be covered only when necessary to carry out universal precautions. If the caregiver (e.g., family individual) is in contact with the individual's blood

and/or other body fluids containing visible blood, a documented communicable disease, or for the specific and medically documented symptoms of impaction.

For individuals enrolled in the Medicaid-funded Technology Assisted Waiver, non-sterile gloves may be used when performing tasks related to tracheostomy care, such as suctioning. The reason for this exception in the use of non-sterile gloves is to reduce the risk of coming in contact with blood and reducing the risk of infection. Individuals in the Technology Assisted Waiver are more susceptible to serious infection and possible repeated hospitalizations due to their fragile respiratory needs.

Disposable items will not be covered for use by the caregiver (e.g., family or provider agency) in carrying out routine infection control procedures (e.g., gloves to clean an incontinent individual, handle soiled linen, clean or empty a bedside commode, empty a urinary drainage bag, or to bathe an individual). (12 VAC 30-50-165)

DMAS will not provide reimbursement for items necessary to carry out either routine or universal precautions when the care is being supplied by a provider agency. The provider will be responsible for the provision of equipment and supplies necessary to minimize the risk of infection including the transmission of the HIV virus and other blood-borne pathogens.

Enteral Nutrition

Coverage of enteral nutrition, that does not include a legend drug, shall be limited to when the nutritional supplement is administered orally or through a nasogastric or gastrostomy tube; and is necessary to treat a medical condition. DMAS shall provide coverage for nutritional supplements for enteral feeding only if the nutritional supplements are not available over the counter. Additionally, DMAS shall cover medical foods that are:

1. Specific to inherited diseases, metabolic disorders, PKU, etc,;
2. Not generally available in grocery stores, health food stores, or the retail section of a pharmacy;
3. Not used as food by the general population.

Coverage of medical foods shall not extend to regular foods prepared to meet particular dietary restrictions, limitations, or needs, such as meals designed to address the situation of individuals with diabetes or heart disease. Coverage of oral administration does not include the provision of routine infant formula or feeding as meal replacement only. (12 VAC 30-50-165). DMAS will reimburse under EPSDT for medically necessary formula and medical foods when used under a practitioner's direction to augment dietary limitations or provide primary nutrition to individuals via enteral or oral feeding methods. A nutritional assessment shall be required for all individuals for who nutritional supplements/medical foods are ordered.

MCOs will cover enteral nutrition for children enrolled in Medicaid managed care.

"Enteral nutrition" refers to any method of feeding that uses the gastrointestinal tract to deliver part or all of an individual's caloric requirements. "Enteral nutrition" may include a routine oral diet, the use of liquid supplements, or delivery of part or all of the daily requirements by use of a tube, which is called "tube feeding."

All of the following shall apply to the provision of enteral nutrition:

· Enteral nutrition shall be reimbursed only to enrolled DME providers. If a pharmacy is currently providing enteral nutrition, but is not enrolled as a DME provider, the pharmacy must become an enrolled DME provider in order to be reimbursed for services;

· Enteral nutrition shall be based on categories of nutritional components (refer to the DME Listing/Appendix B: Feeding Pumps, Nutritional Supplements, Feeding Kits and Tubes);

· The practitioner's order (the CMN/DMAS-352) must specify either a brand name of the supplement being ordered or the category of enteral nutrition which must be provided. If a practitioner orders a specific brand of supplement, the DME provider must supply the brand prescribed. The practitioner's order must include the daily caloric order and the route of administration for the supplement. Where applicable, existing Medicare codes and reimbursement rates will be utilized. An additional category has been added to Appendix B to include certain pediatric supplements that are not covered by Medicare;

The practitioner's order (the CMN/DMAS-352) is valid for a maximum of six (6) months regardless of the individual's age. The order shall not be backdated to cover prior dispensing of enteral nutrition products. A face-to-face nutritional assessment completed by trained clinicians (e.g., practitioner, registered nurse, or a registered dietitian) must be completed as required documentation of enteral nutrition for both the initial order and every six (6) months.

NOTE: Home health visits for the sole purpose of performing a nutritional assessment for individuals whose conditions are stable and chronic in nature will not be covered under the home health program.

Service authorization (SA) of enteral nutrition is not required. The DME provider must assure that there is a valid practitioner's order (CMN/DMAS-352) completed every six months in accordance with DMAS policy and on file for any Medicaid individual for whom enteral nutrition is provided. The DME provider is further responsible for assuring that enteral nutrition is provided in accordance with DMAS reimbursement criteria. Upon post payment review, DMAS will deny or retract reimbursement for any supplements that are not provided and billed in accordance with the criteria described in this manual.

The required medical justification can be included in the supporting documentation that is signed and dated by the practitioner. See Chapter VI for a listing of all the specific documentation requirements for the CMN/supporting documentation.

See the "Medicaid DME and Supplies Listing" in Appendix B of this manual for a current listing of the supplements covered by DMAS. If the supplement that has been ordered by the practitioner is not found on the list, contact the DMAS Provider HELPLINE. The Provider HELPLINE will assist the DME provider in obtaining a classification for all supplements not listed.

NOTE: Codes B4100, B4102. B4103, and B4104 are not considered enteral nutrition.

Enteral Nutrition - Early Periodic Screening, Diagnostic, and Treatment (EPSDT)

The Early Periodic Screening Diagnosis and Treatment (EPSDT) benefit allows DMAS to provide medically necessary formula and medical foods to EPSDT eligible children under the age of 21, based on medical necessity. Medical foods are considered (i) specific to inherited diseases, metabolic disorders, PKU, etc.; not generally available in grocery stores, health food stores, or the retail section of a pharmacy; and not used as food by the general population. Refer to the section titled, "Enteral Nutrition" previously identified in this chapter for EPSDT formula criteria. Routine infant formula is not covered. DMAS will reimburse for medically necessary formula and medical foods when used under practitioner direction to augment dietary limitations or provide primary nutrition to individuals via enteral or oral feeding methods.

Children under the age of five (5) who receive Medicaid through a Medallion 4.0 Managed Care Organization (MCO) will receive medical formula and nutritional supplements through DMAS enrolled DME providers. The provision of medically necessary formula and medical foods for children under the age of five is not required of DMAS contracted MCO's, this service is carved out from the DMAS Medallion 4.0 Managed Care Contract. Medical formula and nutritional supplements must be practitioner recommended to correct or ameliorate a health condition that requires specialized formula and medical foods to supplement diet due to metabolic limitations or provide primary nutrition to individuals via enteral or oral feeding methods. The practitioner must document medical necessity by using the Certificate of Medical Necessity (CMN/DMAS 352) and supporting documentation.

Note: The DME provider must continue to bill the individual's MCO for supplies and equipment, including those needed in relation to enteral nutrition.

Referral Process:

- The child's parent or responsible party should contact their practitioner or metabolic treatment center to determine the medical need for medical formula or medical foods.
- Children under five (5) years who require medical formula must use a DMAS DME enrolled provider for dispensing the medical formula. This will include WIC offices.
- Children aged five or older may receive medical formula and nutritional supplements through either DMAS enrolled DME providers or their MCO providers depending upon their Medicaid enrollment status.
- The Certificate of Medical Necessity (CMN/DMAS-352) and supporting documentation must be completed by a regional metabolic treatment center or a primary care practitioner who is treating the child's medical condition related to the nutritional supplements.
- Deliver the forms to the DME provider.
- The DME provider will provide the formula according to the DME Manual specifications and retain the DMAS 352 and nutritional assessment forms.
- Formula that is not priced in Appendix B of the DME Manual will be reimbursed at the amount of the providers' cost plus a 30% mark up.

Home Infusion Therapy

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

- Ordered by the licensed practitioner on the CMN Medically necessary to treat an individual's medical condition;
- A reasonable and necessary part of the individual's treatment plan;
- Consistent with the individual's diagnosis and medical condition
- In accordance with accepted medical practice; and
- Not for the convenience of the individual or the individual's caregiver.

The individual must:

- Reside in either a private home or an assisted living facility (ALF). Individuals in hospitals, nursing facilities, rehabilitation centers, and other institutional settings are not eligible for this service;
- Be under the care of a practitioner who prescribes the home infusion therapy and monitors the progress of the therapy;
- Have body sites available for I.V. catheter or needle placement or have central venous access or an implanted pump; and
- Be capable of self-administering or have a caregiver who can be adequately trained, is capable, and is willing to administer/monitor home infusion therapy safely and efficiently following the appropriate teaching and adequate monitoring. In those cases where the individual is incapable of administering or monitoring the prescribed therapy, and there is no adequate or trained caregiver, it may be appropriate for a home health agency to administer the therapy.

Provider Eligibility

Providers must have a valid Medicaid national provider identification (NPI) number to participate in the home I.V. therapy program. Providers eligible to participate in this program are:

- I.V. therapy providers;
- Home health agencies;
- Pharmacies; *and*
- DME providers.

A provider must be enrolled as a Medicaid provider, to include all of the following:

- Meet any state licensing and certification requirements;

- Render infusion therapy covered services;
- Use Medicaid-established billing guidelines;
- Accept Medicaid reimbursement as payment in full.

Therapy Coverage

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

- Hydration therapy;
- Pain management;
- Chemotherapy;
- Drug therapy; and
- Total parenteral nutrition (TPN)

Service Day Rate Definition

This payment methodology provides a fixed amount for each day of infusion therapy. The service day rate (per diem) reimburses for all services delivered in a single day. This payment methodology will be mandatory for the reimbursement of all I.V. therapy services, unless the individual is enrolled in one of the waivered services outlined under "Special Considerations." Service day rates are based on an average day of service, and there will be no additional reimbursement for special or extraordinary services. In the event of incompatible drug administration, the provider should use separate HCPCS codes (see Appendix B of this Manual for the appropriate HCPCS codes) to allow for the rental of a second infusion pump and the purchase of extra administration tubing.

When applicable, DMAS may be billed in addition to the service day rate codes for the rental of the second infusion pump and extra administration tubing. There must be documentation to support the use of these codes in addition to the service day rate on the I.V. Implementation Form (DMAS-354). Proper documentation includes the need for pump administration of the medications ordered, the frequency of administration to support that they are ordered simultaneously, and an indication of incompatibility. The service day rate payment will be in two service categories: durable medical equipment (DME) and pharmacy.

Items in the DME service day rate include all supplies required to administer I.V. therapy, including, but not limited to, the following:

- I.V. pump/pole rental/control devices;
- Tubing's, adapters, caps, needles, filters, cannulas, extension sets, and alcohol swabs; *and*
- I.V. start kits and central venous catheter dressing kits.

Items in the pharmacy service day rate include the following:

- Diluent for the therapeutic agent;
- Mixing and compounding;
- Flush kits and solutions (heparin and saline); *and*
- Cassettes and bags/mini-bags.

See the Medicaid Pharmacy Provider Manual for instructions regarding billing pharmacy services day rate available through the Medicaid portal at www.virginiamedicaid.dmas.virginia.gov .

Drugs used in addition to I.V. therapy, such as intramuscular and subcutaneous injections (Compazine, insulin, etc.) and subcutaneous therapies for hydration and/or pain management, are not covered under the I.V. service day rate policy. These medications and their associated DME supplies must be ordered and billed separately according to current Medicaid guidelines.

Special Considerations

Providers of I.V. therapy services to those individuals enrolled in special or waivered Medicaid programs must abide by all the guidelines of the program in which the individual is enrolled.

Nursing Visits

Nursing visits for I.V. therapy are reimbursed under home health services. To receive reimbursement for the I.V. therapy nursing services, the provider must be a Medicaid home health provider with a valid home health provider NPI number. If a nurse from a company that is a non-participating Medicaid home health provider acts as a "back up" for the nurse at the home health agency, the two companies must make arrangements between themselves for reimbursement. The home health visit reimbursement for all nursing services, includes but is not limited to, travel time, individual education, and I.V. administration. A home health nurse must be present delivering a service that is deemed medically necessary in order to receive reimbursement. Supplies used by the nurse during the course of the home health visit for I.V. therapy, such as I.V. start kits, angiocaths, midline catheters, etc., will be reimbursed under the DME service day rate allowance to whichever provider furnishes the supplies.

Multiple Therapies

Multiple therapies of the same therapy are included in one service day rate of reimbursement. For example, if an individual receives two antibiotics under drug therapy on the same day, the provider may only bill one service day rate for the DME and pharmacy services. In the event of incompatible drug administration, the provider should use separate

HCPCS codes (see Appendix B of this Manual for the appropriate HCPCS codes to use) to allow for the rental of a second infusion pump and the purchase of extra administration tubing. When applicable, DMAS may be billed in addition to the service day rate codes for the rental of the second infusion pump and extra administration tubing. There must be documentation to support the use of these codes in addition to the service day rate on the I.V. Implementation Form (DMAS-354). Proper documentation includes the need for pump administration of the medications ordered, the frequency of administration to support that they are ordered simultaneously, and an indication of incompatibility.

Multiple therapies of different therapies under DME will be reimbursed at 100% for the most expensive therapy and 50% for the second and each additional therapy. For example, if an individual receives chemotherapy, hydration, and pain management on the same day, the DME provider may bill $44.00 for pain management, $18.50 for chemotherapy, and $15.00 for hydration, based on current rates.

Hydration Therapy

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

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

- Covered drugs: Electrolytes and flushes (heparin and saline); and
- Cassettes/bags/mini-bags, mixing, and compounding.

The hydration solution is billed on the most current version of the Daily Pharmacy Drug Claim Ledger (DMAS-173), Point-of-Service (POS) on-line billing, or approved electronic billing method.

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

- The I.V. pump/pole rental, administration sets, tubing's, adapters, cannulas, extension sets, gloves, alcohol wipes, needles, dressing/start kits, etc.

SPECIAL NOTES:

- There is no additional reimbursement for special or extraordinary services.
- The pharmacy service allowance includes containers (cassettes/bags/minibags) and flushes (heparin and saline).

Pain Management

Definition: Pain management is the intravenous administration (or subcutaneous administration via patient-controlled analgesia (PCA) or CAAD ambulatory infusion pump) of narcotics and other drugs to relieve pain.

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

- Covered drugs**:** Diluent, electrolytes, and flushes (heparin and saline); and
- Cassettes/bags/mini-bags, mixing, and compounding.

The DME service day rate includes, but is not limited to: I.V. pump/pole rental, administration sets, tubings, adapters, cannulas, extension sets, remote reservoirs, needles, alcohol wipes, gloves, dressing/start kits, etc.

SPECIAL NOTES:

- There is no additional reimbursement for special or extraordinary services.
- The pharmacy service allowance includes containers (cassettes/bags/minibags) and flushes (heparin and saline).

Chemotherapy

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

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

- Covered drugs**:** Diluent, electrolytes, and flushes (heparin and saline); and
- Cassettes/bags/mini-bags, mixing, and compounding.

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

- The I.V. pump/pole rental, administration sets, tubings, adapters, cannulas, extensions sets, needles, alcohol wipes, gloves, dressing/start kits, spill kits, etc.

Special Notes:

- There is no additional reimbursement for special or extraordinary services.
- The pharmacy service allowance includes containers (cassettes/bags/minibags) and flushes (heparin and saline).
- Multiple chemotherapies are included in the one service day rate.
- Hydration solutions may be billed separately.

Drug Therapy

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

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

- Covered drugs: Diluent, electrolytes, and flushes (heparin and saline); and
- Cassettes/bags/mini-bags, mixing, and compounding.

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

- I.V. pump/pole rental, administration sets, tubings, cannulas, extension sets, adapters, needles, remote reservoirs, alcohol wipes, gloves, dressing/start kits, etc.

SPECIAL NOTES:

- There is no additional reimbursement for special or extraordinary services.
- The pharmacy service allowance includes containers (cassettes/bags/minibags) and flushes (heparin and saline).
- Multiple drug therapies are included in the one service day rate.

Total Parenteral Nutrition - TPN

Definition: TPN is the administration of nutritional substance by intravenous infusion to nourish individuals who are malnourished or may develop malnutrition and who are not candidates for enteral support.

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

- Covered drugs: Diluent, electrolytes, nutritional additives, lipids, and flushes (heparin and saline); and
- Cassettes/bags/mini-bags, mixing, and compounding.

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

- I.V. pump/pole rental, administration sets, tubings, cannulas, extension sets, adapters, needles, alcohol wipes, gloves, dressing/start kits, etc.

SPECIAL NOTES:

- There is no additional reimbursement for special or extraordinary services.
- The pharmacy service allowance includes containers (cassettes/bags/minibags) and flushes (heparin and saline).
- The pharmacy service allowance includes solutions, additives (such as KCL and MVI), and lipids. Refer to the Medicaid Pharmacy Provider Manual for additional information on the Medicaid web portal at www.virginiamedicaid.dmas.virginia.gov .

Codes for Use with Purchased I.V. Pumps

For those cases where an individual owns an I.V. pump for the long-term administration of I.V. therapy, two DME codes have been created to reimburse for service day rate services.

Use HCPCS code defined in Appendix B of this Manual for those individuals who own their own IV pump and require IV drug therapy. The reimbursement does not include the pump

rental, but does include an allowance for battery reimbursement.

DMAS will not reimburse the DME provider for any DME and supplies provided prior to the date of the practitioner's signature when the signature is not obtained within 60 days of the first date of service. Under the item/service and HCPCS code on the CMN/DMAS-352, list the proper code and therapy service as well as the estimated length of time needed. The I.V. Therapy Implementation Form (DMAS-354) must be completed, signed, and dated by the practitioner within 60 days of the therapy start date. Additionally, a copy of the doctor's order for discontinuing the therapy must also be attached to each CMN/DMAS-352 and I.V. Therapy Implementation form upon completion of the therapy.

Code to Use for Incompatible Drug Therapy

In the event of incompatible drug administration, the provider may bill the rental of a second infusion pump for each day of service and extra administrative tubing. There must be documentation to support the use of the second pump on the I.V. Therapy Implementation Form (DMAS-354). Proper documentation includes the need for pump administration of the medications ordered, the frequency of administration to support that they are ordered simultaneously, and an indication of incompatibility.

Respiratory Equipment and Services

Apnea Monitors

Apnea monitor usage for individuals with one of the following diagnoses or identified high-risk conditions may be approved for payment if the diagnosis/condition is supported with a completed CMN/DMAS-352 and includes appropriate supporting and verifiable documentation:

- Those who have experienced a brief unexplained event (BRUE) and are NOT characterized as low risk* (see below for low risk factors). If monitored due to BRUE, use of an apnea monitor is considered medically necessary until event free for 2-3 months;
- Apnea of prematurity, defined as sudden cessation of breathing that lasts for at least 20 seconds, or is accompanied by bradycardia (heart rate less than 80 beats per minute), or oxygen desaturation less than 90 % or cyanosis in an infant with early home discharge prior to term (38 weeks). Continued use is considered medically necessary up to 43 weeks postmenstrual age or event free for two (2) weeks, whichever comes later;
- Bronchopulmonary dysplasia/chronic lung disease of infancy with oxygen dependency;
- Respiratory control disorder such as: congenital hypoventilation, obstructive sleep apnea, central apnea, obstructive airway disease;
- Infant or child with tracheostomy;

- Those discharged home on a schedule of weaning narcotics;
- Congenital anomalies, at risk of airway obstruction;
- Those with a diagnosis of pertussis and are < six (6) months old, with positive cultures. If monitored for pertussis, use of monitor is considered medically necessary for up to one (1) month post diagnosis;
- Those with bradycardia on caffeine, theophylline, or similar agents, until event free for two (2) weeks off medication;
- Those with diagnosis of gastroesophageal reflux disease (GERD) that results in apnea (at least 20 seconds), bradycardia (heart rate less than 80 beats per minute), or oxygen desaturation (O_2 saturation less than 90%, or cyanosis), until event freee for six (6) weeks.

BRUE is defined as an event occurring in an infant < one (1) year of age when the observer reports a sudden, brief, and now resolved episode of > one (1) of the following:

- Cyanosis or pallor

- Absent, decreased or irregular breathing

- Marked change in tone (hyper or hypotonia)

- Altered level of responsiveness

BRUE Low Risk Factors:

1. Age> 60 days
2. Prematurity with gestational age of > 32 weeks and postconceptional age of > 45 weeks
3. First BRUE (no previous BRUE ever and not occurring in clusters)
4. Duration of event < one (1) minute
5. No CPR required by trained medical provider
6. No concerning historical features
7. No concerning physical examination findings

NOTE*:* Information specific to all documentation requirements related to the use of apnea monitors can be found in Ch. VI of this manual.

If the individual does not have any of the above diagnoses, the request will be reviewed in accordance with the following criteria below:

Criteria for Home Monitoring

The instrument recommended for home use must monitor both cardiac and respiratory status. Apnea mattresses or displacement pads are not covered. The individual may use either the recording or non-recording monitor. At least one of the following must be evident

for an initial and/or ongoing continued use, with appropriate, supporting, individual documentation:

- Observed or recorded episode of prolonged apnea with no identifiable and/or treatable cause, or an inadequate response to treatment; or
- Documented apnea associated with bradycardia, cyanosis, pallor; or
- History of apnea described by parent or caretaker and documented in the medical records; or
- Evidence of abnormal respiratory control.

Guidelines for Discontinuation of Monitor Reimbursement

Unless timeframe is specified in the above criteria, initial approval for reimbursement will be for a period up to four months (120 days). If continued use is indicated by medical necessity, supporting and verifiable medical documentation must be submitted to DMAS or its contractor for review and service authorization.

Reimbursement for apnea monitors will be discontinued when a clinical evaluation (including neurological, developmental and physical examinations) shows that the initial problems or conditions requiring the monitor have been resolved or stabilized. Reimbursement will be discontinued when one of the following scenarios occurs:

- The individual has been free of events requiring stimulation or resuscitation for 2-4 months; *or*
- The individual has experienced significant stressors such as respiratory illness or immunizations without apnea; *or*
- There is normalization of a previously abnormal respiratory pattern or no prolonged apnea episodes for 2-4 months.

Pneumograms/Downloads, Polysomnagrams, and Multi-Channel Sleep Studies

Definitions:

A pneumogram is a 2-channel study of breathing and heart rate, including EKG signal and chest wall movement. A download serves the same purpose as a pneumogram if the individual is monitored on a recording apnea monitor.

A multi-channel sleep study contains three or more signal sources that may include: cardiac EKG signal, respiratory air flow, body position, oximetry, esophageal pH, and quantitative end tidal CO_2.

A polysomnagram includes cardiac EKG signal, respiratory chest wall movement, respiratory abdominal wall movement, respiratory air flow, body position, oximetry, esophageal pH, and quantitative end tidal CO_2, EEG x2, EOG x2, and EMG, attended by a technologist.

Reimbursement for these studies will be considered by DMAS or its contractor based on the number of channels in the study. Criteria for determining the number of appropriate channels to be studied must be determined by the attending or ordering practitioner.

If a recording monitor is being used and downloaded, a pneumogram is not needed to document the continuing need for the monitor. This information will be obtained from the download summary report. Should an individual with a recording monitor need a pneumogram, the DME provider must submit a request for service authorization to DMAS or its contractor.

Criteria for Rental versus Purchase of an Apnea Monitor

DMAS does not require service authorization for the initial 120 days of use of an apnea monitor. If the practitioner determines that the individual will need the apnea monitor beyond 120 days, but less than eight (8) months, the DME provider must obtain service authorization for continued rental from the DMAS service authorization contractor. To obtain service authorization, the DME provider must submit supporting documentation for the additional time requested. If the practitioner determines that the individual will need the apnea monitor eight (8) months or longer, the DME provider must request purchase of the apnea monitor. This SA request must include supporting documentation at the initiation of service or at the time of determination of long-term usage. At the time of purchase, the DME provider is required to provide a new monitor with a full manufacturer's warranty. (12 VAC 30-50-165)

The[BS1] provider must submit a clinical description to DMAS or its contractor for review of what happened during the first 120 days and why the monitor continues to be needed. This description is comprised of a history and physical, interpreted downloads or pneumograms that show a test history, indication of special considerations (need for oxygen, need to receive immunization stressors, or need to reach significant age for a sibling with SIDS), and a practitioner's assessment of what happened during the first 120 days of monitoring to warrant continued use. It is the responsibility of the individual's practitioner to interpret the data. It is the responsibility of the provider to obtain the interpretation from the practitioner and submit the interpretation to DMAS or its contractor. Additional information specific to all documentation required for continued use of apnea monitors and diagnostic studies can be found in Ch. VI of this manual.

Non-Compliant Behavior

The provider shall document the individual's non-compliant use of the apnea monitor in the individual's file. Non-compliant use of the apnea monitor by the individual or the individual's caregiver is a refusal to provide care necessary for the individual's health and creates a substantial risk of death for the individual. The provider shall report non-compliant behavior to the attending practitioner or health care professional. There shall be compliance with 12 VAC 30-50-165. DMAS shall continue to reimburse for the monitor while

reasonable efforts to ensure compliant behavior are taken.

Service Maintenance Agreements for Purchased Apnea Monitors

Use the appropriate HCPCS code which covers the service and maintenance of purchased apnea monitors and requires service authorization. The service maintenance agreement will allow for trouble-shooting and download visits (18 visits per six [6] months). Downloading can be done during a "trouble-shooting" visit. The provider can utilize these 18 visits for any combination of "trouble-shooting" or download visits. (See the "Medicaid DME and Supplies Listing" in Appendix B for the allowable limits and reimbursement information.)

Providers must agree to send the purchased monitor to the manufacturer for necessary servicing. The cost for servicing, shipping, and handling is covered in HCPCS code and service authorization is required. A copy of the manufacturer's invoice for servicing must be attached to the claims invoice. The claim invoices will pend for manual review before reimbursement is made.

The service maintenance agreement does not include repairs. All repairs must be requested under the established HCPCS code for repairs.

All of the following services must be included as part of the service maintenance agreement:

- The provider agrees to employ or contract with staff that are available to make timely necessary home visits related to the use of the apnea monitor. The provider must assure that the staff is qualified to render the necessary services; *and*
- The provider agrees to perform routine maintenance of the apnea monitor in the home, replacing rib belts, lead wires, and electrodes (disposable or reusable) associated with this routine maintenance. Supplies that must be provided under this agreement are:
    - 12 disposable electrodes or 2 reusable electrodes
    - 2 lead wires and 2 rib belts.

Additional supplies that are medically justified must be preauthorized

- The costs for "trouble-shooting" and download visits will be included in the service maintenance agreement fee (18 visits per six [6] months). Downloading can be done during a "trouble-shooting" visit. These 18 visits can be used by the provider for any combination of trouble-shooting or download visits;
- The provider agrees to provide a back-up apnea monitor throughout the period of apnea monitor repairs or services. The provider may bill DMAS for a rental apnea monitor for up to one month during routine repairs/services using the established HCPCS code. The rental must only be for the actual time the monitor is out of the home being serviced by the manufacturer;

- The cost of parts which constitute a repair must be billed separately, as a repair, using the established HCPCS codes for repairs; *and*
- The provider agrees to send the apnea monitor for necessary servicing by the manufacturer. The cost for servicing, shipping, and handling will be covered in a separate HCPCS code (S8189). The provider must attach a copy of the CMN/DMAS-352 and manufacturer's invoice to the claim in order for the claim to be paid. DMAS will pend claims for the HCPCS code (S8189) for manual review.

CO2 Monitors

CO2 monitors are typically used for ventilator dependent individuals in the acute care setting, often in conjunction with a pulse oximeter. The term capnography refers to the noninvasive measures of the partial pressure of carbon dioxide in exhaled breath expressed as the C02 concentration over time. These results are usually represented through a capnograph that is a waveform that shows how much C02 present at each phase of the respiratory cycle. The results must be reviewed by the practitioner before nursing intervention is performed based on the study. These studies will not be approved for obstructive sleep apnea. Capnography is generally used in the inpatient setting to verify endotracheal tube placement after intubation, change in the clinical status of an intubated individual, and during procedural sedation.

Use of a C02 monitor in the home has been demonstrated in certain *limited* circumstances. The cost of conducting a capnography study, when ordered by the practitioner, will be covered in the following circumstances:

- Weaning from a ventilator
- Individuals who have a history of C02 retention which requires periodic monitoring
- Monitoring of members with congenital central alveolar hypoventilation syndrome

There as been recent research involving capnography in the detection of nocturnal hypoventilation and intitial assessment of mechanical ventilation efficiency in individuals with neuromuscular disorders. These areas are currently considered investigational and further research will be needed to determine the standard of care.

All requests must be preauthorized. The DME provider must obtain a CMN/DMAS-352, completed by the practitioner who treats the individual's pulmonary condition. The CMN/DMAS-352 must address the reason for the study, the length of time the study will require, and the frequency requested within the six-month service authorization period. Two nights will be the maximum length of the study which will be reimbursed. The CO2 monitor reading must be submitted to the practitioner for assessment, and the practitioner must report back to the DME provider regarding any changes to be made based upon the practitioner's evaluation of the reading taken. Requests for further studies after the first request must include documentation of the progress toward weaning or evidence of continued CO2 retention. If the practitioner does not indicate that progress toward

weaning is shown or can be expected, the SA request may be denied.

The amount of reimbursement for the CO2 study will depend on whether DMAS is reimbursing for the professional component necessary to assure an accurate reading is obtained. For an individual receiving in-home nursing care (e.g., individuals enrolled in the CCC+ Waiver (for vent or complex trach care), the health care coordinator will discuss with the nursing agency and DME provider whether the private duty nurse is knowledgeable and comfortable with the use of the equipment for the study. If the nurse is able to assure an adequate reading, the DME provider will be reimbursed for the cost of the delivery of the equipment, a one-day rental of the equipment, and a scoring fee for the CO2 study. If the nurse is not able to assure the accurate reading, or the individual does not receive nursing services during the time the study would be conducted, DMAS reimbursement will be limited to the time spent by the respiratory therapist, who must be present during the entire period of the study (8-10 hours), rental of the equipment for one day, and the scoring fee. In all cases, the CO2 monitor must be equipped with a printer, and the DME provider must send the results of the study to the practitioner for interpretation.

Humidification Systems

DMAS will reimburse for an aerosol humidification system when the individual's upper airway is bypassed. A vapor phase humidification system will be reimbursed when the individual is on a ventilator. The components of the aerosol system are:

- Reusable dry nebulizer;
- Water trap;
- Compressor;
- Swivel adapter; and
- Corrugated tubing.

A disposable dry nebulizer will only be considered for reimbursement when it is expected that the need for the humidification system will be short-term; (it is expected that the tracheostomy will be closed).

A vapor phase humidification system will be considered for reimbursement for treatment of humidity deficit for an individual with a tracheostomy only when there is justification for the necessity of this device versus an aerosol humidification system, and the aerosol humidification system is documented as contraindicated.

All humidification systems must be purchased except in those instances when humidification is expected to be required for less than nine (9) months. Reimbursement will be a bundled rate for all the components of the system.

Oxygen

DMAS provides reimbursement to DME providers for medically necessary respiratory/oxygen equipment and supplies. Any respiratory/oxygen equipment and supplies must be practitioner-ordered via the CMN/DMAS-352. The flow rate, frequency, and duration of use (an order for PRN use of oxygen must identify the circumstances under which oxygen is to be used) must be identified on the CMN/DMAS-352 as part of the practitioner's order. For portable systems, documentation must provide a description of the activities in which the individual participates, on a regular basis, that require a portable system in the home, and the therapeutic purpose served by that portable system that cannot be met by a stationary system. Coverage of home oxygen and oxygen equipment will be considered reasonable and necessary only for individuals with significant hypoxemia who evidence the following laboratory results, health conditions and for whom the required medical documentation exists. (12 VAC 30-50-165)

Evidence of Medical Necessity

While there is no substitute for oxygen therapy, it is appropriate that each individual should receive optimum therapy before long-term home oxygen therapy is ordered. The practitioner must have examined the individual recently (within 30 days of the start of therapy).

Reasonable and necessary oxygen items and equipment for home use must meet **all** of these criteria:

1. The treating physician examined the individual and determined that he or she has one of these conditions that might be expected to improve with oxygen therapy:

A. Short term supplemental home oxygen therapy is medically necessary for treatment of hypoxemia related symptoms with qualifying laboratory values associated with acute conditions including, but not limited to any of the following:

- Bronchiolitis; or
- Chronic obstructive pulmonary disease exacerbation; or
- Pneumonia.

B. Long term supplemental home oxygen therapy is medically necessary for treatment of hypoxemia related symptoms with qualifying laboratory values from chronic lung conditions including, but not limited to any of the following:

- Bronchiectasis; or
- Chronic lung disease; or
- Chronic obstructive pulmonary disease; or
- Cystic fibrosis; or

- Diffuse interstitial lung disease; or
- Pulmonary hypertension; or
- Pulmonary neoplasm (primary or metastatic);or
- Recurring congestive heart failure due to chronic cor pulmonale.

2. The treating physician or a qualified provider or supplier of laboratory services conducted the qualifying blood gas study. A qualified provider or supplier of laboratory services is:

• Certified to conduct blood gas studies or

• A hospital certified to conduct blood gas studies

3. The qualifying blood gas study value was obtained under these conditions:

• During an inpatient hospital stay - Closest to, but no earlier than, 2 days prior to the hospital discharge date, with home oxygen therapy beginning immediately following discharge or

• During an outpatient encounter - Within 30 days of the date of initial certification while the individual is in a chronic stable state, which is when the individual is not in a period of acute illness or an exacerbation of his or her underlying disease

4. The treating physician tried or considered alternative treatments and they were deemed clinically ineffective.

Conditions for which oxygen therapy is not covered are:

- Angina pectoris in the absence of hypoxemia. This condition is generally not the result of a low oxygen level in the blood, and there are other preferred treatments.
- Breathlessness without cor pulmonale or evidence of hypoxemia. Although intermittent oxygen is sometimes prescribed to relieve this condition, it is potentially harmful and may be psychologically contraindicated.
- Severe peripheral vascular disease resulting in clinically evident desaturation in

one or more extremities. There is no evidence that increased PO2 will improve the oxygenation of tissues with impaired circulation.
- Terminal illnesses that do not affect the lungs.
- Treatment of headaches, including migraines.
- Treatment of other conditions in which oxygen therapy is determined to be experimental or investigational.

Health Conditions

Coverage is available for individuals with significant hypoxemia in a chronic and stable state if the following **three (3)** conditions are met:

1. **The practitioner has determined that the individual has one of the following health conditions**:

- A severe lung disease, such as chronic obstructive pulmonary disease (COPD), diffuse interstitial lung disease of known or unknown etiology; cystic fibrosis, bronchiectasis; and symptoms of widespread pulmonary neoplasm; or
- Hypoxia-related diagnoses or symptoms that might be expected to improve with oxygen therapy. Examples of these are pulmonary hypertension, recurring congestive heart failure (CHF) due to chronic cor pulmonale, erythrocytosis, impairment of cognitive processes, nocturnal restlessness, and morning headache.

2. For initial certifications, the patient's blood gas study (either an arterial blood gas or an oximetry test) values meet one of these criteria:

Group I Criteria:

- Individual on room air while at rest (awake) when tested:
  - Arterial oxygen saturation (pulse ox) is at or below 88 percent or
  - Arterial Partial Pressure of Oxygen (P02) is at or below 55 mm Hg
- Individual tested at rest while awake or during exercise, arterial P02 is at or above 56 mm Hg or an arterial oxygen saturation is at or above 89 percent:
  - Arterial P02 is at or below 55 mm Hg or an arterial oxygen saturation is at or below 88 percent and
  - Documented improvement of hypoxemia during exercise with oxygen
- Individual tested during sleep and if arterial P02 is at or above 56 mm Hg or an arterial oxygen saturation is at or above 89 percent while awake, additional testing must show:

• Arterial P02 is at or below 55 mm Hg or an arterial oxygen saturation is at or below 88 percent for at least 5 minutes taken during sleep or,

• Decrease in arterial P02 of more than 10 mm Hg or a decrease in arterial oxygen saturation more than 5 percent for at least 5 minutes associated with symptoms or signs more than 5 percent from baseline saturation for at least 5 minutes taken during sleep associated with symptoms or signs reasonably attributable to hypoxemia (some examples of symptoms are impairment of cognitive processes and nocturnal restlessness or insomnia and some examples of signs are cor pulmonale, "P" pulmonale on electrocardiogram [EKG], documented pulmonary hypertension, and erythrocytosis reasonably attributable to hypoxemia) or

For infants and children:

- Arterial oxygen saturation is at or below 92 percent or
- Arterial Partial Pressure of Oxygen (P02) is at or below 60 mm Hg

Initial coverage of Group I home oxygen therapy is limited to 12 months or the treating physician-specified length of need for oxygen, whichever is shorter.

Group II Criteria:

Includes portable oxygen systems if the patient is mobile within the home and the qualifying blood gas study is performed at rest while awake or during exercise. Portable oxygen will not be covered as reasonable and necessary if the only qualifying blood gas study is performed during sleep:

1. Individual on room air at rest while awake when tested:

   • Arterial oxygen saturation of 89 percent at rest (awake) **or**

   • Arterial P02 of 56-59 mm Hg **and**

   a. Dependent edema suggesting congestive heart failure or

   b. Hypertension or cor pulmonale, determined by measurement of pulmonary artery pressure, gated blood pool scan, echocardiogram, or "P" pulmonale on EKG (P wave greater than 3 mm in standard leads II, Ill, or AVF) or

   c. Erythrocythemia with a hematocrit greater than 56 percent or

2. Individual tested during exercise:

• Arterial oxygen saturation of 89 percent **or**

• Arterial P02 of 56-59 mm Hg **and**

a. Dependent edema suggesting congestive heart failure

b. Pulmonary hypertension or cor pulmonale, determined by measurement of pulmonary artery pressure, gated blood pool scan, echocardiogram, or "P" pulmonale on EKG (P wave greater than 3 mm in standard leads II, Ill, or AVF) or

c. Erythrocythemia with a hematocrit greater than 56 percent or

3. Individual tested during sleep for at least 5 minutes:

• Arterial oxygen saturation of 89 percent **or**

• Arterial P02 of 56-59 mm Hg **and**

a. Dependent edema suggesting congestive heart failure

b. Pulmonary hypertension or cor pulmonale, determined by measurement of pulmonary artery pressure, gated blood pool scan, echocardiogram, or "P" pulmonale on EKG (P wave greater than 3 mm in standard leads II, Ill, or AVF) or

c. Erythrocythemia with a hematocrit greater than 56 percent or

For infants and children

- Arterial oxygen saturation is at or below 92 percent or
- Arterial Partial Pressure of Oxygen (P02) is at or below 60 mm Hg

Initial coverage of Group II home oxygen therapy is limited to 3 months or the treating physician-specified length of need for oxygen, whichever is shorter.

3. The individual has appropriately tried other alternative treatment measures without demonstrable success or other forms of treatment have not been tried, but oxygen therapy is needed as part of the individual's initial treatment.

Coverage of home oxygen not included in the above criteria must be preauthorized by DMAS or its contractor. The practitioner must submit documentation, in addition to the

CMN/DMAS-352, which specifies why oxygen is medically necessary

Laboratory Evidence

The CMN/DMAS-352 or supporting documentation signed and dated by the practitioner must also include the results of a blood gas study ordered and evaluated by the attending practitioner. This will usually be in the form of a measurement of the partial pressure of oxygen (PO2) in arterial blood. A measurement of arterial oxygen saturation obtained by ear or pulse oximetry; however, will also be acceptable when ordered and conducted by a qualified provider or supplier of laboratory services and evaluated by the attending practitioner. The conditions under which the laboratory tests are performed must be specified in writing and submitted with the CMN/DMAS-352 or supporting documentation (i.e., at rest, while sleeping, while exercising, on room air, or if while on oxygen, the amount, body position during testing, and any similar information necessary for interpreting the evidence).

In situations when the arterial blood gas and the oximetry studies are both used to determine the medical need for home oxygen therapy and the results are conflicting, the arterial blood gas study is the preferred source for this determination.

A DME supplier is not considered a qualified provider or supplier of laboratory services for purposes of these guidelines. This prohibition does not extend to the results of an arterial blood gas test conducted by a hospital certified to do such tests. The preferred sources of laboratory evidence are existing practitioner and/or hospital records that reflect the individual's medical condition. If more than one arterial blood gas test is performed during the individual's hospital stay, the test result obtained closest to the hospital discharge date must be submitted. The attending practitioner's statement of recent hospital test results is acceptable in lieu of copies of the actual hospital records.

A DME provider may be the provider of pulse oximetry services, in accordance with the established DMAS pulse oximetry criteria, for an individual with a progressive disease who may require oxygen at night. The DME provider can be the same provider but must be sure the critiera is met for each type of service. The overnight pulse oximetry study must be ordered by the practitioner, and the DME provider must send a copy of the pulse oximetry readings to the attending practitioner for interpretation. If the practitioner determines that oxygen therapy is medically indicated, the oximetry test results and the practitioner's order for oxygen therapy must be recorded on the CMN/DMAS-352 or in supporting documentation. DMAS will reimburse the DME provider for the oxygen therapy as ordered by the practitioner, and in accordance with the coverage criteria for oxygen therapy.

A repeat arterial blood gas or oximetry study will normally be necessary only when evidence indicates that an individual receiving oxygen has undergone a major change relevant to the home use of oxygen. For example, if there has been a significant increase in the amount of oxygen required (e.g., an increase to more than 4 liters per minute), a repeat blood gas or

oximetry study may be necessary.

Evidence of Medical Necessity

The practitioner must document on the CMN/DMAS-352 or in supporting documentation all of the following:

- A diagnosis of the disease requiring home use of oxygen;
- The oxygen flow rate; and
- An estimate of the frequency, duration of use (e.g., 2 liters per minute, 12 hours a day) and duration of need (e.g., six months or lifetime). Oxygen that is ordered PRN must include justification to determine the amount of oxygen that is reasonable and necessary for the individual.

The practitioner must also specify the type of oxygen delivery system to be used (i.e., gas, liquid, or concentrator). If the type of system is not specified, the provider must provide services in the most cost-effective manner to carry out the practitioner's order and meet the needs of the individual.

The practitioner must submit a new CMN whenever there is a revision to the oxygen requirements based on a change in condition and the subsequent need for oxygen therapy. In the absence of any revision, the CMN authorization is valid for a 12-month period for adults and six months for children. The practitioner may only certify the need for oxygen therapy if the individual has been examined by a practitioner within the past 12 months.

This section was moved to after Evidence of Medical Necessity to keep the flow as original manual

This section was moved to be included on pgs 48-49 per MD review of manual

Reimbursement

DMAS will not provide reimbursement for respiratory/oxygen equipment and supplies which do not meet medical necessity guidelines. Furthermore, DMAS will not provide reimbursement for oxygen and equipment which is not being used by the individual, unless the individual meets **all** the following criteria for an emergency backup system:

1. An individual who requires a ventilator for 12 hours or more per day and is using oxygen, or;
2. The individual is on continuous oxygen use for 12 hours or more per day, and the individual would have decreasing oxygen saturation levels that would place them in a life threating emergency should the primary oxygen source not be available.

The provider must document on the CMN/DMAS-352 or in supporting documentation signed and dated by the practitioner the circumstances in which the above criteria would be met.

The DME provider must monitor utilization and report to the practitioner when oxygen is not being used as prescribed. This notification must be in writing, and a follow-up must be submitted to the DMAS or its contractor, which shows that either the individual has resumed compliance with medical orders or continues to be non-compliant. If non-compliance continues, DMAS or its contractor will notify the individual of the effective date that coverage of the oxygen will cease.

DMAS will reimburse for the stationary oxygen system (gas, liquid or concentrator) using a daily rate. The reimbursement for daily rental of the system (with or without humidification) includes:

- Oxygen set-up;
- Rental;
- Container;
- Contents for gas or liquid;
- Regulator;
- Nebulizer;
- Nasal cannulas or mask;
- Extension tubings;
- Humidifier, if needed; and
- Bubble bottle for humidification, if needed:

A separate portable oxygen code can be used for reimbursement for portable oxygen service authorization. Documentation must provide a description of the activities in which the individual participates on a regular basis that require a portable system. Portable oxygen contents (E0443 and E0444) are separately payable only when the coverage criteria for home oxygen have been met and:

1. The individual owns or rents a concentrator and a portable system, or;
2. The individual rents or owns a portable system and has no stationary system (concentrator, gas or liquid).

DMAS does not cover oxygen analyzers.

Pulse Oximetry

Coverage for daily pulse oximetry may be available when ordered by a practitioner who can document that the individual meets one of the following criteria:

- The individual is dependent on both a ventilator and oxygen; or
- The individual has a tracheostomy and is oxygen dependent; or
- The individual has a tracheostomy and is unable, due to some factor such as age, developmental delay, cognitive status, or neuromuscular involvement, to summon assistance thereby placing the individual at risk of obstruction of the

tracheostomy; or

- The individual requires supplemental oxygen and has unstable saturations. The desired saturation level will depend on the individual's diagnosis and must be documented by the practitioner at the time continuous pulse oximetry is ordered. At the time of the next service authorization period, the saturation levels will be reviewed for stability.

Laboratory Evidence

Documentation of the individual's current SaO2 with and without oxygen therapy must be submitted on the CMN/DMAS-352 and must demonstrate desaturation. A desaturation is considered SaO2 equal to or less than 88% for adults equal to or less than 92% for infants and children. This documentation is required for initial set up or if there has been a change in medical condition.

The "Exception" information and statement re individual not qualifying for daily pulse ox was moved under Evidence of Medical Necessity below

Certificate of Medical Necessity

The practitioner must document on the CMN/DMAS-352 or in supporting documentation that the individual's condition meets:

- One of the above criteria, and;
- Pulse oximetry readings are necessary on a daily basis in order for the individual to remain in the home;
- The individual does not have a condition which contraindicates the effective use of pulse oximetry (e.g., oxygen toxicity is a concern);
- Alternative treatments which have been attempted (e.g., periodic arterial blood gases); *and*
- Evidence of why periodic pulse oximetry readings (e.g., pulse oximetry reading submitted bimonthly showing SaO2 trends over a specified period of time) would not meet the practitioner's need for monitoring.

In addition, the practitioner must specify the current oxygen flow rate and the assessment parameters: the setting at which the device should be set to alarm and the intervention response or corrective action to be taken (e.g., increase oxygen to 50%, increase oxygen to 2 L/min.).

Exceptions: DMAS will consider requests for daily pulse oximetry for individuals who do not meet the health condition criteria, but who require daily pulse oximetry due to complications presented (e.g., acute illness, weaning from oxygen use). These will be evaluated on a case by case basis and will need to be resubmitted after one month to evaluate for futher medical necessity.

An individual who is ventilator-dependent with room air and who is stable does not qualify for daily pulse oximetry coverage.

Reimbursement for Daily Use Pulse Oximetry

Reimbursement for pulse oximeters determined to be medically necessary in the home on a continuous basis will be reimbursed on a rental basis for a maximum of three months. The decision to rent the equipment must be based on the practitioner's attempt to wean the individual from a tracheostomy or a ventilator, or when the individual requires supplemental oxygen and has unstable saturations, but does not have a tracheotomy or ventilator, and the practitioner is unable to determine the length of time the individual will require the continuous pulse oximetry. DMAS will purchase the pulse oximeter for any rental that exceeds two authorizations of three months each when the practitioner cannot definitely state how much longer the individual will require the continuous pulse oximetry.

Reimbursement will be established for the oximeter with a recording device and a permanent probe (unless documented inability to attain an accurate reading exists which would justify use of disposable probes). The rental code E0445RR can be used for all four types of oximeter devices which include: one for the use of the permanent probe, one for the use of disposable probes, and for the inclusion of a battery pack, one with a disposable probe and one with a permanent probe, when determined medically necessary for the individual who requires transport and is at risk of desaturation when transported. There are additional E1399 codes that can be used for replacement parts/accessories for a purchased unit. The rental code should include all necessary parts and accessories. A copy of the pulse oximetry printout must be attached to the request for the rental service authorization.

Pulse Oximetry (Periodic or Intermittent Pulse Oximeter Studies)

Coverage of pulse oximetry on a periodic or intermittent basis is available for any of the following conditions:

- Any individual on a ventilator or on continuous oxygen when periodic pulse oximetry is ordered by the practitioner as a necessary component of monitoring due to a change in clinical status or need to reassess oxygen therapy; *or*
- Any individual with a progressive disease that may require oxygen in the future (e.g., emphysema or neuromuscular disease affecting respiration; *or*
- Any individual with severe cardiac or pulmonary disease (excluding obstructive sleep apnea) where there is a high likehood of nocturnal hypoxia; *or*
- Any individual for whom oxygen has been recently discontinued and for whom the oxygen saturation level is needed to indicate successful weaning.

The practitioner must order the frequency of pulse oximetry readings and the period of time over which the reading must be taken. The pulse oximetry reading must be submitted to the

practitioner for assessment, and the practitioner must report back to the DME provider regarding any changes to be made based upon the reading taken.

Service authorization of periodic pulse oximetry will only be given if there are persons in the home environment who are approved by the practitioner as trained and capable of recording accurate readings. It is the practitioner's responsibility to assure that the persons who will be in the home during the periodic pulse oximetry are capable of assuring the accurate reading before authorization of the pulse oximetry is requested. There is no DMAS reimbursement for the personnel who may be required to assure that the pulse oximetry readings are accurate. In the event that the practitioner is not satisfied that the family individual can adequately monitor to assure that the reading is accurate, the periodic pulse oximetry may have to be performed in a sleep lab or hospital setting. Children who receive private duty nursing through the CCC Plus (for ventilator or complex trach) Waiver or EPSDT may have access to nursing services which can assure the accurate reading. All periodic pulse oximetry must be preauthorized by the DMAS or its contractor. The maximum allowable number of studies will be 12 in a 12-month period. (It is the practitioner's responsibility to assure that the persons who will be in the home during the periodic pulse oximetry are capable of assuring the accurate reading before authorization of the pulse oximetry is requested.)

Reimbursement to the DME provider for pulse oximetry studies includes a two-day rental of the monitor. To bill for pulse oximetry studies, a respiratory therapist must set up the equipment in the home. This rate will be all-inclusive; there will be no further reimbursement for printer, paper, probes or any other supplemental equipment. The DME provider will be responsible for sending a copy of the readings to the practitioner for interpretation.

Suction Machines

Suction machines are covered by DMAS for any individual who has a tracheostomy or who cannot manage his or her own secretions. Suction machines will only be rented when the CMN/DMAS-352 indicates the expected length of use is three months or less. Rental includes the cost of the rental of the machine, tubing, collection jars, a battery, and a charger. Suction machines must be purchased whenever the expected use exceeds three months. Purchase of the suction machine will include the cost of one set of tubing, two collection jars, a battery, and a charger. Supplies can be purchased as necessary according to the limits in the "Medicaid DME and Supplies Listing" in Appendix B. DMAS may provide reimbursement for a portable backup suction machine.

Non-Invasive Airway Assistive Devices

Non-invasive[BS1] airway assistive devices include continuous positive airway pressure (CPAP) and Bi-level positive airway pressure (BiPAP) equipment. CPAP is defined as ventilator assistance equipment that provides continuous positive airway pressure with or

without oxygen, which is intended to keep the individuals's airway patent. BiPap is ventilator assistance equipment that has the capability of providing two different levels of continuous positive airway pressure, with or without oxygen, which is intended to assist to the keep the individual's airway open to allow breathing. BiPap ST is BiPap that includes a back–up rate feature to ensure continuing ventilation.

CPAP/ BiPAP in the setting of Obstructive Sleep Apnea (OSA)

Criteria for individuals greater than or equal to 18 years old for CPAP :

To be diagnosed with OSA, individual must have a complete polysomnogram (sleep study) within the previous year in which the respiratory disturbance index (RDI) or apnea-hypopnea index (AHI) is based on a minimum of two hours of actual recorded sleep and is not extrapolated or projected **and** at least **one** of the following criteria is met:

- AHI or RDI > 15 events per hour with a minimum of 30 events
- AHI or RDI > 5 evets per hour with a minimum of 10 events with at least **one** of the following associated symptoms or conditions:
  - Hypertension
  - History of stroke
  - Ischemic heart disease
  - Excessive daytime sleepiness
  - Impaired cognition
  - Mood disorder
  - Insomnia

Criteria for individuals from 1-17 years old for CPAP

To be diagnosed with OSA, individual must complete a polysomnogram (sleep study) performed within the previous year that demonstrates **one or both** of the following:

1. Greater than or equal to one apnea (mixed or obstructive) or hypopnea per hour of sleep
2. Arterial PaCO2 > 50 mmHg for > 25% of total sleep time and one or more of the following:
   - Snoring
   - Flattening of inspiratory nasal pressure waveform
   - Irregular breathing pattern

Individual must also undergo surgical evaluation and demonstrate **one** of the following:

- Adenotonsillectomy performed and obstructive sleep apnea persists
- Adenotonsillar tissue ruled out as etiology of obstructive sleep apnea
- Adenotonsillectomy contraindicated or inappropriate due to other cause such as craniofacial abnormalities, neuromuscular disease, chronic lung disease, sickle cell disease or Down syndrome

Bi-PAP in the setting of OSA

The individual must meet the criteria for CPAP, there must be documentation of failed CPAP, and meet **all** the following criteria:

- Initial sleep study where CPAP was ineffective during study despite proper mask fitting and selection and appropriate pressure settings, or
- Documented individual's intolerance, pressure discomfort due to high pressures, or CPAP fails to improve the condition, and
  - Documented adherence to > 4 hours of use on > 21 out of 30 consecutive nights on positive airway pressure, and
  - Face to face reevaluation by provider occurred at:
    - 31 days and <91 days after start of initial trial period, or
    - 91 days after start of initial trial period and documented benefit from PAP device

Bi-PAP ST or Bi-PAP with a back-up rate is not medically necessary for obstructive sleep apnea and will not be covered by DMAS for OSA.

Additional clinical scenarios such as replacement of parts, request for re-trial and reauthorization for CPAP/Bi-PAP use for obstructive sleep apnea will be reviewed under the Interqual criteria for medical necessity.

Non-invasive Airway Assistive Devices for Other Respiratory Disorders

Non-invasive airway assistive devices are also used in the treatment of other respiratory disorders such as, but not limited to, central sleep apnea, severe chronic obstructive respiratory disease with no or mild COPD, restrictive thoracic disorder, hypoventilation syndrome without OSA or central sleep apnea being primary cause. Devices that are used for treatment of the above diagnosis include but are not limited to, CPAP, BiPAP, BiPAP-ST, and oral devices. The device which is appropriate for an individual is determined by the practitioner based on underlying diagnosis and severity of the disease.

DMAS considers CPAP medically necessary for the treatment of tracheomalacia and these cases will be reviewed. Additional diagnoses that are not covered under Interqual criteria will be reviewed on a case by case basis.

In some cases, a ventilator with a noninvasive interface is medically necessary for severe

neuromuscular diseases, thoracic restrictive diseases, and chronic respiratory failure consequent to chronic obstructive pulmonary disease where interruption or failure of respiratory of support would lead to death. In these cases, DMAS follow the Center for Medicare & Medicaid (CMS) policy on ventilators with non-invasive interfaces for the above diagnoses. CMS distinguishes BiPAP devices from ventilation in an individual for whom interruption or failure of respiratory support leads to death. These describe clinical conditions that require intermittent and relatively short durations of respiratory support. Thus, any type ventilator would not be considered medically necessary for any of the conditions described above for BiPAP devices even though the ventilator equipment may have the capability of operating in a BiPAP mode.

Documentation and Coverage

Initial authorization of CPAP or BiPAP requires the following documentation on the CMN/ DMAS-352 or in supporting documentation:

- A face-to-face clinical evaluation by the treating licensed practitioner prior to the sleep study test
- Documentation that the individual meets the clinical criteria for the above respiratory disorders
- Sleep study results (exception for neuromuscular disease where a pneumogram or overnight oximetry study that demonstrates hypoventilation or hypoxemia is acceptable)
- If a CPAP or BiPAP is ordered upon discharge from an inpatient hospital stay the provider may use records from the hospital stay (that are signed and dated by the physician) in lieu of the required documentation in addition to a CMN/ DMAS-352

Coverage of a non-invasive airway assistive device for an adult shall be for a two-month rental period. At the end of this period, the practitioner must determine whether continued use is indicated. In an adult, weight loss is usually the most significant factor to consider. If the individual continues to need the respiratory support at the end of the two-month period, the equipment must be purchased as long as there is documentation that the individual is compliant with the treatment and documentation clearly indicates individual benefit (e.g., SaO2, ABG's). If the CPAP/BiPAP supplied for the required two-month rental period is new upon delivery, DMAS will consider paying the full purchase price listed in the DME listing in addition to the initial two-month rental period for these items.

Coverage of a non-invasive airway assistive device for a child shall be based upon the expected length of use. Any time the CMN/DMAS-352 indicates that the CPAP/BiPAP is to be used for a period which will exceed nine months, the equipment must be purchased. Purchase of the CPAP/BiPAP will include the cost of filters, tubing, headgear, and masks. The DMAS or its contractor will pre-authorize a service maintenance contract for all individuals for whom a ventilator/CPAP/BiPAP is purchased.

Service Maintenance for CPAP, BiPAP, and BiPAP S/T

In accordance with the DMAS participation agreement, the DME provider agrees to provide authorized service maintenance for purchased CPAP, BiPAP, and BiPAP S/T [BS6] equipment for Medicaid-eligible individuals. The service maintenance requires service authorization by DMAS in order for the provider to be reimbursed. Following service authorization of service maintenance, the provider may bill using the HCPCS codes listed in the "Medicaid DME and Supplies Listing" in Appendix B.

All the following services must be included as part of the service maintenance agreement:

- The provider agrees to employ or contract with registered or certified respiratory therapists who will be available in a timely manner on a 24-hour-a-day basis for emergency care. The respiratory therapist will make regular home visits to conduct respiratory assessments and to check equipment.
- For CPAP and BiPAP, visits shall be a minimum of once each month for the first three months, or as ordered by the prescribing practitioner. After the first three months, visits must be made at a minimum of once every three months. For BiPAP S/T, visits shall be a minimum of once each month for the first three months, or as ordered by the prescribing practitioner. After the first three months, visits must be made at a minimum of once every other month.
- The provider agrees to abide by the recommended manufacturer maintenance schedule as defined in the "Manufacturer's Individual Product Pamphlet" and "Service Manual."
- The provider agrees to provide a back-up CPAP/BiPAP throughout the period of service or repair; the DME provider may bill DMAS for a rental CPAP/BiPAP during the period of non-routine service or repair.

The cost of parts which would constitute a repair may be billed separately as a CPAP/BiPAP repair under the appropriate HCPCS code. Claims for service maintenance agreements must be submitted for the calendar month in which the service is rendered per the authorization.

Home Invasive and Non-Invasive Mechanical Ventilators

Home invasive mechanical ventilators (HIMV) are covered items when ordered by a practitioner and preauthorized by the DMAS or its contractor. This section refers to the indications and service for home ventilators that require an invasive interface. Per the American Association of Respiratory Care (AARC) guidelines "the patient eligible for invasive long-term mechanical ventilation in the home requires a tracheostomy tube for ventilator support, but no longer requires intensive medical and monitoring services."

Primary Ventilator Criteria

A home invasive mechanical ventilator will be considered medically necessary when an

individual demonstrates all of the following:

- The inability to be completely weaned from ventilator support or a progression of disease that requires increasing ventilator support and a medical condition such as:
- Neuromuscular disorders; or,
- Chest wall deformity; or,
- Central hypoventilation syndrome; or,
- Chronic obstructive pulmonary disease; or,
- Restrictive lung disease: or,
- Cardiac disorders, including congenital anomalies; and,
- Optimal medical therapy has been provided for the underlying respiratory disorder(s); and
- Reversible contributing factors have been treated; and,
- Medical and respiratory stability have been achieved; and,
- A diagnosis of chronic respiratory failure (patients who develop symptomatic nocturnal hypercapnia in the absence of daytime hypercapnia may qualify for nocturnal ventilator support; hypoxemia may or may not be present).

Documentation and Coverage

Initial authorization of a ventilator requires the following documentation on the CMN/ DMAS-352 or in supporting documentation:

Documentation that the patient meets the clinical criteria for the above respiratory disorders

Prognosis for weaning of the ventilator together with the expected length of use of the ventilator

Stability of the patient on the ventilator at the time of discharge from the hospital

Need for continuous or periodic pulse oximetry and/or capnography, if on home oxygen

Coverage of a ventilator for a child and adult shall be based upon the expected length of use:

Any time the CMN/DMAS-352 indicates that the ventilator is to be used for a period which will exceed nine (9) months, the equipment must be purchased.

Coverage for an adult will be based upon the CMN/DMAS-352 indicating that the ventilator is to be used for a period which will exceed three (3) months.

Purchase of the ventilator will include the cost of the ventilator, battery, charger, three sets of reusable circuits and valves, and an initial supply of filters.

Criteria for Back-Up Ventilators

The use of a back-up (second) ventilator in the home setting is considered medically necessary when **one** of the following criteria are met**:**

- The individual is on a ventilator 12 hours or more continuously per day; **or**,
- The individual lives in an area where a replacement ventilaror cannot be provided within two (2) hours

The use of a back-up (second) ventilator in the home setting is considered medically necessary for the following additional indication, when applicable:

- For individuals who require mechanical ventilation during mobility, as prescribed in their plan of care.

Service Maintenance for Ventilators

In accordance with the DMAS DME participation agreement, the DME provider agrees to provide authorized service maintenance for purchased ventilators for Medicaid-eligible individuals. The service maintenance requires service authorization in order for the provider to be reimbursed. Following service authorization, the provider may bill using the HCPCS codes in the DME Listing/Appendix B. All of the following services must be included as part of the service maintenance agreement:

- The provider agrees to employ or contract with registered or certified respiratory therapists who will be available in a timely manner on a 24-hour-a-day basis for emergency care. The respiratory therapist will conduct monthly home visits to conduct a respiratory assessment and to check equipment.
- The provider agrees to perform routine maintenance of the ventilator in the home, replacing filters, cartridges or any other disposables associated with this routine maintenance. Routine maintenance supplies are not billed separately to DMAS by the DME provider; such items are included in the reimbursement for the service agreement.
- The provider agrees to send the ventilator to the manufacturer for routine servicing as recommended by the manufacturer. For example, LTV ventilators should be sent every 10,000 hours/or 2 years, whichever comes first. LP10 ventilators should be sent to the manufacturer every 6,000 hours/or every 12 months, whichever comes first. The cost for this routine servicing, including shipping and handling, are included in the service maintenance agreement fee. If an individual has a backup ventilator in the home as well as the primary ventilator, the provider may bill DMAS separately for the manufacturers recommended maintenance. The provider should use E1399 and provide their cost for the preventative maintenance on the back-up ventilator and it will be marked up 30% by the service authorization contractor.

- The cost of parts which would constitute a repair may be billed separately, as a ventilator repair, under the HCPCS code E1399, which has an assigned fee. Any ventilator repairs which exceed $500.00 must also be preauthorized by the service authorization contractor.
- The cost of a back-up ventilator during the period of time that the purchased ventilator is at the manufacturer for routine servicing is included in the reimbursement for the service maintenance agreement.
- The provider agrees to provide a back-up ventilator throughout the period of ventilator service or repair; the DME provider may bill DMAS for a rental ventilator during the period of non-routine service or repair.

Provider participation requirements for DME related to ventilators can be found in Chapter II of this manual.

Home Non-Invasive Ventilators

Home non-invasive ventilators (NIV) are covered items when ordered by a practitioner and preauthorized by the DMAS or its contractor. This section refers to the indications and service for home ventilators that **do not** require an invasive interface. NIV support is provided through a non-invasive interface, such as a mask that fits over the mouth and nose. NIV can be used in the home environment in order to employ continuous daily support for ventilator dependent individuals (neuromuscular diseases, thoracic cage abnormalities, severe chronic obstructive pulmonary disease, and obesity hypoventilation syndrome).

Examples of home non-invasive ventilators include but are not limited to Trilogy™, Newport™, VELA®, iVent, Puritan Bennett 540™, and LTV®. These ventilators may be used for the treatment of respiratory insufficiency and are considered medically necessary based on the medical criteria below. DMAS distinguishes BiPAP devices from ventilation. Though ventilator equipment has the capability to operate with a BiPAP mode it should not be used for the sole purpose of administering BiPAP or BiPAP ST especially in the setting of isolated obstructive sleep apnea with no other associated diagnoses. Home use of a non-invasive ventilator for the treatment of all other conditions/diseases are considered investigational.

Non-Invasive Ventilator Criteria

Home use of a non-invasive ventilator is considered medically necessary when **all** the following are met:

- Patient is alert and oriented;
- Patient is able to cough or uses an assist device to clear secretions; and
- Absence of **all** of the following:
    1. Anatomic abnormality that precludes mask fitting;

2. Excessive secretions; and
3. Swallowing disorder

- Documentation of **any one** of the following:

1. **Progressive neuromuscular disease** (e.g. muscular dystrophy, myasthenia gravis, polio, amyotrophic lateral sclerosis) resulting in respiratory insufficiency with **all** of the following:

    - Documentation of symptoms characteristic of sleep-associated hypoventilation, such as daytime hypersomnolence, excessive fatigue, morning headache, cognitive dysfunction, or dyspnea;
    - If present, Chronic obstructive pulmonary disease (COPD) does not contribute significantly to the pulmonary limitation; and
    - Documentation of **any one** of the following:
        - An arterial blood gas PaCO2, done while awake and breathing the prescribed FIO2 is greater than or equal to 45 mm Hg; or
        - Nocturnal PaCO2 greater than or equal to 45 mm Hg, or
        - Nocturnal hypercapnia with PaCO2 greater than or equal to 50 mm Hg for over 30 minutes; or
        - Daytime normocapnia with a rise in PtcCO2 of greater than or equal to 10 mm Hg during the night, or
        - Sleep oximetry demonstrates oxygen saturation less than or equal to 88% for greater than or equal to 5 minutes of nocturnal recording time (minimum recording time of 2 hours), done while breathing the prescribed recommended FIO2
    - Documentation of **any one** of the following:
        - Maximal inspiratory pressure is less than 60 cm H20; or
        - Forced vital capacity is less than 50% predicted; or
        - When FVC< 70% and a rapid reduction in FVC of > 10% of the initial value within 3 months

2. **Thoracic-Restrictive Lung Diseases** (e.g., post-thoracoplasty for TB, Fibrothorax, Asphyxiating thoracic dystrophy) resulting in respiratory insufficiency with **all** of the following:

    - Documentation of symptoms characteristic of sleep-associated hypoventilation, such as daytime hypersomnolence, excessive fatigue, morning headache, cognitive dysfunction, or dyspnea;
    - Chronic obstructive pulmonary disease does not contribute significantly to pulmonary limitation; and
    - Documentation of **any one** of the following:
        - An arterial blood gas PaCO2, done while awake and breathing the prescribed FIO2 is greater than or equal to 45 mm Hg; or

- Nocturnal hypercapnia with PaCO2 greater than or equal to 50 mm Hg; or
- Daytime normocapnia with a rise in PtcCO2 of greater than or equal to 10 mm Hg during the night; or
- Sleep oximetry demonstrates oxygen saturation less than or equal to 88% for greater than or equal to 5 minutes of nocturnal recording time (minimum recording time of 2 hours), done while breathing the prescribed recommended FIO2

3. **Hypoventilation Syndrome** resulting in respiratory insufficiency with **all** of the following:

   - Documentation of symptoms characteristic of sleep-associated hypoventilation, such as daytime hypersomnolence, excessive fatigue, morning headache, cognitive dysfunction, or dyspnea;
   - An initial arterial blood gas PaCO2, done while awake and breathing the prescribed FIO2, is greater than or equal to 45 mm Hg;
   - Spirometry shows a forced expired volume in 1 second (FEV1) or forced vital capacity (FVC) greater than or equal to 70%; and
   - A failed initial attempt at CPAP treatment under polysomnographical conditions should take place in patients without significant co-morbidities. The following constitutes a failed CPAP trial:
     - An arterial blood gas PaCO2, done during sleep or immediately upon awakening, and breathing the prescribed FIO2, shows the PaCO2 worsened by 7 mm HG or more compared to the initial arterial blood gas
     - A facility-based polysomnogram testing demonstrates oxygen saturation less than or equal to 88% for greater than or equal to 5 minutes of nocturnal recording time (minimum recording time of 2 hours) that is not caused by obstructive upper airway events, AHI apnea-hypopnea index less than 5

4. Severe **Chronic Obstructive Pulmonary Disease (COPD)** resulting in respiratory insufficiency with **all** of the following:

   - Documentation of symptoms characteristic of sleep-associated hypoventilation, such as daytime hypersomnolence, excessive fatigue, morning headache, cognitive dysfunction, or dyspnea;
   - Obstructive Sleep Apnea (OSA) has been ruled out as a predominant cause of awake hypercapnia or nocturnal arterial oxygen desaturation (Note: Formal sleep testing is not required if there is sufficient information in the medical record to demonstrate that the individual does not suffer from some form of sleep apnea such as Central Sleep Apnea and/or Complex Sleep Apnea desaturation);

- Compliant with a continuous positive airway pressure device (CPAP) use and CPAP has failed to relieve symptoms, improve awake hypercapnia and/or nocturnal arterial oxygen desaturation; and
- Documentation of **any one** of the following:
  - Documentation of an arterial blood gas PaCO2, done while awake and breathing the prescribed FIO2, is greater than or equal to 52 mm Hg AND sleep oximetry demonstrates oxygen saturation less than or equal to 88% for greater than or equal to a cumulative 5 minutes of nocturnal recording time (minimum recording time of 2 hours), done while breathing oxygen at 2 LPM or the prescribed FIO2 (whichever is higher); or
  - Nocturnal hypercapnia with a PaCO2 greater than or equal to 55 mmHg; or
  - Mild diurnal hypercapnia with 46-50 mm Hg and an increase in PtcCO2 greater than or equal to 10 mm Hg during sleep; or
  - When persistent hypercapnia (PaCO2 > 53 mmHg) is present at least 14 days after finishing acute ventilation therapy for acute respiratory acidosis; or
  - When decannulation after prolonged weaning is only possible with the help of NIV, and this is necessary for long-term monitoring of symptoms and prevention of hypercapnia, even after discharge from the hospital

Documentation and Coverage

Initial authorization of a ventilator requires the following documentation on the CMN/ DMAS-352 or in supporting documentation:

- Documentation that the patient meets the clinical criteria for the above respiratory disorders;
- Prognosis for weaning of the ventilator together with the expected length of use of the ventilator; and
- Need for continuous or periodic pulse oximetry and/or capnography

Reauthorization will be considered when **all** of the following are documented:

- A signed and dated statement completed by the provider no sooner than 61 days after initiating use of the device stating **all** of the following:
  - Evaluation has been completed;
  - Member is compliant using the device; and

- Member is benefitting from its use

Coverage for a non-invasive ventilator shall be based on initial trial period and the expected length of use. Anytime the CMN/DMAS-352 indicates that the ventilator is to be used for a period which will exceed nine months, the equipment must be purchased. Purchase of the ventilator will include the cost of the ventilator, battery, charger, three sets of reusable circuits and valves, and an initial supply of filters.

Service Maintenance for Ventilators

In accordance with the DMAS DME participation agreement, the DME provider agrees to provide authorized service maintenance for purchased ventilators for Medicaid-eligible individuals. The service maintenance requires service authorization in order for the provider to be reimbursed. Following service authorization, the provider may bill using the HCPCS codes in the DME Listing/Appendix B.

All of the following services must be included as part of the service maintenance agreement:

- The provider agrees to employ or contract with registered or certified respiratory therapists who will be available in a timely manner on a 24-hour-a-day basis for emergency care. The respiratory therapist will conduct monthly home visits to conduct a respiratory assessment and to check equipment;
- The provider agrees to perform routine maintenance of the ventilator in the home, replacing filters, cartridges or any other disposables associated with this routine maintenance. Routine maintenance supplies are not billed separately to DMAS by the DME provider; such items are included in the reimbursement for the service agreement;
- The provider agrees to send the ventilator to the manufacturer for routine servicing as recommended by the manufacturer. For example, LTV ventilators should be sent every 10,000 hours/or 2 years, whichever comes first. LP10 ventilators should be sent to the manufacturer every 6,000 hours/or every 12 months, whichever comes first. The cost for this routine servicing, including shipping and handling, are included in the service maintenance agreement fee. If an individual has a backup ventilator in the home as well as the primary ventilator, the provider may bill DMAS separately for the manufacturers recommended maintenance on the backup ventilator. The provider should use E1399 and provide their cost for the preventative maintenance on the back-up ventilator and it will be marked up 30% by the service authorization contractor;
- The cost of parts which would constitute a repair may be billed separately, as a ventilator repair, under the HCPCS code E1399, which has an assigned fee. Any ventilator repairs which exceed $500.00 must also be preauthorized by the service authorization contractor;

- The cost of a back-up ventilator during the period of time that the purchased ventilator is at the manufacturer for routine servicing is included in the reimbursement for the service maintenance agreement; and
- The provider agrees to provide a back-up ventilator throughout the period of ventilator service or repair; the DME provider may bill DMAS for a rental ventilator during the period of non-routine service or repair

Hospital Beds

A fixed height hospital bed may be covered if one or more of the following criteria are met:

- The member has a medical condition which requires positioning of the body in ways not feasible with an ordinary bed. Elevation of the head/upper body less than 30 degrees does not usually require the use of a hospital bed, *or*
- The member requires positioning of the body in ways not feasible with an ordinary bed in order to alleviate pain, *or*
- The member requires the head of the bed to elevated more than 30 degrees most of the time due to congestive heart failure, chronic pulmonary disease, or problems with aspiration, or other justified medical conditions, *or*
- The member requires traction equipment, which can only be attached to a hospital bed.

A **variable height hospital bed** may be covered if the member meets one of the above criteria for a fixed height hospital bed and requires a bed height different than a fixed height hospital bed to permit transfers to chair, wheelchair or standing position.

A **semi-electric hospital bed** is covered if the member meets one of the above criteria for a fixed height bed and requires frequent changes in body position and/or has an immediate need for a change in body position.

A **heavy duty extra wide hospital bed** is covered if the member meets one of the above criteria for a fixed height hospital bed and the member's weight is more than 350 pounds, but does not exceed 600 pounds.

An **extra heavy duty hospital bed** is covered if the member meets one of the above criteria for a hospital bed and the member's weight exceeds 600 pounds.

A **total electric hospital bed** may be covered in limited circumstances and will be reviewed on a case by case basis.

Therapeutic Pressure Reducing Mattresses

DMAS will provide coverage for pressure reducing support surfaces when medical necessity criteria are met through the following guidelines and InterQual criteria. Service authorization is required and will be performed by DMAS or its service authorization

contractor.

A pressure ulcer is the result of a pathologic change in the blood supply to the dermal and underlying tissues, usually because of compression of the tissue over a bony prominence. Chronic ulcers of the skin include arterial ulcers, venous stasis ulcers, diabetic ulcers, and pressure ulcers. Pressure ulcers will generally appear in the soft tissue areas mostly over a bony prominence.

Initial treatment for pressure ulcers generally includes frequent turning and repositioning of the individual to relieve pressure over the compromised area. A practitioner must coordinate the home treatment regimen, which will include the use of other treatment modalities, where applicable, including, but not limited to, nursing care, appropriate nutrition, the creation of a tissue-growth environment, and caregiver training/participation. The DME provider must document this information.

A number of medical devices are designed to relieve pressure. The choice of the device should be determined by the practitioner based on each individual and other treatment modalities being used to treat the pressure ulcer.

NOTE: A check for "bottoming out" should generally be done for all devices.

The treatment regimen must be evaluated, and its continued use recertified, at least every 60 days, by the practitioner. There must be written documentation describing all areas of skin breakdown. Documentation must be updated at least every 30 days to include the total number of wounds, location, size (circumference and depth), drainage (amount, appearance and odor), and the presence of tunneling. Staging must be documented by the practitioner.

Staging of Pressure Ulcers

When evaluating pressure ulcers, a staging system is typically used that measures tissue destruction by classifying wounds according to the tissue layers involved.

Stage I: An observable, pressure-related alteration of intact skin. Skin changes may include one or more of the following: skin temperature (warmth or coolness), tissue consistency (firm or boggy feel), and or sensation (pain, itching). The skin appears as a defined area of persistent redness in lightly pigmented skin and may be persistent red, blue or purple hues in darker skin. These changes are not relieved within 15-30 minutes of pressure relief.

Stage II: Partial-thickness skin loss involving the epidermis, dermis or both. The ulcer is superficial and usually presents as a blister, abrasion or shallow crater.

Stage III: Full-thickness skin loss involving damage to, or necrosis of, subcutaneous tissue that may extend down, but not through, underlying fascia.

The ulcer presents as a deep crater with or without undermining of adjacent tissue and can produce serosanguineous drainage.

Stage IV: Full-thickness skin loss with extensive destruction, tissue necrosis, or damage to muscle, bone or supporting structures (e.g., tendon, joint capsule). Undermining and sinus tracts also may be associated with Stage IV pressure ulcers.

Group I Pressure Reducing Support Surfaces

The HCPCS codes included in this group stand for static overlays and mattress replacements. Group I pressure reducing support surfaces are covered as medically necessary when the individual shows early skin changes consistent with the development of a pressure ulcer **OR** cannot independently make changes in body position significant enough to relieve pressure **AND** is at risk for developing a pressure ulcer **AND** one of the following criteria is met:

- Fecal or urinary incontinence; or
- Altered sensory perception; or,
- Compromised circulatory status.

For Group I Support Surfaces, HCPCS Codes Fall Into 3 Categories:

Pressure pads for Mattresses: Code E0185 and codes E0197, E0198 and E0199, termed pressure pad for mattresses, represent nonpowered pressure reducing mattress overlays. These devices are designed to be placed on top of a standard hospital or home mattress.

- (E0185) A gel mattress overlay is a gel layer with a height of two or more inches.
- (E0197) An air mattress overlay is characterized by interconnected air cells that have a cell height of three or more inches and are inflated with an air pump.
- (E0198) A water mattress overlay is characterized by a filled height of three or more inches.
- (E0199) A foam mattress overlay typically possesses the following characteristics:

  Base thickness of two or more inches and either of the following:

  1. Peak height of three or more inches if the overlay is convoluted (e.g. eggcrate)
  2. Overall height of at least three inches if the overlay is not convoluted.
  3. Foam of such density or other qualities that it provides adequate pressure reduction.
  4. Durable water proof cover.

Nonpowered Pressure Reducing Mattresses: An air, water or gel mattress (E0186,

E0187, and E0196) has the following characteristics:

- Height of five or more inches of air, water or gel layer.
- Durable, waterproof cover.
- Can be placed directly on a hospital frame.
- A foam mattress (E0184) has the following characteristics:
    1. Height of five or more inches.
    2. Foam of such density and other qualities that it provides adequate pressure reduction.
    3. Durable, waterproof cover.
    4. Can be placed directly on a hospital bed frame.

Powered Pressure Reducing Mattress Overlay Systems: Codes E0181, E0182 and A4640 represent powered pressure reducing mattress overlay systems (alternating pressure or low air loss) that have the following characteristics:

- An air pump or blower provides either, sequential inflation and deflation of air cells or low interface pressure throughout the overlay.
- The inflated cell height of the air cells through which air circulates is 2.5 inches or more.
- The height of the air chambers, proximity of the air chambers to one another, frequency of air cycling (for alternating pressure overlays), and air pressure provide adequate individual lift, reduce pressure and prevent bottoming out.

Group II Pressure Reducing Support Surfaces

Group II pressure reducing support surfaces are covered as medically necessary when **ONE** of the following criteria is met:

1. Large or multiple Stage III or IV pressure ulcers are present on the trunk or pelvis.
2. A myocutaneous flap or skin graft has been performed within the last 60 days for a pressure ulcer on the trunk or pelvis **AND** the individual has been on a Group II or III support surface immediately prior to a recent discharge from a hospital or nursing facility (discharged in the last 30 days). Following a myocutaneous flap or skin graft, coverage is usually limited to 60 days from the date of surgery.
3. Multiple Stage II pressure ulcers are located on the trunk or pelvis and have not improved over the past month despite the use of an appropriate Group I support surface **AND** a comprehensive ulcer treatment program which includes all of the following:
    - Education of the individual and caregiver on the prevention and or management of pressure ulcers.
    - Regular assessment by a nurse, practitioner or other licensed health care practitioner (usually at least twice weekly for individuals with a Stage III or IV).

- Appropriate turning and positioning.
- Appropriate wound care for Stage II, III or IV ulcer.
- Appropriate management of moisture/incontinence.
- Nutritional assessment and intervention consistent with the overall plan of care.

HCPCS codes included in Group II are defined as follows:

Powered Pressure Reducing Mattress: Code E0277 stands for a powered pressure reducing mattress (alternating pressure, low air loss, or powered flotation without low air loss) that has the following characteristics:

- An air pump or blower provides either sequential inflation and deflation of the air cells or low interface pressure throughout the mattress.
- The inflated cell height of the air cells through which air circulates is five inches or more.
- The height of the air chambers, proximity of the air chambers to one another, frequency of air cycling (for alternating mattresses), and air pressure provides adequate individual lift, reduce pressure and prevent bottoming out.
- The surface is designed to reduce friction and shear.
- The surface can be placed directly on a hospital bed frame.

Code E0193 (RR) describes a semi-electric or total electric hospital bed with a fully integrated powered pressure reducing mattress which has all of the characteristics defined above.

NOTE: This code is available for use as a rental option only.

Advanced Nonpowered Pressure Reducing Mattress Overlay: Code E0371 describes an advanced, nonpowered pressure reducing mattress overlay with the following characteristics:

- The height and design of the individual cells provide significantly more pressure reduction than a Group I overlay and prevent bottoming out.
- The total height is three inches or more.
- The surface is designed to reduce friction and shear.
- There is documented evidence to substantiate that the product is effective in treating conditions described by the coverage criteria for Group II support surfaces.

Powered Pressure Reducing Mattress Overlay: Code E0372 describes a powered pressure reducing mattress overlay (low air loss, powered flotation without low air loss, or alternating pressure) with the following characteristics:

- An air pump or blower provides either sequential inflation or deflation of the

air cells or low interface pressure throughout the overlay.
- The inflated cell height of the air cells through which air circulates is 3.5 inches or more.
- The height of the air chambers, proximity of air chambers to one another, frequency of air cycling (for alternating pressure overlays), and air pressure provide adequate individual lift, reduce pressure and prevent bottoming out.
- The surface is designed to reduce friction and shear.

Advanced Nonpowered Pressure Reducing Mattress: Code E0373 describes an advanced, manually powered pressure reducing mattress with the following characteristics:

- The height and design of the individual cells provide significantly more pressure reduction than those in a Group I mattress and prevent bottoming out.
- The total height is five inches or more.
- The surface is designed to reduce friction and shear.
- There is documented evidence in treating conditions described by the coverage criteria for Group II support surfaces.
- The mattress can be placed directly on a hospital bed frame.

Group III Pressure Reducing Support Surface

Group III pressure reducing support surface is covered as medically necessary when **ALL** of the following criteria are met:

- The individual has a Stage III or Stage IV pressure ulcer.
- The individual is bedridden or chair-bound as a result of severely limited mobility.
- Without an air-fluidized bed, the individual would require institutionalization.
- The air-fluidized bed is ordered following a comprehensive assessment and evaluation of the individual after at least 30 days following conservative medical management has been attempted without success.
- Education of the individual and caregiver on the prevention and or management of pressure ulcers.
- Assessment by a practitioner, nurse or other licensed health care practitioner at least weekly.
- Appropriate turning and repositioning
- Use of a Group II support surface, if appropriate.
- Appropriate wound care.
- Appropriate management of moisture/incontinence.
- Nutritional assessment and intervention consistent with the overall plan of care.

Group III pressure reducing support surfaces are described by a single HCPCS code (E0194

RR, rental only), and are defined by all of the following characteristics:

- The bed employs circulation of the filtered air through silicone-coated ceramic beads, creating the characteristics of fluid.
- The bed consists of a tank filled with silicone-coated microsphere beads that resemble grains of sand.
- The tank is covered with a loose fitting bed sheet that separates the individual from the micro beads.
- Room air is drawn into the base unit, then filtered, heated and pushed into the tank through a diffuser board.
- The bed sheet moves freely underneath the individual. Usually, the individual sinks only 4-6 inches into the beads, and the pressure put on the skin is well below capillary closing pressure.
- The sheet is permeable to the downward flow of body fluids (e.g., wound drainage, urine, and perspiration). As body fluids come in contact with beads, the beads clump and drop to the bottom of the tank, where the alkaline environment kills the bacteria. The clumps are removed during routine maintenance.
- Individual transfers in and out of the bed may be difficult and, in most models, the head cannot be elevated.
- When airflow is turned off, the beads settle into a mold around the body, creating a support surface that stabilizes the individual for nursing care, wound cleaning and other care needs.

The DME provider must certify that:

- The home's electrical system is sufficient to meet the requirements of the proposed bed.
- The housing structure is adequate to support the weight of the bed or mattress as well as will accommodate entrance of the bed into the house.

Use of an air-fluidized bed is contraindicated if the following pertain:

- There is severe coexisting pulmonary disease (lack of firm back support makes coughing ineffective, and dry air inhalation thickens pulmonary secretions).
- The bedding system being used does not meet the positioning needs of the individual.
- Treatment is required that utilizes wet soaks or moist dressings that are not protected by an impervious covering, such as a plastic wrap or other occlusive material.

Authorizations for therapeutic beds, mattresses and overlays will be considered in 60 day maximum increments. To request continued authorization, the item must continue to meet the InterQual and above criteria. In addition, progress towards healing must be

documented. If progress has not been made, documentation regarding the practitioner's changes or efforts in the treatment program to promote healing is required.

NOTE: Please refer to Appendix B of this manual for coverage limitations for the HCPCS codes noted above. Some codes are available as rental only.

Wound Care Supplies

Wound Care supplies are protective covers or fillers for openings on the body caused by surgical procedures, wounds, ulcers or burns. DMAS will cover wound care supplies that are medically necessary to treat these wounds. Coverage of wound care supplies include both primary and secondary dressings based on the individuals wound care needs. Primary dressing are covering applied directly to wounds or lesions on the skin or wounds caused by an opening in the skin. Secondary dressings include adhesive tape, roll gauze and bandages.

The quantity and type of dressings dispensed at any one time must take into account the current status of the wound(s), the likelihood of change, and the recent use of dressings. Dressing may need changed frequently in the early phases of wound treatment and/or with heavily draining wounds. DME providers are also expected to have a mechanism for determining the quantity of dressing that the individual is actually using and to adjust their deliver of dressings according to what the individual still have available for use in the current treatment.

Dressing size should be based on the type and size of the wound. For wound covers, the pad size is usually about 2 inches greater than the dimensions of the wound. For example, a 5x5 cm (2in x 2in) wound requires a 4 x 4 in pad size. Surgical dressings must be tailored to the specific individual and the wound treatment needs. When surgical dressings are provided in a kit, only those components of the kit that meet the definition of a surgical dressing, that are ordered by the practitioner, and that are medically necessary are covered.

Surgical dressings are covered for as long as medically necessary. Dressing over a percutaneous catheter or tube (e.g. intravascular, epidural, nephrostomy etc) are covered as long as the catheter or tube remains in place and after removal until the wound heals. When a wound cover with adhesive border is being used, no other dressing is needed on top of it and additional tape is usually not required. Reasons for use of additional tape must be well documented. An adhesive border is usually more binding than that obtained with separate taping and is therefore indicated for use with wounds requiring less frequent dressing changes.

Use of more than one type of wound filler or more than one type of wound cover in a single wound is rarely medically necessary and the reasons must be well documented. An exception is an alginate or other fiber gelling dressing wound cover or a saline, water, or hydrogel impregnated gauze dressing which might need an additional wound cover. It may

not be appropriate to use some combinations of a hydrating dressing on the same wound at the same time as an absorptive dressing (e.g. hydrogel alginate). Because composite dressings, foam and hydrocolloid wound covers, and transparent film, when used as secondary dressing, are meant to be changed at frequencies – less than daily. Appropriate clinical judgement should be used to avoid their use with primary dressings which require more frequent dressing changes. Changes greater than once every other day for these dressings is not considered medically necessary. While a highly exudative wound might require such a combination initially, with continued proper management the wound usually progressed to a point where the appropriate selection of these products results in the less frequent dressing changes which they are designed to allow. An example of an inappropriate combination is the use of a specialty absorptive dressing on top of non-impregnated gauze being used as a primary dressing.

Alginate or other fiber gelling dressing (A6196-A6199)

Alginate or other fiber gelling dressing covers are covered for moderately to highly exudative full thickness wounds (e.g. stage III or IV ulcers). They are not medically necessary on dry wounds or wounds covered with eschar. Usual dressing change is up to once per day. A wound cover sheet of approximate size of the wound or up to 2 untis of wound filler (1 unit = 6 inches of alginate or other fiber gelling dressing rope) is usually used at each dressing change. It is usually inappropriate to use alginates or other fiber gelling dressings in combination with hydrogels.

Composite Dressing (A6203-A6205)

Usual composite dressing changes are up to 3 times per week, one wound cover per dressing change.

Contact Layer (A6206-A6208)

Contact layer dressings are used to line the entire wound; they are not intended to be changed with each dressing change. Usual dressing change is up to once per week.

Foam Dressing (A6209-A6215)

Foam dressings are covered when used on full thickness wounds (e.g. stage III or IV ulcers) with moderate to heavy exudate. Usual dressing change for a foam wound cover used as a primary dressing is up to 3 times per week. When a foam wound cover is used on a secondary dressing for wounds with very heavy exudate, dressing change may be up to 3 times per week. Usual dressing change for foam wound fillers is up to once per day.

Gauze, non-impregnated (A6216-A6221, A6402-A6404, A6407)

Usual non-impregnated gauze dressing change is up to 3 times per day for a dressing without a border. It is usually not necessary to stack more than 2 gauze pads on top of each

other in any one area. Usual dressing change for gauze, impregnated, with other than water, normal saline, hydrogel or zinc paste (A6222-A6224, A6266) is up to once per day.

Gauze, impregnated, water or normal saline (A6228-A6230)

There is no medical necessity for these dressings compared to non-impregnated gauze which is moistened with bulk saline or sterile water.

Hydrocolloid dressing (A6234-A6241)

Hydrocolloid dressings are covered for use on wounds with light to moderate exudate. Usual dressing change for hydrocolloid wound covers or hydrocolloid wound fillers is up to 3 times per week.

Hydrogel Dressing (A6231-A6233, A6242-A6248)

Hydrogel dressings are covered when used on full thickness wounds with minimal or no exudate (e.g. stage III or IV ulcers). Hydrogel dressings are not usually medically necessary for stage II ulcers. Documentation must substantiate the medical necessity for use of hydrogel dressings for stage II ulcers (e.g. location of ulcer is sacro-coccygeal area). Usual dressing change for hydrogel wound covers **without** adhesive border or hydrogel wound fillers is up to once per day. Usual dressing change for hydrogel wound covers **with** adhesive border is up to 3 times per week.

The quantity of hydrogel filler used for each wound must not exceed the amount needed to line the surface of the wound. Additional amounts used to fill a cavity are not medically necessary. Documentation must substantiate the medical necessity for code A6248 billed in excess of 3 units (fluid ounces) per wound in 30 days. Use of more than one type of hydrogel dressing (filler, cover, or impregnated gauze) on the same wound at the same time is not medically necessary.

Specialty absorptive dressing (A6251-A6256)

Specialty absorptive dressings are covered when used for moderately or highly exudative wounds (e.g. stage III or IV ulcers). Usual specialty absorptive dressing change us up to once per day for a dressing without an adhesive border and up to every other day for a dressing with a border.

Transparent Film (A6257-A6259)

Transparent film dressings are covered when used on open partial thickness wounds with minimal exudate or closed wounds. Usual dressing change is up to 3 times per week.

Wound filler, not elsewhere classified (A6261-A6262)

Usual dressing change is up to once per day.

Wound pouch (A6154)

Usual dressing change is up to 3 times per week.

INCONTINENCE PRODUCTS

The Department of Medical Assistance Services (DMAS) made modifications to the Durable Medical Equipment and Supplies (DME) Program related to incontinence supplies, specifically, incontinent briefs, pull-ups, liners and underpads (i.e. “chux”).

If any Medicaid individual is enrolled in a Virginia Medicaid Managed Care Organization (MCO), the MCO is responsible for their DME incontinent supplies.

Disposables Related to Incontinent Supplies

DMAS will not provide reimbursement for the routine use of diapers for children under three (3) years of age. Service authorizations for diapers for children must be associated with a medical condition and will not be approved solely because toilet training has not been accomplished. The billing unit for incontinence products changed from ‘case’ to ‘each’. This change affected incontinent briefs, pull-ups and panty liners. As a result of this change, the DME provider may now break cases, but for sanitation reasons, the inner seal packages may not be broken. The DME provider is not required to break cases; however, by breaking cases the provider should be able to provide a more accurate amount of products per month to decrease the amount of overage needed. Providers are required to obtain Service Authorization (SA) for incontinence products over the allowable limit.

NOTE: The allowable limit per month (listed in Appendix B) does not allow the provider to send every individual who needs incontinence products that amount each month. The amount of incontinence products is dependent on the frequency of use. DMAS understands that an individual package cannot be broken so the individual may receive more than needed; however, if the individual has left over products then the next month’s delivery would be adjusted, based on the amount of products left over. The provider determines the product amounts during the monthly call to the individual prior to the next delivery. The provider should contact the individual/caregiver prior to the next month’s delivery and document the need for any overage in the individual’s record. If the individual’s needs remain the same, the individual would need less products delivered the next month.

Once the provider determines the individual meets medical necessity, (i.e. incontinence) the decision to use tab briefs or pull-ups shall be left to the individual or caregiver.

If an individual requires more than one kind of incontinence product each month, the provider should document why each product is necessary in the same month. This applies to incontinent briefs, pull-ups and panty liners. For example, an individual may use pull-ups during the day and use a diaper at night. Providers must demonstrate the frequency of use to justify the quanity ordered.

The CMN/DMAS-352 must include all of the following information:

- A complete order that includes the type of incontinence product(s), quantity, and the

frequency of use. (Frequency of use means – how often something is used. Quantity means – total. The provider will need to know frequency in order to determine quantity. Quantity and Frequency are separate required entities).

- A description of the individual's incontinent condition including the degree and type of incontinence.
- Functional limitations that may affect the individual's incontinence, amount and type of product required per month.

NOTE: Frequency of use is part of the practitioner's order and describes how often an individual uses a supply and provides the justification for the quantity ordered per month. Docuemenation of the frequency of use (how often the supplies are used) should be on the CMN. For example, the individual needs incontinent briefs and changed seven (7) times per day. Seven times per day is the frequency of use. The frequency of use multiplied by 31 days should justify the quantity ordered per month on the CMN. Documentation of usage can be by the day, the week or the month depending on the type of supply and the individual's needs. The frequency of supplies may be once per week or twice per month; if an item is needed less than monthly the provider should document accordingly. The provider can give a usage range, for example, 6-7 times per day but should **never** use PRN or as needed.

To ensure against stock-piling of incontinence products beyond the needed amount, the provider must make affirmative contact, document the contact with the individual/caregiver prior to the next monthly delivery, and document in the individual's record the amount of product the individual has left over each month. In addition, the provider must contact the individual/cargiver prior to the recertification CMN/DMAS-352 to assure that the quantity, frequency and product are appropriate.

Unless the individual has a specific medical need, in addition to incontinence, for using an underpad (Chux) along with the incontinence briefs, DMAS will not provide reimbursement for underpads when used in conjunction with incontinent briefs since a washable pad serves the same purpose as the disposable underpad. (12 VAC 30-50-165)

NOTE: Providers are not allowed to alternate diapers/pull-ups and chux to avoid this criteria. For example, if an individual received pull-ups for a month, then switched to chux for a month, then back to pull-ups, eventually the individual may have either too much of one of the products or not enough to last until the next delivery. The individual could potentially receive too many supplies that would last until the next delivery or not receive enough supplies to last until the next delivery. If the individual/caregiver wants only chux that decision should be documented in the record.

DMAS has created an optional continence assessment form for use in conjunction with the CMN to assess and document the need for incontinence products. Use of this optional form provides an option for the providers to document specific information to support the requested incontinence supply on the CMN. This form must be signed and dated by the practitioner.

Types of Urinary Incontinence

Functional Incontinence affects people with medical problems that interfere with thinking, moving, or communicating. Functional incontinence is the result of these physical and medical conditions.

Overactive Bladder occurs when abnormal nerves send signals to the bladder at the wrong time, causing its muscles to squeeze without warning. Specifically, the symptoms of overactive bladder include:

- Urinary frequency – bothersome urination eight or more times a day or two or more times at night.
- Urinary urgency – the sudden, strong need to urinate immediately
- Urge incontinence – leakage or gushing of urine that follows a sudden, strong urge
- Nocturia – awaking at night to urinate.

Overflow Incontinence happens when the bladder does not empty properly, causing it to spill over. A practitioner can check for this problem. Weak bladder muscles or blocked urethra can cause this type of incontinence.

Stress Incontinence is more common in women and in many cases, is treatable. Physical changes from pregnancy, childbirth and menopause often cause stress incontinence resulting in leakage of small amounts of urine during physical movement (coughing, sneezing, and exercising).

Urge Incontinence causes urine loss for no apparent reason after suddenly feeling the need or urge to urinate. A common cause of urge incontinence is inappropriate bladder contractions. Abnormal nerve signals might be the cause of the bladder spasms.

Mixed – Usually the occurrence of stress and urge incontinence together.

Transient – Leakage that occurs temporarily because of a situation that will pass (infection, taking a new medication, colds with coughing)

When determining the appropriate incontinence product several things to be considered are: individual circumstances, medical condition, and medical need. Some important things to consider about incontinence products are:

- Level of absorbency
- Complete or partial bladder emptying
- Frequency of changes
- Intermittent or constant need
- Activity level
- Changing product with sitting, standing or lying
- Manual dexterity of the individual/caregiver
- Size

Providers should monitor the needs of the individual on a regular basis to ensure the individual's products are still appropriate to meet their care needs. The provision of incontinence supplies is dependent on the individual's ongoing clinical need.

Transcutaneous Electrical Nerve Stimulators (TENS)

Requests for transcutaneous electrical nerve stimulator units may be approved if all of the following criteria are met; these criteria are applicable to all types of transcutaneous

electrical stimulators:

- Documentation verifies that other alternative equipment and conservative treatment modalities have been exhausted without success;
- The use of the TENS unit will benefit the individual to a degree not attainable by the use of other methods of care and treatment;
- A practitioner must direct the home treatment regimen, which will include the use of treatment modalities including, but not limited to, nursing services and physical therapy;
- The treatment regimen must be evaluated at least bi-monthly and can be determined effective after one month's use;
- The absence of this device would require that the individual visit the practitioner or therapist for treatment or medications more often than with the device;
- There must be documentation that the individual or the caregiver is able to manage the application of the device; and
- Rental of the TENS unit will be approved for the first two months, and purchase will be made after that period. Rental is only applicable to the initiation of new therapy. If the TENS device supplied for the required two-month rental period is new upon delivery, DMAS will consider paying the full purchase price listed in the Appendix B in this manual in addition to the initial two-month rental period for these items.

The purchase of the TENS unit and supplies will be considered after the 60 day trial rental when all of the following occur:

- Documentation indicates that the individual is compliant with treatment;
- Documentation describes how the TENS treatment modality is effective; and
- Use of the TENS unit is not contraindicated and/or not effective.

Coverage of Orthotics

Orthotic device services include devices that support or align extremities to prevent or correct deformities or improve functioning and services necessary to design the device, including measuring, fitting, and instructing the individual in its use.

A licensed Podiatrist is permitted to sign and date the CMN/DMAS-352 and any supporting documentation relating to orthotics needed in the treatment of the individual. The allowance of the Podiatrist signature only applies to the provision of orthotics. Orders must be related to the treatment plan of the individual and the individual shall be under the care of the Podiatrist for a related condition.

General Medicaid Population

Practitioners may bill for supplies and/or equipment, beyond those routinely included in the office visit, when used in the course of treatment in the practitioner's office. These supplies include, for example, ace bandage, sling, splint, rib belt, cervical collar, lumbosacral support, etc. The applicable CPT/HCPCS codes may be used when billing for a specific supply item used. See the "Durable Medical Equipment" section" in the Physician/Practitioner Medicaid Provider Manual located on the DMAS portal for additional information.

Items made for the individual by an occupational therapist, including splints, slings, and any normally stocked supplies, are part of the cost of the DMAS approved outpatient rehabilitation therapy visit. These items are billed as ancillary charges on the CMS-1500 Universal Claim Form.

Orthotics, including braces, splints, and supports, are not covered for the general adult Medicaid population under the DME program, with the exception of the Intensive Rehabilitation program described below.

Medicaid Individuals Participating in an Intensive Rehabilitation Program

Coverage for both adults and children is available for medically necessary orthotics when recommended as part of an approved intensive rehabilitation program (including CORF), and when all of the following criteria are satisfied via adequate and verifiable documentation which must include:

- Ordered by the practitioner on the CMN/DMAS-352 (CMN);
- Directly and specifically related to an active, written, and practitioner-approved rehabilitation treatment or discharge plan;
- Based upon a practitioner's assessment of the individual's rehabilitation potential, where the individual's condition will improve significantly in a reasonable and predictable period of time, or shall be necessary to establish an improved functional state of maintenance; and
- Consistent with generally accepted professional medical standards (i.e., not experimental or investigational).

The orthotist participating as a DMAS DME provider coordinates completion of the CMN/DMAS-352 (CMN) with the prescribing practitioner, using the correct HCPCS "L" codes. Service authorization is required. Reference the service authorization (SA) Appendix D of this manual for instructions on how to obtain service authorization. Documentation of the provider cost will be required for "L" procedure codes that do not have an established reimbursement allowance. Reimbursement (under the HCPCS "L"

codes) to the DME orthotic provider is all inclusive; no supplemental reimbursement will be made for time involved in fitting, measuring, and designing the orthotic, or for providing the individual with instructions for proper use.

EPSDT (Children Under 21 Years of Age)

All medically necessary orthotics are covered for children under the age of 21 years. The same program guidelines, as identified in the above paragraph, apply to this category.

Coverage of Prosthetics

General Information

The provision of medically necessary artificial arms, legs, their necessary supportive devices, and breast prostheses for Medicaid-eligible members in the Commonwealth of Virginia requires service authorization by DMAS or its designated agent, prior to rendering service.

Service Authorization

Refer to Appendix D of this manual for further information regarding service authorization, timely submittal of requests and service specific details.

Coverage and Limitations

A. Prosthetic services shall mean the replacement of missing arms, legs, eyes, and breasts and the provision of an internal (implant) body part. Nothing in this regulation shall be construed to refer to orthotic services or devices or organ transplantation services. (12VAC30-50-210)
B. Artificial arms and legs, and their necessary supportive attachments, implants, and breasts are provided when prescribed by a physician or other licensed practitioner of the healing arts within the scope of their professional license as defined by state law. This service, when provided by an authorized vendor, must be medically necessary, and service authorized for the minimum applicable component necessary for the activities of daily living (ADLs).
C. Eye prostheses are provided when eyeballs are missing regardless of the age of the member or the cause of the loss of the eyeball. Eye prostheses are provided regardless of the function of the eye. Service authorization is not required, but post-payment review is conducted.

To obtain the required service authorization for coverage, the prosthetist will ask the prescribing practitioner to complete a DMAS Certificate of Need form (DMAS-4001). The prosthetist will then submit the Certificate of Need, a copy of the physician’s prescription, and a completed Service Authorization Request form (DMAS-363) to DMAS’ Service Authorization contractor. Refer to Chapter V titled “Service Authorization Information” in

the Medicaid Prosthetic Devices Manual.

Forms are located on the DMAS preauthorization contractor's web site.

Non-Covered Services

The following devices are not covered for adults:

- Orthotic Devices - Spinal
- Orthotic Devices - Cervical
- Orthotic Devices - Thoracic
- Orthotic Devices - Sacral
- Orthopedic Footwear
- Orthopedic Footwear Modifications
- Shoe Modifications
- Trusses
- Penile Prostheses

Payment for Services

The payment criteria established for prosthetic devices are designed to enlist the participation of a sufficient number of suppliers so that Medicaid-eligible persons receive prostheses at least to the extent that they are available to the general population.

Participation as a prosthetic provider is limited to those who accept the amount paid by the Virginia Medicaid Program as payment in full.

Payment for services will not exceed the amount indicated to be paid in accordance with the policy and methods described in the State Plan for Medical Assistance, and payment will not be made in excess of the upper limits described in 42 CFR § 447.304(a).

Federal requirements prohibit Medicaid from paying prosthetic device providers more than Medicare would allow for the same service.

Payment Methodology

Payment for prostheses is the lowest of Medicaid's fee schedule, the actual charge, or the Medicare allowance.

For Medicare crossover claims, the payment will be the deductible and co-insurance amounts computed by Medicare based on the Medicare-allowed charge, as reported on the Explanation of Medicare Benefits (EOMB) received from the Medicare carrier.

Cost Sharing

There are no Medicaid deductible or co-insurance amounts imposed for any prosthetic

device provided to Medicaid members. As previously mentioned, Medicaid will pay the deductible and co-insurance amounts imposed on Medicaid members who are also Medicare beneficiaries and whose claims the Medicare carrier processes initially.

Equipment Repairs

The cost to repair rental equipment is considered the DME provider's responsibility. Therefore, rental repair charges, caused by normal wear and tear, abuse, or neglect, may not be billed to DMAS or to the individual. All HCPCS codes listed in Appendix B must have a CMN/DMAS-352 practitioner order, including equipment repairs.

Charges for repair(s) to medically necessary, individual owned equipment may be billed to DMAS using the proper DMAS HCPCS code. DMAS is not responsible for repairs covered under manufacturer warranties. Any payment made by DMAS for equipment repairs covered under warranty will be recovered in post-payment reviews. The provider should document in the individual record if the equipment is individual owned. If the repair cost is less than the rate paid under the appropriate HCPCS code as defined in Appendix B of this Manual, and the repair is done by the DME provider, the DME provider must bill DMAS under the miscellaneous parts/repair code and the labor code as applicable. If the cost of the repair parts exceeds the rate paid under the appropriate HCPCS code, or if the repair requires that the item be shipped to the manufacturer, the provider must use the miscellaneous (E1399) HCPCS code, and service authorization is required.

The provider must accept Medicaid payment as payment in full and may not bill the individual for any portion of the repair, including shipping and handling charges. Costs incurred for shipping and handling, except when otherwise noted, are considered to be a part of the DME provider's overhead/business expenses. If the repair is covered under warranty, the provider serving the individual's DME needs is responsible for the cost of shipping and handling.

NOTE: If a provider accepts a Medicaid individual as a client, the provider must provide all of the DME services that are provided to the general population. Refer to Chapter 2 of this manual for provider participation requirements.

REPAIR VERSUS REPLACEMENT/PURCHASE GUIDELINES

Providers shall evaluate individual owned equipment and every effort shall be made to repair the equipment, especially if the service limit has not expired for the purchased item. The service limits in Appendix B for all HCPCS codes are guidelines for normal use. DMAS understands that some equipment may not last until the service limit has expired due to unique circumstances of each individual. If individual owned equipment needs to be replaced prior to the service limit expiring the provider will be required to justify and obtain service authorization. Documentation for service authorization should include the required information as stated in this manual and the provider shall also include additional

documentation as stated below:

- What equipment the individual is currently using and why that equipment is no longer appropriate for the individual. This description shall include the reason why repairs could not be done or why the option to repair the equipment was not cost effective.
- The provider shall include a breakdown of what items need to be repaired and include the cost to repair the items to justify why the purchase of new equipment would be more cost effective; *and*
- If the item is no longer appropriate due to a change in medical condition, limitations and symptoms, or if the equipment was provided inappropriately, the provider shall give justification to describe the circumstances.

Rental and Purchase Guidelines

All medically necessary supplies and equipment shall be covered. Unusual amounts, types, and duration of usage must be authorized by DMAS in accordance with published policies and procedures. When determined to be cost effective by DMAS, payment may be made for rental of the equipment in lieu of purchase. (12 VAC 30-50-165)

Equipment rental is indicated for short-term use when an individual's need or condition is expected to change, including when the individual is expected to recover. When usage is anticipated to be long-term, and the individual's need or condition is not expected to change, the items must be considered for purchase. Most items can be rented for a short time without service authorization; an extension may be requested if the continued use is expected to continue short-term. If it is determined through utilization review activities that a rented item should have been purchased, DMAS will only provide reimbursement up to the established purchase price. (12 VAC 30-50-165) A description of the equipment and limitations for rental is found in the Appendix B section of this manual.

The purchase prices listed in the Appendix B of this manual represents the amount that DMAS will pay for new equipment purchases. Unless otherwise approved by DMAS, documentation on the delivery ticket must reflect that the purchased equipment is "new" upon the date of service billed. Any warranties associated with new equipment shall be effective with the date of service billed. Medicaid is the payer of last resort; therefore, the DME provider is responsible for exploring coverage available under the warranty prior to requesting coverage of repairs, etc., through DMAS or its contractor.

Coverage of a non-continuous ventilator for a child shall be based on the expected length of use. Any time the CMN indicates that the ventilator/CPAP/BiPAP is to be used for a period which exceeds nine months, the equipment must be purchased.

DMAS will consider paying the full purchase price listed in the Appendix B in this manual in addition to the initial required two-month rental period, for communication devices, TENS Units, CPAPs, and BiPAPs, when this equipment is new upon delivery.

Medicaid reimbursement for rental items is a daily rate. DMAS will not provide rental reimbursement for days that the individual is not receiving or not using the services. DMAS will also not provide reimbursement for rental equipment that is damaged or abused by the individual.

There are a few items in Appendix B that can only be rented and will not be allowed for purchase. These items can be identified because they will only have a rental HCPCS code and will have no HCPCS code for purchase. All of these codes require service authorization and like all codes that always require service authorization; the service limit is provided as a guideline to normal use. If the individual needs the item longer and it is appropriate and medically necessary, DMAS or its contractor may allow additional rental above the service limit if purchase is not permitted. DMAS or its contractor may allow for purchase of new equipment when the previously purchased item has not reached the allowable limit. For example, if a purchased wheelchair is destroyed in a fire prior to the service limit of 1 wheelchair per 5 years. Therefore, the provider will submit for a new wheelchair with supporting documentation and an explanation as to why the item is required prior to the service limit guideline.

Replacement DME Following a Natural Disaster

Medicaid individuals who live in areas that have been declared by the Governor of the Commonwealth of Virginia as a disaster or emergency in accordance with § 44-146.16 of the Code of Virginia, who need to replace DME and supplies previously approved by Medicaid, that was damaged as a result of the disaster or emergency, may contact a DME provider (either enrolled in Fee for Service Medicaid or a Medicaid Health Plan) of their choice to obtain a replacement.

For Medicaid enrolled providers, the provider must make a request to the Service Authorization contractor; however, a new CMN and medical documentation is not required unless the DME and supplies are beyond the service limit (e.g. the individual has a wheelchair that is older than five years). The provider should keep documentation in the individual's chart that includes the individual's current place of residence and states that the original DME or supplies were lost due to the natural disaster.

Individuals who are approved to receive DME and supplies from a DME provider in an area that has been declared by the Governor of the Commonwealth of Virginia as a disaster or emergency and with DME or supplies that were damaged as a result of the disaster or emergency in accordance with § 44-146.16 of the Code of Virginia but are unable to obtain replacement DME and supplies because the provider is no longer in business or unable to provide the approved DME and supplies may obtain the approved items from a new DME provider of their choice who is enrolled in Medicaid or contracted with a Medicaid Health Plan. The original authorization will be cancelled or amended and a new authorization will be given to the new DME provider. The DME provider will need to submit a signed

statement from the Medicaid individual requesting a change in DME provider due to the declaration by the Governor of the Commonwealth of Virginia as a state of emergency due to a natural disaster and giving his or her current place of residence.

Payment for Services

General Information

The payment criteria established for medical supplies, equipment, and appliances are designed to enlist the participation of a sufficient number of suppliers so that Medicaid-eligible individuals can receive covered services at least to the extent that these services are available to the general population. Participation as a medical equipment and supply provider is limited to those who accept as payment in full the amounts paid by the Virginia Medicaid Program. Payments for services will not exceed the amounts indicated to be paid in accordance with the policy and methods described in Virginia Administrative Code, and payment will not be made in excess of the upper limits described in 42 CFR 447.304(a).

Important: DME providers must provide all of the same DME services/items to the Medicaid individual as provided to the general population, in accordance with the established Medicaid reimbursement rate. As per the provider agreement, a Medicaid-enrolled provider must accept Medicaid payment as payment in full.

DME providers are responsible for knowing which items require service authorization and the limitation on the provision of certain items as described in the "Medicaid DME and Supplies Listing" in Appendix B of this manual. Since the Medicaid Program has established guidelines regarding which items require service authorization and the limitations that may be imposed on certain items, providers can reasonably be expected to know for which items Medicaid will pay.

The DME provider must not bill DMAS prior to the date of the physician's signature when the signature is not obtained within 60 days of the first day (CMN/DMAS-352 begin date) of service. The DME provider will be reimbursed only for services that are provided in accordance with published policies and procedures. If reimbursement is denied for one of these reasons, the DME provider may not bill the Medicaid individual for the items/service that was provided. (12 VAC 30-50-165)

The DME provider must not provide items or extended quantities of items which require service authorization prior to obtaining the written service authorization from DMAS. Therefore, the liability for the charges for denied items or services which the provider supplied prior to obtaining the required written authorization rests with the DME provider.

A provider cannot bill an individual for Medicaid-covered services if the provider is denied reimbursement due to his or her failure to obtain service authorization or to perform other required administrative functions. (12 VAC 30-50-165)

As per the Virginia Medicaid provider agreement, a DME provider may only bill a Medicaid individual for non-covered services. The DME provider is responsible for determining if an item is covered, whether or not it requires service authorization, and for verifying Medicaid eligibility. If the DME provider does not follow the established procedure for obtaining authorization for any item, and the request is denied, the provider may not bill the individual for that item. (12 VAC 30-50-165)

Communication with the Medicaid individual is important when an item is non-covered so the individual can make a decision as to if they want to purchase and "pay out-of-pocket" for the item(s).

The DME provider must advise the Medicaid individual in writing of any fiscal liability (potential or actual) for items delivered prior to the receipt of authorization by the service authorization contractor. If all established guidelines are followed by the provider, and the request is denied, the DME provider may seek reimbursement from the individual. The provider may not require the individual to make a deposit or "pay in advance" for any item that is covered and requires service authorization. If the provider fails to follow established procedures for authorization or fails to notify the individual of any fiscal liability and the item requested is determined not to be medically justified or does not meet criteria for reimbursement, the DME provider may not bill the Medicaid member. (12 VAC 30-50-165)

Cost Sharing

No Medicaid deductible or coinsurance amounts are imposed for any medical supplies, equipment, and appliances provided to Medicaid individuals. Medicaid will pay the Medicare deductible and coinsurance amounts up to Medicaid limits imposed on Medicaid individuals whose Medicare claims are processed initially by the Medicare carrier.

Ordering Forms

DMAS no longer provides a supply of agency forms. Providers can download forms from the DMAS portal (www.virginiamedicaid.dmas.virginia.gov). To access the forms, click on the "provider search forms". You may either search by form name or number. If you do not have internet access, you may request forms for copying by calling the DMAS form order desk at 1-804-780-0076.

Billing Instructions (DME)

Updated: 11/9/2015

Billing Instructions: Introduction

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

Two major areas are covered in this chapter:

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

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

Electronic Submission of Claims

Electronic billing using Electronic Data Interchange (EDI) is an efficient way to submit Medicaid claims. Providers use EDI software that enables the automated transfer of data in a specific format following specific data content rules directly to DMAS. For more information, go to https://vamedicaid.dmas.virginia.gov/edi.

The mailing address, phone number and fax number for the EDI program are:

EDI Coordinator

Virginia Medicaid Fiscal Agent

P.O. Box 26228

Richmond, Virginia 23260-6228

Phone: (866) 352-0766

Fax number: (888) 335-8460

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

Billing Instructions: Direct Data Entry

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

Timely Filing

Federal regulations [42 CFR § 447.45(d)] require the initial submission of all Medicaid claims

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

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

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

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

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

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

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

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

Other Primary Insurance - The provider must bill other insurance as primary. However, all claims for services **must be billed to DMAS within 12 months from the date of the service.** If the provider waits for payment before billing DMAS and the wait extends beyond 12 months from the date of the service, DMAS will make no reimbursements. If payment is

made from the primary insurance carrier after a payment from DMAS has been made, an adjustment or void should be filed at that time.

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

Billing Instructions: Billing Invoices (DME)

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

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

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

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

Billing Instructions: Automated Crossover Claims Processing (DME)

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

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

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

claim to Virginia Medicaid will reduce the need for submitting follow-up paper claims.

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

Billing Procedures (Hospital)

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

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

Department of Medical Assistance Services

P.O. Box 27443

Richmond, Virginia 23261-7443

Or

Department of Medical Assistance Services

CMS Crossover

P. O. Box 27444

Richmond, Virginia 23261-7444

Billing Instructions: Electronic Filing Requirements

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

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

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

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

277 - Unsolicited Response (5010)

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

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

835 - Health Care Claim Payment/ Remittance (5010)

837 - Dental Health Care Claim or Encounter (5010)

837 - Institutional Health Care Claim or Encounter (5010)

837 - Professional Health Care Claim or Encounter (5010)

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

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

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

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

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

Billing Instructions: ClaimCheck

- Effective June 3, 2013, DMAS implemented the Medicaid National Correct Coding Initiative (NCCI) Procedure to Procedure (PTP) and Medically Unlikely Edits (MUE) edits. This implementation was in response to directives in the Affordable Care Act of 2010. These new edits will impact all Physicians, Laboratory, Radiology, Ambulatory Surgery Centers, and Durable Medical Equipment and Supply providers. Effective January 1, 2014, all outpatient hospital claims will be subject the the NCCI edits thru the EAPG claim processing. Please refer to the Hospital Manual, Chapter 5 for details related to EAPG. The NCCI/ClaimCheck edits are part of the daily claims adjudication cycle on a concurrent basis. The current claim will be processed to edit history claims. Any adjustments or denial of payments from the current or history claim(s) will be done during the daily adjudication cycle and reported on the providers weekly remittance cycle. All NCCI/ClaimCheck edits are based on the following global claim factors: same member, same servicing provider, same date of service or the date of service is within established pre- or post-operative time frame. All CPT and HCPCS code will be subject to both the NCCI and ClaimCheck edits. Upon review of the denial, the provider can re-submit a corrected claim. Any system edits related to timely filing, etc. are still applicable.

- PTP Edits:

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

- MUE Edits:

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

- Exempt Provider Types:

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

- Service Authorizations:

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

- Modifiers:

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

may result in recovery of overpayment(s) if the medical record does not appropriately demonstrate the use of the modifiers.

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

Reconsideration

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

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

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

Billing Instructions: Reconsideration (DME)

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

Payment Processing Unit, Claim Check

Division of Program Operations

Department of Medical Assistance Services

600 East Broad Street, Suite 1300

Richmond, Virginia 23219

There is a 30-day time limit form the date of the denial letter or the date of the remittance advice containing the denial for requesting reconsideration. A review of additional documentation may sustain the original determination or result in an approval or denial of

additional day(s). Requests received without additional documentation or after the 30-day limit will not be considered.

Billing Instructions Reference for Services Requiring Service Authorization

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

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

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

Locator 22 **Medicaid Resubmission**

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

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

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

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

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

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

Richmond, VA 23219

Billing Instructions: Group Practice Billing Functionality

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

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

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

Billing Instructions: Negative Balance Information

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

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

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

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

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

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

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

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

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

LOCATOR SPECIAL INSTRUCTIONS

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

17 Enter the name of the referring primary care provider.

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

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

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

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

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

Billing Instructions: EDI Billing (Electronic Claims)

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

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

The Direct Data Entry (DDE) Crossover Part B claim form is on the Virginia Medicaid Web Portal. Please note that providers are encouraged to use DDE for submission of claims that cannot be submitted electronically to DMAS. Registration thru the Virginia Medicaid Web Portal is required to access and use DDE. The DDE User Guide, tutorial and FAQ's can be accessed from our web portal at: www.virginiamedicaid.dmas.virginia.gov. To access the DDE system, select the Provider Resources tab and then select Claims Direct Data Entry (DDE). Providers have the ability to create a new initial claim, as well as an adjustment or a void through the DDE process. The status of the claim(s) submitted can be checked the next business day if claims were submitted by 5pm. DDE is provided at no cost to the provider. Paper claim submissions should only be submitted when requested specifically by DMAS.

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

Locator	Instructions	
1	**REQUIRED**	**Enter an "X" in the MEDICAID box for the Medicaid Program. Enter an "X" in the OTHER box for Temporary Detention Order (TDO) or Emergency Custody Order (ECO).**
1a	**REQUIRED**	**Insured's I.D. Number** - Enter the 12-digit Virginia Medicaid Identification number for the member receiving the service.
2	**REQUIRED**	**Patient's Name** - Enter the name of the member receiving the service.
3	NOT REQUIRED	Patient's Birth Date
4	NOT REQUIRED	Insured's Name
5	NOT REQUIRED	Patient's Address
6	NOT REQUIRED	Patient Relationship to Insured
7	NOT REQUIRED	Insured's Address
8	NOT REQUIRED	Reserved for NUCC Use
9	NOT REQUIRED	Other Insured's Name
9a	NOT REQUIRED	Other Insured's Policy or Group Number
9b	NOT REQUIRED	Reserved for NUCC Use
9c	NOT REQUIRED	Reserved for NUCC Use
9d	NOT REQUIRED	Insurance Plan Name or Program Name
10	**REQUIRED**	**Is Patient's Condition Related To:** - Enter an "X" in the appropriate box. a. Employment? b. Auto accident c. Other Accident? (This includes schools, stores, assaults, etc.) NOTE: The state should be entered if known.
10d	Conditional	**Claim Codes (Designated by NUCC)** Enter "ATTACHMENT" if documents are attached to the claim form. **Medicare/Medicare Advantage Plan EOB should be attached.**
11	NOT REQUIRED	Insured's Policy Number or FECA Number
11a	NOT REQUIRED	Insured's Date of Birth
11b	NOT REQUIRED	Other Claim ID
11c	**REQUIRED**	**Insurance Plan or Program Name** Enter the word '**CROSSOVER**' **IMPORTANT: DO NOT** enter 'HMO COPAY' when billing for Medicare/Medicare Advantage Plan copays! Only enter the word **'CROSSOVER'**

11d	**REQUIRED** **If Applicable**	**Is There Another Health Benefit Plan?** If Medicare/Medicare Advantage Plan and Medicaid only, check "NO". Only check "Yes", if there is additional insurance coverage **other than** Medicare/Medicare Advantage Plan and Medicaid.
12	NOT REQUIRED	Patient's or Authorized Person's Signature
13	NOT REQUIRED	Insured's or Authorized Person's Signature
14	NOT REQUIRED	Date of Current Illness, Injury, or Pregnancy Enter date MM DD YY format Enter Qualifier 431 – Onset of Current Symptoms or Illness
15	NOT REQUIRED	Other Date
16	NOT REQUIRED	Dates Patient Unable to Work in Current Occupation
17	NOT REQUIRED	Name of Referring Physician or Other Source – Enter the name of the referring physician.
17a shaded red	NOT REQUIRED	I.D. Number of Referring Physician - The '1D' qualifier is required when the Atypical Provider Identifier (API) is entered. The qualifier 'ZZ' may be entered if the provider taxonomy code is needed to adjudicate the claim. Refer to the Medicaid Provider manual for special Billing Instructions for specific services.
17b	NOT REQUIRED	I.D. Number of Referring Physician - Enter the National Provider Identifier of the referring physician.
18	NOT REQUIRED	Hospitalization Dates Related to Current Services
19	NOT REQUIRED	Additional Claim Information Enter the CLIA #.
20	NOT REQUIRED	Outside Lab?
21 A-L	**REQUIRED**	**Diagnosis or Nature of Illness or Injury** - Enter the appropriate ICD diagnosis code, which describes the nature of the illness or injury for which the service was rendered in locator 24E. Note: Line 'A' field should be the Primary/Admitting diagnosis followed by the next highest level of specificity in lines B-L. **Note: ICD Ind. Not required at this time.**

<table>
<tr>
<td>22</td>
<td>REQUIRED
If Applicable</td>
<td>
Resubmission Code – Original Reference Number. Required for adjustment or void. Enter one of the following resubmission codes for an adjustment:
<table>
<tr><th>Code</th><th>Description</th></tr>
<tr><td>1023</td><td>Primary Carrier has made additional payment</td></tr>
<tr><td>1024</td><td>Primary Carrier has denied payment</td></tr>
<tr><td>1025</td><td>Accommodation charge correction</td></tr>
<tr><td>1026</td><td>Patient payment amount changed</td></tr>
<tr><td>1027</td><td>Correcting service periods</td></tr>
<tr><td>1028</td><td>Correcting procedure/ service code</td></tr>
<tr><td>1029</td><td>Correcting diagnosis code</td></tr>
<tr><td>1030</td><td>Correcting charge</td></tr>
<tr><td>1031</td><td>Correcting units/visits/studies/procedures</td></tr>
<tr><td>1032</td><td>IC reconsideration of allowance, documented</td></tr>
<tr><td>1033</td><td>Correcting admitting, referring, prescribing, provider identification number</td></tr>
<tr><td>1053</td><td>Adjustment reason is in the Misc. Category</td></tr>
</table>
Enter one of the following resubmission codes for a void:
<table>
<tr><th>Code</th><th>Description</th></tr>
<tr><td>1042</td><td>Original claim has multiple incorrect items</td></tr>
<tr><td>1044</td><td>Wrong provider identification number</td></tr>
<tr><td>1045</td><td>Wrong enrollee eligibility number</td></tr>
<tr><td>1046</td><td>Primary carrier has paid DMAS maximum allowance</td></tr>
<tr><td>1047</td><td>Duplicate payment was made</td></tr>
<tr><td>1048</td><td>Primary carrier has paid full charge</td></tr>
<tr><td>1051</td><td>Enrollee not my patient</td></tr>
<tr><td>1052</td><td>Miscellaneous</td></tr>
<tr><td>1060</td><td>Other insurance is available</td></tr>
</table>
Original Reference Number - Enter the claim reference number/ICN of the Virginia Medicaid paid claim. This number may be obtained from the remittance voucher and is required to identify the claim to be adjusted or voided. Only one paid claim can be adjusted or voided on each CMS-1500 (02-12) claim form. (Each line under Locator 24 is one claim).
NOTE: ICNs can only be adjusted or voided through the Virginia MMIS up to three years from the date the claim was paid. After three years, ICNs are purged from the Virginia MMIS and can no longer be adjusted or voided through the Virginia MMIS. If an ICN is purged from the Virginia MMIS, the provider must send a refund check made payable to DMAS and include the following information:
• A cover letter on the provider's letterhead which includes the current address, contact name and phone number.
• An explanation about the refund.
• A copy of the remittance page(s) as it relates to the refund check amount.
• Mail all information to:
Department of Medical Assistance Services
Attn: Fiscal & Procurement
Division Cashier
600 East Broad St, Suite 1300
Richmond, VA 23219
</td>
</tr>
<tr>
<td>23</td>
<td>REQUIRED
If Applicable</td>
<td>Prior Authorization (PA) Number – Enter the PA number for approved services that require a service authorization.
NOTE: The locators 24A thru 24J have been divided into open and shaded line areas. The shaded area is ONLY for supplemental information. DMAS has given instructions for the supplemental information that is required when needed for DMAS claims processing. <u>ENTER REQUIRED INFORMATION ONLY.</u></td>
</tr>
<tr>
<td>24A lines 1-6 open area</td>
<td>REQUIRED</td>
<td>Dates of Service - Enter the from and thru dates in a 2-digit format for the month, day and year (e.g., 01 01 14).</td>
</tr>
</table>

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

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

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

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

Invoice Processing (PP)

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

- Remittance Voucher
- **Approved** - Payment is approved or Pended. Pended claims are placed in a pended status for manual adjudication (the provider must not resubmit).
- **Denied** - Payment cannot be approved because of the reason stated on the remittance voucher.
- **Pend** – Payment is pended for claim to be manually reviewed by DMAS staff or waiting on further information from provider.
- **NO RESPONSE -** if one of the above responses has not been received within 30 days, the provider should assume non-delivery and rebill using a new invoice form.

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

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

Billing Instructions: Exhibits

Utilization Review and Control (DME)

Updated: 6/25/2021

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

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

Individuals Enrolled in Managed Care (DME)

Most individuals enrolled in the Medicaid program have their services furnished through contracted managed care organizations (MCOs) and their network of providers. Durable medical equipment (DME) providers serving individuals enrolled within an MCO shall reference their MCO provider agreement regarding Utilization Review and Control. All providers are responsible for adhering to this manual, their provider contract with the

MCOs, and state and federal regulations. For those who are enrolled in Medicaid and continue to receive care under Medicaid fee-for-service, the provider is responsible for adhering to state and federal regulations, as well as this manual.

Compliance Reviews (DME)

The Department of Medical Assistance Services routinely conducts compliance reviews to ensure that the services provided to Medicaid members are medically necessary and appropriate and are provided by the appropriate provider. These reviews are mandated by Title 42 C.F.R., Part 455.

Providers and members are identified for review by

- Systems generated exception reporting using various sampling methodologies or by referrals and complaints from agencies or members. Exception reports developed for providers compare a member provider's billing activities with those of the provider peer group. An exception profile report is generated for each provider that exceeds the peer group averages by at least two standard deviations.
- Referrals and complaints from agencies or members. Referrals and complaints of inappropriate utilization of Medicaid services are investigated to determine if a Quality Management Review is necessary. The case may be referred to DMAS' Provider Review Unit or the Attorney General's Office for further review.

Reviews are conducted by:

- The reviewer, who is either a Health Care Compliance Specialist (HCCS), trained professional employed by DMAS or a Contractor of DMAS, reviews all cases using available resources, including appropriate consultants, and makes on-site reviews of medical records as necessary.

On-site review process:

- Upon arrival at the facility, the reviewer will supply the provider with a list of the records to be reviewed. The provider must supply the reviewer with the records as requested. The reviewer will begin the review at the facility.
- At completion of the on-site portion of the review, the reviewer will conduct an Exit Conference. This conference is a brief summary of the onsite findings.
- Upon return to DMAS the reviewer will complete the review. Completion of this review includes a summary letter to the provider. This letter includes technical assistance, areas of citation and, if applicable, documentation of overpayment.
- If overpayment occurs, a copy of the letter will be forwarded to the Provider Reimbursement Division at DMAS. The provider will receive another letter from this Division outlining the repayment requirements.

Desk review process:

- The reviewer will mail, via United States Post Office certified mail, a list of the records to be reviewed. The provider must supply the reviewer with the records as requested. The records must be received by DMAS by the date instructed. Upon receipt of the documents the reviewer will review the records received. The reviewer may contact the provider for clarification of any document received.
- Upon completion of the review the reviewer will send a summary letter to the provider via certified mail. This letter includes technical assistance, areas of citation and, if applicable, documentation of overpayment.
- If overpayment occurs, a copy of the letter will be forwarded to the Fiscal Division at DMAS. The provider will receive another letter from Provider Reimbursement Division outlining the repayment requirements.

Overpayments:

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

Documentation Requirements for All DME

Medical documentation must provide DMAS with a clear understanding of the individual's needs. The following applies to the medical justification necessary for **all DME services** regardless of whether or not service authorization (SA) is required. The documentation is necessary to identify:

- The medical need for the requested DME;
- The diagnosis related to the reason for the DME request;
- The individual's functional limitation and its relationship to the requested DME;
- How the DME service will treat the individual's medical condition;
- The quantity needed and the medical reason the requested amount is needed;
- *The frequency of use (holds more weight for expendable supplies – see "note" below);
- The estimated length of use of the equipment (holds more weight for DME especially related to rental vs. purchase);
- Any conjunctive treatment related to the use of the DME or supplies;
- How the needs were previously met and identifying changes that have occurred which necessitate the DME;
- Other alternatives tried or explored and a description of the success or failure of

these alternatives;
- How the DME service is required in the individual's home or community environment; and
- The individual or caregiver's ability, willingness, and motivation to use the DME.

NOTE: *Frequency of use is part of the practitioner's order and describes how often a supply is used by the individual and provides the justification for the quantity ordered per month. Frequency of use should be documented by how often the individual uses the supplies ordered. For example, an individual needs incontinent briefs and must be changed seven (7) times per day. Seven times per day is the frequency of use. The frequency of use is multiplied by 31 days and should justify the quantity ordered per month on the CMN/DMAS-352. This documentation can be noted by the day, the week or the month depending on the type of supply and the individual's needs. Some items may be used once per week or twice per month so if an item is needed less than monthly the provider should document accordingly. Frequency of use holds more weight for expendable supplies but can be required for DME. (Frequency of use means – how often something is used. Quantity means – total. The provider will need to know how often the supply is used to determine quantity).

Face to Face Documentation Requirements for DME -- Fee-for-Service

This only applies to FFS members and not those enrolled in one of DMAS' managed care plans.

Beginning July 1, 2017, no payment shall be made for new DME (as defined in 12VAC30-50-165) unless a face-to-face encounter has been performed by an approved practitioner (outlined below) no more than six (6) months prior to the begin service date. The face-to-face encounter shall be related to the primary reason the individual enrolled in Medicaid requires DME.

The practitioner performing the face-to-face encounter must document the clinical findings in the individual's medical record and communicate the clinical findings of the encounter to the ordering physician.

Providers must use the CMN form to document the new requirements. Completion of all elements related to the face-to-face requirements on the CMN will satisfy the face-to-face encounter documentation requirements. For DME items that require service authorization as indicated in the table below, providers must during the service authorization process, "attest" that the face-to-face encounter requirement has been met. For those items that do not require a service authorization, the CMN with the face-to-face encounter documentation should be maintained in the individual's medical record. Additional information regarding the face-to-face requirements are found in Ch. IV of this manual.

Instructions for Completing the CMN/DMAS-352

Section I - Individual Data

Section I contains demographic information for the individual and the servicing provider. This section is the **only** section of the CMN/DMAS-352 that can be changed after the practitioner has signed the CMN/DMAS-352. This information is considered technical information that will not affect the practitioner's order.

Section II – Individual Clinical Information

Section II contains the individual's information. There are eight questions that should be answered, if applicable, to the DME/supplies being requested. If the answer is "yes" to any of the questions, additional information should be provided on the CMN/DMAS-352 or in supporting documentation signed and dated by the practitioner. To the right of the eight questions is a box for description/additional information. This section can be used to provide medical justification for the item/s being ordered. This section also includes the documentation for the face-to-face encounter required for specified DME HCPCS codes. The practitioner should check the appropriate box indicating if a face-to-face was completed and the name, credentials and date of the practitioner who completed encounter. Below the eight questions are two additional questions to respond to when appropriate.

The first question must be answered on the CMN/DMAS-352 or in the supporting documentation. If the individual/caregiver is unwilling or unable to use the item it would not be covered.

The second question is the date the individual was last examined by the practitioner and must be completed on the CMN/DMAS-352 or in the supporting documentation. The individual must have seen the ordering practitioner within the last 2 years; however, some DME/supplies have stricter criteria. See the criteria for the ordered items for the guidelines in Chapter IV of this manual.

The last part of Section II is for the individual's diagnoses. The diagnoses should be related to the reason for the DME/supplies request. The ICD code is optional. The clinical diagnosis narrative is required. The date of onset should be noted if available.

Section III – Specific Physician Ordered DME and Supplies

Section III is to be completed for all DME/supplies ordered for the individual, to include each component of the DME and supplies. Page two of the CMN allows for additional orders that won't fit on the first page of the CMN.

The begin service date on the CMN/DMAS-352 is optional. If the provider enters a begin service date, the CMN/DMAS-352 must be signed and dated by the practitioner within 60 days of the begin service date in order for the CMNDMAS-352 to start from the begin service date. Refer to the following examples:

- If the begin service date is 01/01/2015 and the practitioner signs and dates the CMN/DMAS-352 on 02/03/2015, the CMN/DMAS-352 meets the 60 day requirement. If the individual is 21 years of age and older the CMN is good from 01/01/2015 to 12/31/2015, if all other requirements are met. If the individual is under 21 years old the CMN/DMAS-352 is good from 01/01/20015 to 06/30/2009, if all other requirements are met.
- If the begin service date is 01/01/2015 and the practitioner signs and dates the CMN/DMAS-352 on 03/14/2015, the CMN/DMAS-352 does not meet the 60 day signature requirement. If this individual is 21 year of age and older the CMNDMAS-352 is good from 03/14/2015 to 12/31/2015, if all other requirements are met. For an individual under 21 years of age the CMN/DMAS-352 is good from 03/14/2015 to 06/30/2015, if all other requirements are met.
- If **no** begin service date is provided on the CMN/DMAS-352 the date of the practitioner's signature is the start date of the CMN/DMAS-352. If the CMN/DMAS-352 is signed by the practitioner on 02/01/2015 and the individual is 21 of age and older the CMN/DMAS-352 is good from 02/01/2015 to 01/31/2016 if all other requirements are met. If the individual is under 21 years of age the CMN/DMAS-352 is good from 02/01/2015 to 07/31/2015, if all other requirements are met.

The HCPCS code column on the CMN/DMAS-352 is optional. However, the provider is responsible for using the correct HCPCS code for service authorization (if required) and billing. The DME provider can contact the manufacturer of the DME/supplies or visit the Noridian site at https://www.dmepdac.com/dmecsapp/do/search for coding assistance. Coding accuracy may be reviewed at post payment audit.

The item ordered description is a required field to be completed on the CMN/DMAS-352. If this section is not completed the CMN/DMAS-352 is invalid for this item. If the item is an E1399 (miscellaneous), the description of the item should not be miscellaneous DME, the provider should specify the DME item/supply.

The length of time needed should be documented on the CMN/DMAS-352 or in the supporting documentation signed and dated by the practitioner. The length of time the item is needed must be evaluated for durable items when determining whether the item is purchased or rented.

The quantity ordered column is a required field on the CMN/DMAS-352 and is part of the practitioner's order. For expendable supplies the provider must designate supplies needed

for one month. If an item is not needed every month the provider may designate an alternate time frame. For example, if an individual needs a supply once every two months the provider may document 1 every 2 months or 1/2M in the quantity section. If this section is left blank the order is not complete and the CMN/DMAS-352 would be invalid for that item.

The Quantity/Frequency of use/Justification/Comments column provides a space for this documentation but can also be documented on the supporting documentation signed and dated by the practitioner. Frequency of use must be documented for expendable supplies to justify the quantity but can also be required for durable medical equipment Frequency of use is a required part of the practitioner's order and describes how often a supply is used by the individual and provides the justification for the quantity ordered per month. Frequency of use must be documented and can be determined by how often the individual uses the supplies ordered. For example, the individual needs incontinent briefs and is changed 7 times per day. Seven times per day is the frequency of use. The frequency of use is multiplied by 31 days and should justify the quantity ordered per month on the CMN/DMAS-352.

Documentation can be noted by the day, the week or the month depending on the type of supply and the individual's needs. Some items may be used once per week or twice per month so if an item is needed less than monthly the provider should document accordingly. Frequency of use holds more weight for expendable supplies but can be required for DME. (Frequency of use means – how often something is used. Quantity means – total. The provider will need to know how often the supply is used to determine quantity).

Section IV – Practitioner Certification

Section IV is for practitioner certification. The practitioner shall print his/her full name in the first blank. The second blank is for the practitioner signature. The third blank is for the date of the signature and should contain the full date (day/month/year). Note: An attached practitioner prescription will **not** be accepted in lieu of the practitioner's signature and date on the CMN. If orders for DME/supplies are written on both pages of the CMN, the practitioner must sign and fully date both pages on the CMN. The complete practitioner Medicaid provider number (NPI) and phone number are optional.

NOTE: The practitioner signature and full date is required on the CMN. If either the signature or full date or both is missing the **entire** CMN is **invalid** and a new CMN must be obtained. The purpose of the practitioner certification is to certify that the ordered DME/supplies are a part of the treatment plan and, in the opinion of the practitioner, are medically necessary.

Documentation Requirements for Repair of Rented or Purchased DME

The provider shall document the following:

- What equipment the individual is currently using and why that equipment is no longer appropriate for the individual. This description shall include the reason why repairs could not be done or why the option to repair the equipment was not cost effective.
- The provider shall include a breakdown of what items need to be repaired and include the cost to repair the items to justify why the purchase of new equipment would be more cost effective.
- If the item is no longer appropriate due to a change in medical condition, limitations and symptoms, or if the equipment was provided inappropriately, the provider shall give justification to describe the circumstances.

The provider must demonstrate short term need versus long term need

Documentation Requirements for Specific DME Items

In addition to the Medical Necessity guidelines described in Ch. IV of this manual and the documentation requirements for all DME, described previously in this chapter, additional specific medical justification and/or documentation requirements are in place for the following DME:

Documentation Requirements for Hospital Beds

Describe all of the following:

- How the bed will be used to treat a medical condition;
- How needs have and are currently being met;
- The functional abilities/disabilities;
- Other alternatives tried; and
- Why a non-hospital bed would not meet the individual's medical needs.

The following must be documented on the CMN/DMAS-352 or in supporting documentation, along with medical necessity for all Hospital Beds submitted under E1399:

- Will the home support the electricity requirements of the bed?
- Will the home support the weight of the bed?
- Need to list what other beds have been ruled out and why.
- Why is a standard hospital semi/total electric bed with support surface not sufficient?
- Does the bed already include a mattress?

Documentation Requirements for Patient Lifts

The following must be documented on the CMN/DMAS-352 or in supporting documentation.

Describe all of the following:

- The individual's weight;
- Identify the caregiver and his or her ability to use the lift;
- The individual's functional limitations;
- How needs were previously met;
- What has changed in the individual's condition to require the lift; and
- The home's accessibility for the lift

Documentation Requirements for Individual Bath Lifts

The following must be documented on the CMN/DMAS-352 or in supporting documentation. Describe all of the following:

- The individual's medical condition and the need for the bath chair;
- The individual's weight;
- Identify the caregiver and his or her ability to use the equipment;
- The individual's functional limitations;
- How needs were previously met,
- What has changed in the individual's condition to require the bath chair; and
- The bathroom's accessibility for the bath chair

Documentation Requirements for All Wheelchairs

The provider **must** document **all** of the following in addition to the minimum documentation requirements:

- Document the diagnosis or condition requiring the wheelchair, and how the requested wheelchair treats that diagnosis/condition;
- Describe how any additional components added to the wheelchair will treat the diagnosis/condition;
- Describe the distance (in feet) the individual can functionally ambulate with or without an assistive device;
- Describe upper and lower extremity strength/weakness;
- Identify how the individual's needs have been met/unmet previously and what changes have occurred to now require a mobility device, or if current mobility device is not meeting need and why;
- Describe cost effective alternatives tried and ruled out;
- Describe home accessibility for the mobility device and how the requested device is needed within the individual's home or for community use;
- If the individual currently owns a wheelchair, describe the type of wheelchair, condition of the wheelchair (describe damage/cost to repair), and any special features included on the wheelchair.

In addition to CMN/DMAS-352, documentation for wheelchairs can be in the form of a letter of medical necessity (LMN), office notes, written documentation on the CMN/DMAS-352 or other supporting documentation that is signed and dated by the practitioner.

Note: All items related to wheelchairs, including correct quantities, hardware, upgraded foam, labor, any item that is an upcharge, etc., must be ordered on the CMN/DMAS-352 and justified either on the CMN/DMAS-352 or in attached, supporting, verifiable documentation, regardless of whether or not the item requires service authorization. All supporting documentation must be individual-specific and must be signed and dated by the practitioner.

Documentation Requirements for Power Wheelchairs

1. Fully completed CMN/DMAS-352, to include the minimum documentation requirements, signed and dated by the practitioner.

2. A specialty evaluation (face to face) will be required for all individuals receiving a Group 2 single power or multi-power option PWC, and Group 3, 4 or 5 PWC, or a push rim activated power assist device for a manual wheelchair. The evaluation must be performed by a health care professional with experience in fitting wheelchairs and making recommendations based on the individual's need (specifically, practitioner, physical therapist, occupational therapist, or rehabilitation engineer in coordination with the physical therapist or occupational therapist). The physical therapy and/or occupational therapy evaluation is a covered rehabilitation program service that may be billed to DMAS. DMAS requires the assessment to be performed by a physical therapist or occupational therapist, especially for wheelchairs with specialized seating and positioning components and features, or for wheelchairs operated via specialty electronics. All evaluations should include but are not limited to the following;

    - Range of motion and semi-quantitative assessment of strength in the extremities
    - Quantitative limitations to passive range of motion in the extremities
    - Detailed description of the individual's condition to include related diagnosis and history
    - Presence or absence of increased muscle tone or spasms
    - Describe head and trunk control in relation to the specific components/type of wheelchair requested
    - Describe how the equipment benefits the individual in performing activities of daily living (ADLs)
    - Detailed list, description and justification of wheelchair base and accessories
    - Detailed description of the individual's long-term prognosis

- Size, weight and measurements of the individual
- Description of the medical condition necessitating use of a wheelchair
- Extent of the individual's ability to ambulate. If the individual can ambulate, what are the limitations to this ambulation and does it require an assistive device? If a device is currently being used, indicate the device and why the device no longer meets the individual's needs. Indicate other alternatives tried and ruled out.

3. Home Assessment – The provider must perform an on-site evaluation of the patient's home prior to delivery. A written report must be kept in the individual's clinical record. The home assessment must verify the following:

    - The wheelchair is accessible in the home setting
    - The individual can adequately maneuver the wheelchair in the home, taking into consideration:
        - Physical layout;
        - Doorway width(s);
        - Doorway thresholds; and,
        - Surfaces

4. The wheelchair is provided by a supplier that employs a RESNA-certified Assistive Technology Supplier (ATS) or Assistive Technology Practitioner (ATP) who specializes in wheelchairs and who has direct, in-person involvement in the wheelchair selection for the individual.

5. Manufacturer information to include price, make, model of wheelchair and all accessories for the wheelchairs reimbursed as Individual Consideration (IC).

Documentation Requirements for Wound Care Supplies

Describe all of the following:

- The total number of wounds;
- The location;
- Stage;
- Size;
- Depth;
- Drainage;

- Color of each wound;
- Who is providing the wound care (individual, caregiver, home health nurse);
- Frequency of the wound care; and
- The complete practitioner's order for the wound care

Additional documentation requirements for specific items may be found in the "Medicaid DME and Supplies Listing" in Appendix B and as described in Chapter IV of this manual.

Documentation Requirements for Communication Devices

The speech-language pathology documentation must show that the individual's ability to use the device is improving and that the individual is motivated to continue to use the device.

The CMN/DMAS-352, speech/language evaluation, and/or other verifiable supporting documentation must include all the following:

- The complete practitioner's prescription for the augmentative communication device, including an itemization of the components (i.e., special switches, special mounting devices, etc.) required by the individual;
- Documentation describing the individual's medical condition/diagnosis, including a description of the individual's disease, general prognosis, and prognosis for intelligible speech;
- Documentation if the condition permanent, temporary, or changing;
- Documentation to demonstrate if the medical condition will result in an increased or decreased need for a device in the future;
- A description of how the individual communicates medical needs now and how communication needs are currently unmet\met;
- Is the individual cognitively/physically able and motivated to use an augmentative communication device? Documentation must include an assessment of the individual's gross and fine motor skills, e.g., hand use skill, including finger dexterity;
- A description of related impairments including audio/visual, perceptual, and/or memory, that would limit his or her ability to use a device, or that would require the use of a specific augmentative communication device;
- A description of the plan to provide ongoing speech-language therapy and support in the use of the communication device in the individual's home and community; a list of other devices that have been tried by the individual (describe the success/failure); a description of how the requested device better meets the individual's medical needs than more cost-effective devices available;
- A description of the extent to which the individual and/or family/caregivers are able to properly program and utilize the device; and
- Specific information about the device including: the manufacturer's name, catalog number, product description, a photo (if available), and documentation of the provider's cost, less any discounts available.

Documentation Requirements for Enteral Nutrition

For individuals eligible for enteral nutrition, the DME provider must obtain and maintain all of the following documentation:

- The CMN/DMAS-352 is required for all nutritional supplements and supplies regardless of whether or not the individual is enrolled in a Medicaid home and community based waiver program.
- A complete description of the item(s) being supplied;
- A copy of the supplier's invoice or the dealer cost information to document the cost of the item(s) marked as Individual Consideration (IC) as listed in the Fee column of the Appendix B; any discount received must be indicated; and
- Delivery tickets for the items provided

The required medical justification can be included in the supporting documentation that is signed and dated by the practitioner. The CMN/supporting documentation must include all of the following elements:

1. Height (or length for pediatric individuals);
2. Weight (if unobtainable, may provide mid-arm circumference and triceps skinfold test data). For initial assessments, indicate the individual's weight loss over time;
3. Formula tolerance (e.g., is the individual experiencing diarrhea, vomiting, and constipation?). This element is only required if the individual is already receiving a supplement;
4. Tube or stoma site assessment, as applicable;
5. Indication of whether the supplement is the primary or sole source of nutrition;
6. Route of administration;
7. The daily caloric order and the number of calories per package, can, etc.
8. Title, signature, and date of the qualified personnel completing the assessment; and
9. Practitioner signature and date in accordance with criteria for supporting documentation. See Chapter IV of this manual.

NOTE: If the practitioner is unable to obtain a current weight, the practitioner must document the reason why a weight was unable to be obtained and how the practitioner is able to monitor therapy status without an individual's weights documented.

Documentation Requirements for Home Infusion Therapy - Certificate of

Medical Necessity

The CMN/DMAS-352 must be completed for intravenous (I.V.) therapy DME services. The provider may complete the CMN/DMAS-352, but the practitioner must fully date and sign the CMN/DMAS-352 within 60 days of the begin date of service.

The I.V. Therapy Implementation form must be initiated with the beginning of each drug and therapy service provided. The I.V. Therapy Implementation Form (DMAS-354) may be completed by the provider, but must be signed and dated by the practitioner. **Do not attach either the I.V. therapy implementation form (dmas-354) or the CMN to claim requests**.

The Medicaid Program must ensure that only medically necessary I.V. therapy is provided to Medicaid individuals. For DME services, I.V. therapy providers must maintain records that contain the fully completed CMN/DMAS-352, signed and dated by the practitioner; the I.V. Therapy Implementation Form (DMAS-354), with the begin and end dates for each drug/therapy provided and signed and dated by the practitioner; and the order to discontinue the therapy (the official end date), signed and dated by the practitioner. These forms shall be furnished to DMAS staff or its contractors upon request. The absence of documentation to support I.V. therapy services may result in the retraction of reimbursement.

DMAS forms are located on the Medicaid Web Portal at https://www.virginiamedicaid.dmas.virginia.gov/wps/portal.

Documentation Requirements for Reimbursement of Apnea Monitors and Diagnostic Studies

For the initial 120 days which do not require service authorization, there must be a CMN/DMAS-352 stating the individual's diagnosis that indicates the need for a monitor or a description of the individual's condition.

All of the following documentation (listed in number 1 and 2) is required for the continued use of an apnea monitor over 120 days:

1. A CMN/DMAS-352 and documentation outlining the condition of the individual related to apnea in the previous 120 days of monitoring, including all of the following:
    2. The dates and the number of occurrences of observed apnea;
    3. An interpretation of any related diagnostic tests;

        For example: an upper GI series for GE reflux; pneumograms or downloads for recording apnea monitors, that are interpreted and indicate the child had clinically significant apnea during the first 120 days and/or the condition is resolving;

c. Download reports with clinical interpretation from recording monitors. The practitioner is encouraged to order a pneumogram for those children on non-recording apnea monitors in order to document the clinical status;
d. Adequate and verifiable documentation of the oxygen flow rate for those individuals who continue on oxygen; and
e. Adequate and verifiable documentation of the month of death of any sibling who expired due to Sudden Infant Death Syndrome (SIDS) if the child was placed on the monitor for this reason; and

2. A comprehensive history and record of physical examination, with appropriate work-up including specific pulmonary studies as indicated (i.e., sleep airway studies and fluoroscopy, transcutaneous oxygen, pulse oximetry, recording monitor download analysis, and carbon dioxide monitor findings or pneumogram studies).

Documentation for pneumograms, polysomnagrams, and multi-channel sleep studies must specify the number of signals, what signals are to be done, and whether or not interpretation is to be done. Documentation must include the download documentation and a wave form analysis.

Documentation on the CMN/DMAS-352 must specify the number of signals, what signals are to be done and whether or not interpretation is to be done. Documentation must also include the download findings and a wave form analysis. A summary report of the study and all other required documentation must be maintained at the provider's location.

Documentation Requirements for Oxygen

The CMN/DMAS-352 must include all of the following:

- A diagnosis of the disease requiring home use of oxygen;
- The oxygen flow rate;
- An estimate of the frequency, duration of use (e.g., 2 liters per minute, 12 hours a day) and duration of need (e.g., six months or lifetime).
- Oxygen that is ordered PRN must include justification to determine the amount of oxygen that is reasonable and necessary for the individual; and
- Blood gas study results.

The CMN/DMAS-352 or supporting documentation signed and dated by the practitioner must also include the results of a blood gas study ordered and evaluated by the attending practitioner.

Documentation Requirements for Pulse Oximetry

The practitioner must document on the CMN/DMAS-352 or in supporting documentation

that the individual's condition meets one of the criteria (see Ch. 4) and provides evidence of all of the following:

- Pulse oximetry readings are necessary on a daily basis in order for the individual to remain in the home;
- The individual does not have a condition which contraindicates the effective use of pulse oximetry (e.g., oxygen toxicity is a concern);
- Alternative treatments which have been attempted (e.g., periodic arterial blood gases); and
- Why periodic pulse oximetry readings (e.g., pulse oximetry reading submitted bimonthly showing SaO2 trends over a specified period of time) would not meet the practitioner's need for monitoring.

In addition, the practitioner must specify the current oxygen flow rate and the assessment parameters: the setting at which the device should be set to alarm and the intervention response or corrective action to be taken (e.g., increase oxygen to 50%, increase oxygen to 2 L/min.).

Documentation Requirements General Information

The DME provider must provide equipment and supplies as prescribed by the physician on the CMN/DMAS-352. The CMN/DMAS-352 shall not be changed, altered, or amended after the attending physician signature date. If changes in the ordered DME or supplies are necessary, as indicated by the individual's condition, the DME provider must obtain a new CMN/DMAS-352. All CMN/DMAS-352's must be signed and dated by the attending physician within 60 days from the time ordered supplies are furnished by the DME provider (CMN/DMAS-352 begin date). (12 VAC 30-50-165)

DME providers shall retain copies of the CMN/DMAS-352 and all applicable supporting documentation on file for post payment audit reviews. Durable medical equipment and supplies that are not ordered on the CMN/DMAS-352 for which reimbursement has been made by Medicaid will be retracted. Supporting documentation is allowed to justify the medical need for durable medical equipment and supplies. Supporting documentation does not replace the requirement for a properly completed CMN/DMAS-352. The dates of the supporting documentation must coincide with the dates of service on the CMN/DMAS-352 and the medical practitioner providing the supporting documentation must be identified by name and title. DME providers shall not create or revise CMN/DMAS-352's or supporting documentation for durable medical equipment and supplies provided before or after the post payment audit review has been initiated. (12VAC 30-60-75)

Some items in the "Appendix B: Durable Medical Equipment and Supplies Listing" of this manual do not have a fee and indicate that a fee is determined by individual consideration (I.C.). In those cases the provider submits for service authorization and provides documentation of their cost. This cost may be an estimate or a quote. The reimbursement

amount is determined by adding 30% to the providers cost for the item. Upon receipt of the manufacturer's invoice, if the cost is less than reported on service authorization, the provider must only bill 30% over the cost of that item. Likewise, if the cost is more than the original estimates, the provider may submit a change request to the service authorization contractor for consideration (See Appendix D of this manual for more service authorization information). The actual cost of the item billed must be documented in the individual's record.

DME Provider Documentation Responsibilities for DME and Supplies

To receive reimbursement, the DME provider must have evidence of the following documentation:

- Maintain a copy of the physician's orders (CMN) and all verifiable supporting documentation for all durable medical equipment/supplies ordered;
- Document and justify the description of services (labor, repairs, maintenance of equipment);
- Document and justify the medical necessity of all items and supplies as described in Chapter IV of this manual; and
- Once medical necessity (i.e. incontinence) is established the decision to use tab diapers or pull ups shall be left to the individual or caregiver and shall be documented by the provider on the CMN/DMAS-352; and
- Document all equipment and supplies provided to an individual in accordance with the physician's orders. The delivery ticket/proof of deliver must document the information described under the "Proof of Delivery" section below.

Miscellaneous HCPCS and Individual Consideration (IC)

All of the following must be provided and kept on file in the member's record:

- A complete description of the item(s) being supplied;
- A copy of the supplier's invoice or the dealer cost information to document the cost of the item(s);
- Any discount received; and
- MSRP for durable items. MSRP is not required for expendable supplies if it is not available from the manufacturer or supplier.

The manufacturer's invoice, the dealer's price list showing the dealer's cost of the item, or a statement from the manufacturer detailing estimates of cost for specially designed item, are all acceptable documentation. The documentation must include the manufacturer's cost, any discounts provided to the provider, and the provider's ancillary cost of providing the DME and/or supplies to the member. Documentation of the actual cost of the item

billed must be in the member's record.

Providers must make sure that the Invoice, CMN/DMAS-352 and delivery ticket are clearly documented for the auditors and service authorization contractor to discern. For example, if the provider has multiple lines of items on a CMN/DMAS-352, the provider should make sure the invoice and delivery ticket are clearly correlated to the items on the CMN/DMAS-352. This can be done by highlighting, numbering or another method that demonstrates which item correlates to the same item on the CMN/DMAS-352, invoice and/or delivery ticket.

Proof of Delivery

Delivery tickets must contain all of the following:

- The individual's name and Medicaid number **or** date of birth or a unique identifiers (for example, an individual's medical record number);
- A detailed description of the item being delivered. The product name and brand;
- The serial number or product number of the durable medical equipment or supplies if available, not required;
- The quantity that was delivered;
- The signature of the individual, caretaker, or their designee. The designee's signature on the delivery ticket shall be legible. If it is not legible, the supplier must note the name of the designee on the delivery ticket;
- Providers or anyone else having a financial interest in the delivery of an item shall not sign or accept an item on behalf of a Medicaid individual.

Refills or Repeat Orders

- Providers shall make affirmative contact with the individual/caregiver prior to dispensing repeat orders or refills to assure that the item is still needed, the amount is still appropriate and the individual still resides at the same location. The provider must contact the individual prior to each delivery. This contact should take place no sooner than 7 days prior to the delivery/ship date and must be documented in the individual's record. If no affirmative contact is made with the individual or caregiver the monthly refill should not be delivered until affirmative contact is made. Providers should make the individual/caregiver aware of this policy from the start of services and document this conversation in the member's record. Providers can use the mail for affirmative contact; however, if a mailing is being used for monthly contact the provider shall have in person contact (face to face, by phone, or via electronic means such as use of a provider's web based portal or ordering system) prior to annual recertification on the CMN/DMAS-352.
- Providers shall not deliver refills sooner than 5 days prior to the end of usage. For example, they may not deliver all cases of incontinence briefs for a two month period on one date.

Shipping

- If a commercial shipping service is used, the provider's records must reference, in addition to the above information, the delivery services' package identification number, and a copy of the delivery ticket from the delivery service (this may be a printed from an on-line record on the delivery service's website). The delivery service's identification number must be on the provider's delivery ticket. It is recognized that commercial delivery services may not obtain a signature of the receiving party. Therefore, this documentation will substitute for the individual's signature above as proof of delivery.
- Providers may use a return postage-paid delivery invoice from the individual or designee as a form of proof of delivery. The descriptive information concerning the item(s) delivered, as described above, as well as the required signature/date from either the individual or designee should be included on this invoice as well.

Billing and Delivery

Providers shall not bill for dates of service prior to delivery. The provider must confirm receipt (shipping service record showing the item was delivered is acceptable) prior to billing.

For repeat orders only: Since DMAS allows the provider to ship repeat orders no sooner than five (5) days prior to the end of usage, the provider will need to bill for the item on the date of the refill month and not the delivery date to avoid overlapping claims. This should be documented in the individual's record and only done for repeat monthly orders. For example: If an individual's first months delivery was on January 1st the refill for the 2nd month and all proceeding months should also be on the 1st of the month. For billing purposes the provider should bill delivery on the 1st of the month for this member even though they may have delivered up to five (5) days prior to the 1st of the month.

Discharges from a Hospital or Nursing Facility

DME equipment and supplies delivered for home or community use for individuals being discharged from a hospital or nursing facility DME may be delivered to the facility prior to discharge; however, the claim date of service may not begin prior to the date of discharge from the hospital or nursing facility.

DMAS RESPONSIBILITY – QUALITY MANAGEMENT REVIEW (QMR) FOR DME AND SUPPLIES

DMAS or its contractor will conduct either a desk review or an on-site quality management review (QMR) for enrolled DME and Supply providers. Such post payment review audits may be unannounced. Medical records of individuals currently receiving DME and Supplies as well as a sample of closed records may be reviewed. DMAS may also conduct an on-site

investigation of any complaints that are received.

DMAS staff or its contractors may visit Medicaid individuals in their homes and conduct a professional review (covering physical, emotional, social, and cognitive factors) with respect to all of the following:

- Care being provided to the Medicaid individual by the DME and Supplies provider;
- Adequacy of the services available to meet current health needs and to provide the maximum physical and emotional well-being of each individual;
- Necessity and desirability of the continued service to the individual;
- Feasibility of meeting the individual's health needs in alternate care arrangements;
- Verification of the existence of all documentation required by Medicaid,

  regardless of whether or not the item has been preauthorized; and

- Determination if the item billed was received by the individual.

NOTE: Services/items not specifically documented in the individual's DME medical record as having been rendered or received, as described under Proof of Delivery, shall be deemed not to have been rendered, and no reimbursement shall be provided. Supporting documentation is allowed to justify the medical need for DME and supplies, but supporting documentation does not replace the requirement for a properly completed CMN/DMAS-352. (12 VAC 30-60-75)

Following a post payment review, a report will be written detailing the findings of the utilization review. Based on the review report and recommendations, DMAS or its contractor may request a corrective action plan. (12 VAC 30-60-75) Actions taken and the level of management involved will be based on the severity of the cited deficiencies which adversely affect the health and safety of the individuals, the quality of life of the individuals, or utilization control regulations.

If DMAS or its contractor requests a corrective action plan, the DME provider must submit the corrective action plan within 30 days of the receipt of the utilization review findings report, to DMAS or its contractor.

Subsequent contact may be made to the provider for the purpose of follow-up of deficiencies or problems, complaint investigations, or to provide technical assistance.

DMAS or its contractor will deny or retract payment from the DME provider if any of the following occur, but are not limited to (12 VAC 30-60-75):

- No current, fully completed CMN/DMAS-352 (physician's order), appropriately signed and fully dated by the physician;
- Documentation does not verify that the DME item was provided to and received by the individual;
- Lack of medical documentation, signed and dated by the physician, to justify the DME and supplies; or
- Item is non-covered or does not meet DMAS criteria for reimbursement.

I. reimbursement is denied by Medicaid, the DME provider shall not bill the Medicaid individual for the service that was provided.

Medical Records and Record Retention (DME)

The provider must ensure the confidentiality of individual record information and provide safeguards against loss, destruction, or unauthorized use. Written procedures must govern record use and removal and the conditions for the release of information. The individual or his/her authorized representative's written consent is required for the release of information not authorized by law. Current individual records and those of discharged individuals must be fully completed and in a timely manner. All clinical information pertaining to an individual must be centralized in the individual's record. All information should meet all established guidelines for the Health Insurance Portability and Accountability Act (HIPAA) compliance and security of records.

The provider must maintain records on all individuals who were provided DME supplies for a minimum of not less than six (6) years from the last date of service. For minors records must be retained for at least six (6) years after such minors have reached 21 years of age in accordance with accepted professional standards and practice. The records must be

completely and accurately documented, readily accessible, legible, and systematically organized to facilitate the retrieval and compilation of information. All DME record entries must be fully signed and dated (month, day, and year), including the title (professional designation) of the author.

Electronic Signatures (DME)

The Department of Medical Assistance Services' (DMAS) clarified written policy regarding the use of electronic signatures for clinical documentation purposes. Provider failure to properly maintain or authenticate medical records (signed and dated entries) may result in the retraction of Medicaid payments.

An electronic signature that meets the following criteria is acceptable for clinical documentation:

- Identifies the individual signing the document by name and title;
- Assures that the documentation cannot be altered after the signature has been affixed by limiting access to the code or key sequence; and,
- Provides for nonrepudiation; that is, strong and substantial evidence that will make it difficult for the signer to claim that the electronic representation is not valid.

Use of 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 have written policies and procedures in effect regarding use of electronic signatures. In addition to complying with security policies and procedures, providers who use computer keys or codes of electronic signatures, must sign a statement assuring that they alone will have access to and use the key or codes, or computer password. The policies and procedures and statements of exclusive use must be maintained and available at the provider's location. Additionally, the use of electronic signatures must be consistent with the applicable accrediting and licensing authorities and the provider's own internal policies. These requirements for clinical documentation apply only to Medicaid claims, and do not preclude other state or federal requirements.

Fraudulent Claims (DME)

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 Medicaid 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 Virginia Medicaid 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 and all of their employees are responsible for reading and adhering to applicable State and federal regulations and to the requirements set forth in this manual. 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 the Department of Medical Assistance Services 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

Division of Program Integrity

Department of Medical Assistance Services

600 East Broad Street

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 addressed to:

Director, Medicaid Fraud Control Unit

Office of the Attorney General

900 E. Main Street, 5th Floor

Richmond, Virginia 23219

Individual Fraud

Allegations about fraud or abuse by members are investigated by the Division of Program Integrity of the Department of Medical Assistance Services. The Division focuses primarily on determining whether members misrepresented material facts on the application for Medicaid benefits or failed to report changes that, if known, would have resulted in ineligibility. The Division 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 individuals 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:

Program Integrity Division

Department of Medical Assistance Services

600 East Broad Street

Richmond, Virginia 23219

Referrals to the Client Medical Management Program (PP)

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 clients will be reviewed by DMAS staff to determine if the utilization meets regulatory criteria for restriction to a primary physician and 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 clients 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

Fax: (804) 371-8891

When making a referral, provide the name and Medicaid number of the client 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.

Contact Information for Provider Questions (DME)

Upon review of this manual, if DME providers continue to have clinical or documentation related questions, providers have the following options:

- The "Ask Questions" link on the DMAS website, listed under the Long-Term Care and Waiver Services section. The link access is; http://www.dmas.virginia.gov/Content_pgs/ltc-faq_form.aspx
- Questions may be directed to the DMAS DME e-mail address at:
- Virginia Medicaid Web Portal at:

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

- Billing or Policy Questions, call the DMAS Provider Helpline at:

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

  1-800-552-8627 All other areas (in-state, toll-free long distance

The helpline is for provider use only. Providers must have their Medicaid National Provider Identification Number (NPI) available when calling.

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.

Term	Definition
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.
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.

Term	Definition
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.
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.

Term	Definition
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.
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).

Term	Definition
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
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.

Term	Definition
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.
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.

Term	Definition
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.
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.

Term	Definition
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.
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.

Term	Definition
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.
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.

Term	Definition
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.
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.

Term	Definition
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.
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.

Term	Definition
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.
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.

Term	Definition
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.
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.

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

Appendix D: Service Authorization Information (DME)

Updated: 7/13/2022

Service Authorization (Srv Auth) is the process to approve specific services for an enrolled Medicaid, FAMIS Plus, FAMIS or FAMIS MOMS individual by a Medicaid enrolled provider prior to service delivery and reimbursement. Some services do not require Srv Auth and some may begin prior to requesting authorization.

Purpose of Service Authorization

The purpose of service authorization is to validate that the service requested is medically necessary and meets DMAS criteria for reimbursement. Service authorization does not guarantee payment for the service; payment is contingent upon passing all edits contained within the claims payment process, the individual's continued Medicaid/FAMIS eligibility, the provider's continued Medicaid eligibility, and ongoing medical necessity for the service. Service authorization is specific to an individual, a provider, a service code, an established quantity of units, and for specific dates of service. Service authorization is performed by DMAS or by a contracted entity. Medallion 3 MCO-enrolled members are subject to service authorization requirements of the individual's MCO.

General Information Regarding Service Authorization

Various submission methods and procedures are fully compliant with the Health Insurance Portability and Accountability Act (HIPAA) and other applicable federal and state privacy and security laws and regulations. Providers will not be charged for submission, via any media, for Srv Auth requests.

The Srv Auth entity will approve, pend, reject, or deny all completed Srv Auth requests. Requests that are pended or denied for not meeting medical criteria are automatically sent to medical staff for review. When a final disposition is reached the individual and the provider is notified in writing of the status of the request.

Changes in Medicaid Assignment

Because the individual may transition between fee-for-service and the Medicaid managed care (MCO) program, the Srv Auth entity will honor the Medicaid MCO service authorization if the client has been retroactively disenrolled from the MCO. Similarly, the MCO will honor the Srv Auth Contractor's authorization based upon proof of authorization from the provider, DMAS, or the Srv Auth Contractor that services were authorized while the member was eligible under fee- for-service (not MCO enrolled) for dates where the member has subsequently become enrolled with a DMAS contracted MCO Srv Auth decisions by the DMAS Srv Auth Contractor are based upon clinical review and apply only to individuals enrolled in Medicaid fee-for-service on dates of service requested. The Srv Auth Contractor decision does not guarantee Medicaid eligibility or fee-for-service enrollment. It is the provider's responsibility to verify member eligibility and to check for managed care organization (MCO) enrollment. For MCO enrolled members, the provider must follow the MCO's Srv Auth policy and billing guidelines.

Commonwealth Coordinated Care Plus (CCC Plus) Program

Members Transitioning into CCC Plus

For members that transition into the CCC Plus Program, the CCC Plus Health Plan will honor the Srv Auth contractor's authorization for a period of not less than 90 days or until the Srv Auth ends whichever is sooner, for providers that are in-and out-of-network.

When a member enrolls in CCC Plus, the provider should contact the CCC Plus Health Plan to obtain an authorization and information regarding billing for services if they have not been contacted the CCC Plus Health Plan.

Members Transitioning from CCC Plus and Back to Medicaid Fee-For Service (FFS)

Should a member transition from CCC Plus to Medicaid FFS, the provider must submit a request to the Srv Auth Contractor and needs to advise the Srv Auth Contractor that the request is for a CCC Plus transfer within 60 calendar days. This will ensure honoring of the approval for the continuity of care period and waiving of timeliness requirements. The Srv Auth Contractor will honor the CCC Plus approval up to the last approved date but no more than 60 calendar days from the date of CCC Plus disenrollment under the continuity of care provisions. For continuation of services beyond the 60 days, the SA Contractor will apply medical necessity/service criteria.

Should the request be submitted to the Srv Auth Contractor after the continuity of care period:

A. The dates of service within the continuity of care period will be honored for the 60-day timeframe;
B. The dates of service beyond the continuity of care period, timeliness will be waived and reviewed for medical necessity, all applicable criteria will be applied on the first day after the end of the continuity of care period
C. For CCC Plus Waiver Services, cap hours will be approved the day after the end of the continuity of care period up to the date of request. The continuation of service units will be dependent upon service criteria being met and will either be authorized or reduced accordingly as of the date of the request.

The best way to obtain the most current and accurate eligibility information is for providers to do their monthly eligibility checks at the *beginning* of the month. This will provide information for members who may be in transition from CCC Plus at the very end of the previous month.

Should there be a scenario where DMAS has auto closed (ARC 1892) the SA Contractor's service authorization but the member's CCC Plus eligibility has been retro-voided, continuity of care days will not be approved by the CCC Plus health plan and will not be on the transition reports since the member never went into CCC Plus. The SA Contractor will re-open the original service authorization for the same provider upon provider notification.

CCC Plus Exceptions:

The following exceptions apply:

- If the service is not a Medicaid covered service, the request will be rejected;
- If the provider is not an enrolled Medicaid provider for the service, the request will be rejected. (In this situation, a Medicaid enrolled provider may submit a request to have the service authorized; the Srv Auth Contractor will honor the CCC Plus approved days/units under the continuity of care period for up to 60 calendar days. The remaining dates of services will be reviewed and must meet service criteria but timeliness will be waived as outlined above.)
- If the service has been authorized under CCC Plus for an amount above the maximum allowed by Medicaid, the maximum allowable units will be authorized.
- Once member is FFS, only Medicaid approved services will be honored for the continuity of care.
- If a member transitions from CCC Plus to FFS, and the provider requests an authorization for a service not previously authorized under CCC Plus, this will be considered as a new request. The continuity of care will not be applied and timeliness will not be waived.

When a decision has been rendered for the continuity of care/transition period and continued services are needed, providers must submit a request to the Srv Auth Contractor according to the specific service type standards to meet the timeliness requirements. The new request will be subject to a full clinical review (as applicable).

DMAS has published multiple Medicaid memos that can be referred to for detailed CCC Plus information. For additional information regarding CCC Plus, click on the link: http://www.dmas.virginia.gov/Content_pgs/mltss-home.

The Governor's Access Plan (GAP) (Fee-for-Service Members)

Some GAP members will remain in fee-for-service and will receive their medical service authorization through DMAS' Service Authorization Contractor, Keystone Peer Review Organization (KEPRO). The services received through fee-for-service will not changes from the current GAP services. These members will **not** receive the new Medicaid Expansion benefits and will continue to use their GAP identification card through March

31, 2019, when the GAP program ends. KEPRO will accept requests for GAP (medical) services through March 31, 2019 at 11:59 pm. Requests received on and after April 1, 2019 will be rejected.

The Governor's Access Plan (GAP) for medical and behavioral health services is restricted to Virginia adults (ages 21 through 64) who have a serious mental illness. The GAP benefit plan includes limited medical coverage where some of these services require service authorization through DMAS' Service Authorization Contractor, Keystone Peer Review Organization (KEPRO). Service authorization is required for the following Traditional medical services:

- Non-emergent, outpatient Magnetic Resonance Imaging (MRI scan) *
- Non-emergent, outpatient Computerized Axial Tomography (CAT scan) *
- Durable Medical Equipment: limited to overage Diabetic Supplies only
- Surgical Procedures (specific procedure codes only)
- Medical Device Services/Maintenance (specific procedure/HCPCS codes only)

*Only services performed in outpatient facility settings. All others limited to physician's office only. Physician office includes Health Department Clinics, Rural Health Clinics (RHC), and Federally Qualified Health Clinics (FQHC).

Should a service require service authorization under the GAP benefit plan, providers must submit a request according to the specific service type standards to meet the timeliness requirements (when appropriate) as well as medical documentation to meet the service specific criteria.

The specific DME diabetic supply codes covered by GAP are included in the Durable Medical Equipment and Supplies Manual, Appendix B, "Diabetic Products" section. Providers should review Chapter IV and Appendix B to determine medical necessity criteria, the allowable amount for each code (no service authorization required) and any overage amount that requires service authorization.

Refer to KEPRO's website http://dmas.kepro.com/ for procedure codes and HCPCS codes that are included in the GAP benefit and require service authorization by KEPRO. All codes are subject to change so providers must refer to KEPRO's website for any updates. Information may be found on the DMAS website, Service Authorization section, at the following link: http://www.dmas.virginia.gov/Content_pgs/pa-home.aspx.

For general GAP information, refer to the GAP Supplement C found on the DMAS web portal, Provider Services, Provider Manuals section. The GAP link also provides useful information: http://www.dmas.virginia.gov/Content_pgs/GAP.aspx.

Service Authorization: Communication

Provider manuals are located on the DMAS and KEPRO websites. The contractor's website has information related to the service authorization processes for programs identified in this manual. You may access this information by going to http://dmas.kepro.com and clicking on the *Forms* tab for fax forms to request services. A service specific checklist may be found by clicking on "Service Authorization Checklists" on KEPRO's website. For educational material, click on the *Training* tab and scroll down to click on the *General* or *Outpatient* tab.

The Srv Auth entity provides communication and language needs for non-English speaking callers free of charge and has staff available to utilize the Virginia Relay service for the deaf and hard-of- hearing.

Updates or changes to the Srv Auth process for the specific services outlined in this manual will be posted in the form of a Medicaid Memo to the DMAS website. Changes will be incorporated within the manual.

Submitting Requests for Service Authorization

Service Authorization reviews will be performed by DMAS' service authorization contractor, Keystone Peer Review Organization, (KEPRO). All submission methods and procedures are fully compliant with the Health Insurance Portability and Accountability Act (HIPAA) and other applicable federal and state privacy and security laws and regulations. Providers will not be charged for submission, via any media, for service authorization requests submitted to KEPRO.

There are no automatic renewals of service authorizations. Providers must submit a service authorization request if a member requires continued services or the current authorization will end without renewal.

KEPRO accepts service authorization (srv auth) requests through direct data entry (DDE), fax, phone and US mail. The preferred method is by DDE through KEPRO's provider portal, Atrezzo Connect. To access Atrezzo Connect on KEPRO's website, go to http://dmas.kepro.com. For direct data entry requests, providers must use Atrezzo Connect Provider Portal.

Provider Registration is Required to use Atrezzo Connect

The registration process for providers happens immediately on-line. From http://dmas.kepro.com, providers not already registered with Atrezzo Connect may click on the Atrezzo icon on the website to register. Newly registering providers will need their 10-digit National Provider Identification (NPI) number and their most recent

remittance advice date for YTD 1099 amount.

The Atrezzo Connect User Guide is available at http://dmas.kepro.com: Click on the *Training* tab, then the *General* tab.

Providers with questions about KEPRO's Atrezzo Connect Provider Portal may contact KEPRO by email at atrezzoissues@kepro.com. For service authorization questions, providers may contact KEPRO at providerissues@kepro.com. KEPRO may also be reached by phone at 1-888-827-2884, or via fax at 1-877-OKBYFAX or 1-877-652-9329.

KEPRO's website has information related to the service authorization processes for all Medicaid programs they review. Fax forms, service authorization checklists, trainings, methods of submission and much more are on KEPRO's website. Providers may access this information by going to http://dmas.kepro.com.

Processing Requests at KEPRO:

KEPRO will approve, pend, reject, or deny requests for service authorization. When a final disposition is reached KEPRO notifies the member and the provider in writing of the status of the request through the MMIS letter generation process.

If there is insufficient information to make a final determination, KEPRO will pend the request back to the provider and request additional information. If the information is not received within the time frame requested by KEPRO, the request will automatically be sent to a physician for a final determination with all information that has been submitted. Providers and members are issued appeal rights through the MMIS letter generation process for any adverse determination. Instructions on how to file an appeal is included in the MMIS generated letter.

If services cannot be approved for members under the age of 21 using the current criteria, KEPRO will then review the request by applying EPSDT criteria.

The MMIS generates letters to providers, case managers, and members depending on the final determination. DMAS will not reimburse providers for dates of service prior to the date(s) identified on the notification letter. All final determination letters, as well as correspondence between various entities, are to be maintained in the individuals file, and are subject to review during post payment review. Please see additional requirements in Chapter VI of this manual.

The following documentation is required in order to determine if the individual meets criteria:

(1) Certificate of Medical Necessity (CMN), unless items meet exception criteria stated in Chapter IV; (2) Supporting documentation verifying item specific coverage criteria

stated in Chapter IV; and (3) Documentation of usual and customary charges or cost as necessary for each HCPCS code used from Appendix B.

All items and supplies must meet the coverage criteria in Chapter IV of this manual and the Virginia Administrative Code. In addition, DMAS requires specific categories of items meet the InterQual criteria. These categories are: adaptive strollers, nebulizers (including compressors), augmentative communication devices (AAC and speech generating devices), continuous passive motion devices, cranial molding orthosis, oxygen, hospital beds, insulin pumps, lower extremity orthosis (knee braces and immobilizers), lymphedema compression devices, manual wheelchairs, negative pressure wound therapy devices, CPAP and BiPAP devices, power wheelchairs and scooters, seat lift mechanisms (not lift chairs), secretion clearance devices, standing frames, support surfaces, TENS, wheelchair cushions and seating systems.

The above list is subject to change with InterQual updates and DMAS discretion.

- The medical justification provided to the Service Authorization Contractor must meet the DME InterQual Criteria upon review. These criteria may be obtained through:

McKesson Health Solutions LLC

275 Grove Street

Suite 1-110

Newton, MA 02466-2273

Telephone: 800-274-8374

Fax: 617-273-3777

Website: www.mckesson.com or www.InterQual.com

Subsequent Recertification Review

Prior to the end of the last authorized date, the provider should submit the required documents for continued service authorization. The documentation will be reviewed to determine if it meets DMAS criteria and documentation requirements found in Chapters IV and VI of this manual, including the practitioner’s signature and date on the certificate of medical necessity. The DMAS service authorization contractor will make a decision to approve, pend, deny, or reject the request. If approved, the service authorization contractor will authorize a specific number of units and dates of service based on the documentation submitted.

Face-to-Face Encounter for Fee-for-Service DME

This only applies to FFS members and not those enrolled in one of DMAS' managed care plans. Beginning July 1, 2017, no payment shall be made for new DME (as defined in 12VAC30-50-165) unless a face-to-face encounter has been performed by an approved practitioner (outlined below) no more than six (6) months prior to the begin service date. The face-to-face encounter shall be related to the primary reason the individual enrolled in Medicaid requires DME.

The face-to-face encounter for DME must be conducted by one of the following four (4) practitioners:

- A physician licensed to practice medicine;
- A licensed nurse practitioner or licensed clinical nurse specialist within the scope of their practice under state law, working in collaboration and with a practice agreement with the physician who orders the Medicaid individual's services;
- A licensed physician assistant within the scope of their practice under state law and working under the supervision of the physician who orders the individual's services; or
- For individuals requiring DME immediately after an acute or post-acute stay, the attending acute or post-acute physician.

The practitioner performing the face-to-face encounter must document the clinical findings in the individual's medical record and communicate the clinical findings of the encounter to the ordering physician.

Providers must use the revised CMN form to document the new requirements. Completion of all elements related to the face-to-face requirements on the CMN will satisfy the face-to-face encounter documentation requirements.

Please refer to Chapters IV and VI of the DME Provider Manual for DME items that require service authorization. When a face-to-face encounter is required, providers must, during the service authorization process, "attest" that the face-to-face encounter requirement has been met. For those items that do not require a service authorization, the CMN with the face-to-face encounter documentation should be maintained in the individual's medical record.

NOTE: A face-to-face encounter is only required for Medicaid DME items that also require a face- to-face encounter under the Medicare program. If a face-to-face encounter is not required for a specific DME item under the Medicare program, then it is not required for the Medicaid program. For a list of fee-for-service DME codes that require a face-to-face, please refer to Chapters IV and VI of the DME Provider Manual.

Service Authorization for Breast Pumps for Pregnant and Postpartum Women

Coverage of breast pumps, for pregnant and postpartum women enrolled in the fee-for-service Medicaid/FAMIS/FAMIS MOMS benefits is effective January 1, 2016. (Refer to DMAS Memo dated December 2015.) Please note that as of July 1, 2022, Medicaid and FAMIS MOMS coverage is effective for the duration of pregnancy and for a 12-month postpartum period beginning on the last day of the pregnancy and including any remaining days of the calendar month in which the 12-month period ends. See also Chapter IV and Appendix B of this manual. The DMAS contracted MCOs currently cover breast pumps for their enrolled members.

Breast Pumps

DMAS will cover a manual or standard electric breast pump as medically necessary for the initiation or continuation of breastfeeding (up to the child's first birthday). These breast pump codes are available as of January 1, 2016:

- E0602 Manual breast pump, purchase – does **not** require service authorization;
- E0603 Single user electric breast pump, purchase – requires service authorization;
- E0604 Multi-user (Hospital grade) electric pump, rental – requires service authorization;
- E1399 Additional collection kit for use with the single and multi-user electric breast pumps - requires service authorization.

E0603 - Single user electric breast pumps - purchase

A personal use electric breast pump is designed for mothers who are breastfeeding without problems. A personal use electric breast pump is defined as a double electric (AC and/or DC) pump, intended for a single user and is capable of being used multiple times per day. Payment includes supplies necessary for operation of the pump (pump, adapter/charger, breast shields, bottles, lids, tubing, locking ring, connectors, valves, filters and membranes). DMAS medical necessity criteria as follows:

- Mother must express the desire to breastfeed;
- The pump must be FDA registered;
- The pump has a minimum one-year manufacturer's warranty; and
    - The pump must have a mechanism to prevent suction beyond 250 mm Hg to prevent nipple trauma.

Limits: One purchase every three (3) years. Request must be medically justified. Request duration is 30 days (for pick up/delivery). DMAS allows for one additional purchase every three years with medical justification.

E0604 – Multi-user (Hospital grade) electric pumps - rental

Multi-user/Hospital grade electric pumps are designed to initiate and maintain a milk supply when a baby is not feeding well. The pump must be FDA registered and have a mechanism to prevent

suction beyond 250 mm Hg to prevent nipple trauma.

DMAS coverage of hospital grade rental pumps must meet the medical necessity criteria below:

- When the infant is premature at 24-34 weeks of gestation, and the mother is pumping

  breast milk, awaiting the baby's ability to nurse directly from the breast;

- When the infant is premature at 35-37 weeks of gestation and continues to experience difficulty coordinating suck and swallow, and the mother is pumping breast milk, awaiting the baby's ability to nurse directly from the breast;
- For infants with cleft lip and/or palate or ankyloglossia who are not able to nurse directly

  from the breast;

- For infants with cardiac anomalies or any medical condition that makes them unable to

  sustain breast feeding due to poor coordination of suck and swallow or fatigue;

- For multiples (including twins), until breast-feeding at the breast is established consistently;
- When the mother has an anatomical breast problem, which may resolve with the use of

  breast pump, such as insufficient glandular tissue;

- For any infants for medical reasons who are temporarily unable to nurse directly from the

  breast, such as NICU babies, or during any hospitalization of the mother or baby which will

  interrupt nursing; or

- When the infant has poor weight gain related to milk production and pumping breast milk

  is an intervention in the provider's plan of care and infant has a documented weight loss of 7% or greater despite use of conventional breast pump.

A hospital grade breast pump is not medically necessary when one of the above criteria are not met or when it is requested solely to allow for the mother's return to work or mother's or family convenience.

Limits: Up to 6 months initial rental period based on medical necessity. 12-month **maximum** rental period per member with medical justification. Requests for additional months after the initial 6 months must include why purchase of a single user electric pump (E0603) will not meet member's needs.

E1399 – Collection kits for use with the single and multi-user electric breast pumps

One collection kit for electric breast pumps includes necessary supplies and collection containers. The service limit is one additional kit per single or multi-user electric breast pump authorization.

Providers must include medical justification when requesting an additional kit. Each breast pump includes an initial collection kit. Providers must bill their Usual and Customary Charge (UCC). Additional collection kits have a maximum reimbursement rate; 1 unit equals 1 kit. **There is no mark up for additional collection kits.**

Limits: One (1) per service limit period for single-user and multi-user electric pumps. Request must be medically justified; provider must indicate pump is owned or rental and that the additional collection kit is appropriate for member owned (or rental) pump. Request duration: 30 days (for pick up/delivery).

DME providers must submit medical justification to KEPRO when requesting these codes. Providers must have a completed CMN (DMAS 352) on file.

Service Authorization Out of State Provider Information

Effective March 1, 2013, there is a change in the policy and procedure for out-of-state requests submitted by out-of-state providers. This change impacts out-of-state providers who submit Virginia Medicaid service authorization requests to Keystone Peer Review Organization (KEPRO), DMAS' service authorization contractor, and any other entity to include, but not limited to, DMAS and the Department of Behavioral Health and Developmental Services (DBHDS) when providing service authorizations for the services listed in the DMAS memo dated February 6, 2013 and titled *"Notification of a Procedural Change for Out-of-state Providers Submitting Requests for Service Authorization Through KEPRO," which can be accessed at* https://www.virginiamedicaid.dmas.virginia.gov/wps/portal.

KEPRO's service authorization process for certain services will include determining if the submitting provider is considered an out-of-state provider. Out-of-state providers are defined as those providers that are either physically outside the borders of the Commonwealth of Virginia or do not provide year end cost settlement reports to DMAS. Please refer to the above referenced DMAS memo dated February 6, 2013. Additional information is provided below.

Specific Information for Out-of-State Providers

Out-of-state providers are held to the same service authorization processing rules as instate providers and must be enrolled with Virginia Medicaid prior to submitting a request for out-of- state services to KEPRO. If the provider is not enrolled as a participating provider with Virginia Medicaid, the provider is encouraged to submit the request to KEPRO, as timeliness of the request will be considered in the review process. KEPRO will pend the request back to the provider for 12 business days to allow the provider to become successfully enrolled.

If KEPRO receives the information in response to the pend for the provider's

enrollment from the newly enrolled provider within the 12 business days, the request will then continue through the review process and a final determination will be made on the service request.

If the request was pended for no provider enrollment and KEPRO does not receive the information to complete the processing of the request within the 12 business days, KEPRO will reject the request back to the provider, as the service authorization cannot be entered into MMIS without the providers National Provider Identification (NPI). Once the provider is successfully enrolled, the provider must resubmit the entire request.

Out-of-state providers may enroll with Virginia Medicaid by going to https://www.virginiamedicaid.dmas.virginia.gov/wps/myportal/ProviderEnrollment. At the toolbar at the top of the page, click on *Provider Services* and then *Provider Enrollment* in the drop down box. It may take up to 10 business days to become a Virginia participating provider.

Out-of-State Provider Requests

Authorization requests for certain services can be submitted by out-of-state providers. Procedures and/or services may be performed out-of-state only when it is determined that they cannot be performed in Virginia because it is not available or, due to capacity limitations, where the procedure and/or service cannot be performed in the necessary time period.

Services provided out-of-state for circumstances other than these specified reasons shall not be covered:

1. The medical services must be needed because of a medical emergency;
2. Medical services must be needed and the recipient's health would be endangered if he were required to travel to his state of residence;
3. The state determines, on the basis of medical advice, that the needed medical services, or necessary supplementary resources, are more readily available in the other state;
4. It is the general practice for recipients in a particular locality to use medical resources in another state.

The provider needs to determine which item 1 through 4 is satisfied at the time of the request to the Contractor. If the provider is unable to establish one of the four, the Contractor will:

· Pend the request utilizing established provider pend timeframes; and

· Have the provider research and support one of the items above and

submit back to the Contractor their findings.

"Effective September 12, 2016, KEPRO added additional questions to the Out-of-state Provider questionnaire (found on the Provider Portal):

a. Question #2-Are the medical services needed, will the recipient's health be endangered if required to travel to state of residence? If a provider answers "Yes", then additional question #2.1.1 asks: "Please explain the medical reason why the member cannot travel".
b. Question #5- "In what state is the provider rendering the service and/or deliveringthe item physically located?"
c. Question #6- "In what state will this service be performed?"
d. Question 7- "Can this service be provided by a provider in the state of Virginia? If a provider answers "No", then additional question #7.2.1: "Please provide justification to explain why the item/service cannot be provided in Virginia."

Should the provider not respond or not be able to establish items 1 through 4 the request can be administratively denied using ARC 3110. This decision is also supported by 12VAC30-10-120 and 42 CFR 431.52.

Service Authorization Process

The "Medicaid DME Supplies Listing"/Appendix B which is based on the Health Care Financing Administration Common Procedure Coding System (HCPCS), describes equipment and supplies and identifies those which require service authorization. Service authorization is required for items identified with a "Y" in the authorization column of the DME Listing/Appendix B, and for any item exceeding the established limits identified in the "limit" column of the DME Listing/Appendix B. **The DME Listing/Appendix B identifies the information above. It does not determine coverage of an item. Coverage criteria are in Chapter IV of the Durable Medical Equipment and Supplies Manual and the Virginia Administrative Code.**

Service authorization is requested by the enrolled DME provider and not by healthcare professionals involved with the enrollee's care. The provider completes and/or gathers the necessary documentation to meet the Medicaid criteria as described in Chapter IV of this manual.

When extended utilization or unusual amounts of equipment and/or supplies are required, the provider must request service authorization. If the item does not require service authorization or does not exceed the established limits, the provider may provide and bill for these items up to the established limit without service

authorization. If service authorization is required, service authorization must be obtained regardless of whether or not Medicaid is the primary payer, except for Medicare-crossover claims.

The purpose of service authorization is to validate that the service or item being requested is medically necessary and meets DMAS criteria for reimbursement. Service authorization does not automatically guarantee payment for the service. Payment is contingent upon passing all edits contained within the claims payment process; the member's continued Medicaid eligibility; and the ongoing medical necessity for the service being provided. Service authorizations are specific to a member, a provider, a service code, an established quantity, and for specific dates of service. (12 VAC 30-50-165)

Appendix B

The Appendix B is based upon the Healthcare Common Procedure Coding System (HCPCS), which describes equipment and supplies, coverage limitations, and service authorization requirements. Service authorization by Medicaid is not required when Medicare is the primary payer.

When extended utilization or unusual amounts or types of equipment or supplies are required, the provider must request service authorization from the Department of Medical Assistance Services' (DMAS) service authorization contractor. Items not identified in the Appendix B listing require service authorization and may be submitted for service authorization under the appropriate miscellaneous HCPCS code. Lack of a specific HCPCS code for the item does not determine coverage. The appropriate miscellaneous code may be used and submitted for service authorization.

Providers must maintain documentation in accordance with the coverage criteria, documentation requirements, and Certificate of Medical Necessity (CMN) requirements as defined in Chapters IV and VI of this Provider Manual, regardless of whether or not service authorization is required.

Miscellaneous HCPCS Codes

Miscellaneous codes may only be used when the item requested differs significantly in narrative description from the established HCPCS code. Miscellaneous codes will not be recognized for the sole purpose of cost variances. In order for the service authorization contractor to determine the appropriate reimbursement for miscellaneous items not in the Appendix B with a fee, all of the following information must be provided:

· A complete description of the item(s) being supplied;

- A copy of the manufacturer's/supplier's invoice or the dealer cost information to document the cost of the item(s);

· For any specially designed items, a statement from the manufacturer detailing cost; and

· Any discount received must be indicated.

The service authorization file in VAMMIS combines all like miscellaneous DME codes into one 'summary' line, which carries the status of AC (approved combined). Providers see the AC line on their service authorization notification report and in order to bill for miscellaneous DME lines, providers will need to total the authorized amounts as well as the authorized units for each of the miscellaneous codes and submit this total or 'summary line' amount as one-line item on the claim.

The provider should bill the total number of units and the total authorized fee once all supplies are delivered. If the provider does not deliver all units at one time the provider can follow the instructions below:

1. Submit a change request to the DMAS Srv Auth Contractor. The provider will request a change to the line item that was not delivered by either decreasing the number of units or voiding the line item for the DME/supplies that was not delivered and if necessary create a new service authorization for item not delivered;
2. Wait until all DME/supplies are delivered to submit the claim for reimbursement; or

3. If the provider has already billed for the all DME/supplies but has not delivered all units, the provider will need to adjust the claim. If it is found on post payment audit that the provider has billed all units but not delivered all units the provider may have funds retracted.

For DME items that have a national code but do not have a DMERC or rate for July 1, 2010 mark- up of 30 percent of the actual cost (less any discounts available to the DME provider), as determined by the service authorization contractor. If the provider receives a manufacturer/supplier discount and cost plus 30% mark-up equates to greater than the manufacturer's suggested retail price (MSRP), then reimbursement will be the MSRP. The provider should mark box 23 on the Outpatient Service Authorization Request Form/ DMAS 363 (7/2010) with the cost plus 30% mark up. The reimbursement will be based on the provider description of the item(s) or supplies. Providers should review instructions for the DMAS 363 form prior to completing the form. Adequate and complete descriptions, quantities, and the unit price are essential for the evaluation of the charge. Wherever possible, use the appropriate HCPCS codes.

Incontinence Supplies

Effective July 1, 2010, the Department will be changing the billing unit for incontinence supplies (diapers/pull-up/panty liners) from per 'case' to 'each'. See Chapter IV of this manual for details.

For Service Authorization Requests Submitted Through the DMAS Srv Auth Contractor On and After January 1, 2010

In order to facilitate the change from 'case' to 'each' providers should request service authorization (Srv Auth) through the DMAS Srv Auth Contractor through June 30, 2010 on a separate line of the request, identifying the number of cases needed. For requests with dates of service July 1, 2010 and forward, a separate line is needed identifying the number of each product being requested. Both lines may be submitted within the same request.

Any requests to change existing Service Authorizations must include the Srv Auth number, and reference 'cases' for dates of service through June 30, 2010 and reference 'each' for dates of service July 1, 2010 and forward. When requesting the changes, be sure to include the existing Srv Auth number as reference.

Refer to the Durable Medical Equipment Manual, Chapter IV, for incontinence supplies changes effective January 1, 2014.

HOW TO DETERMINE IF SERVICES NEED SERVICE AUTHORIZATION

In order to determine if services need to be service authorized, providers should go to the DMAS website: http://dmasva.dmas.virginia.gov and look to the right of the page and click on the section entitled Procedure Fee Files which will then bring you to this: http://www.dmas.virginia.gov/Content_pgs/pr-ffs_new.aspx. You will now see a page entitled DMAS Procedure Fee Files. The information provided there will help you determine if a procedure code needs service authorization or if a procedure code is not covered by DMAS.

To determine if a service needs Service Authorization, you would then determine whether you wish to use the CSV or the TXT format. The CSV is comma separated value and the TXT is a text format. Depending on the software available on your PC, you may easily use the CSV or the TXT version. The TXT version is recommended for users who wish to download this document into a database application. The CSV Version opens easily in an EXCEL spreadsheet file. Click on either the CSV or the TXT version of the file. Scroll until you find the code you are looking for. The Procedure Fee File will tell you if a code needs to be prior authorized as it will contain a numeric value for the PA Type, such as one of the following:

00-No PA is required

01-Always needs a PA

02-Only needs PA if service limits are exceeded

03-Always need PA, with per frequency.

To determine whether a service is covered by DMAS you need to access the Procedure Rate File Layouts page from the DMAS Procedure Fee Files. Flag codes are the section which provides you special coverage and/or payment information. A Procedure Flag of "999" indicates that a service is non-covered by DMAS.

EARLY PERIODIC SCREENING, DIAGNOSTIC, AND TREATMENT SERVICE AUTHORIZATION (DME)

EPSDT is a Federal law (42 CFR § 441.50 et seq) which requires state Medicaid programs to assure that health problems for individuals under the age of 21 are diagnosed and treated as early as possible, before the problem worsens and treatment becomes more complex and costly. EPSDT requires a broad range of outreach, coordination and health services that are distinct from general state Medicaid requirements, and is composed of two parts:

1. EPSDT promotes the early and universal assessment of children's healthcare needs through periodic screenings, and diagnostic and treatment services for vision, dental and hearing. These services must be provided by Medicaid at no cost to the member.

2. EPSDT also compels state Medicaid agencies to cover other services, products, or procedures for children, if those items are determined to be medically necessary to "correct or ameliorate" [make better] a defect, physical or mental illness, or condition [health problem] identified through routine medical screening or examination, regardless of whether coverage for the same service/support is an optional or limited service for adults under the state plan. For more information, visit: https://www.medicaid.gov/medicaid/benefits/epsdt/index.html.

EPSDT is Medicaid's comprehensive and preventive child health benefit for individuals under the age of 21. Federal law (42 CFR § 441.50 et seq) requires a broad range of outreach, coordination, and health services under EPSDT distinct from general state Medicaid program requirements. EPSDT is geared to the early assessment of children's health care needs through periodic screenings. The goal of EPSDT is to assure that health problems are diagnosed and treated as early as possible before the problem becomes complex and treatment is costlier. Examination and treatment services are provided at no cost to the member.

All Medicaid and FAMIS Plus services that are currently service authorized by the Srv Auth Contractor are services that can potentially be accessed by children under the age of 21. However, in addition to the traditional review, children who are initially denied services under Medicaid and FAMIS Plus require a secondary review due to the EPSDT provision. Some of these services will be approved under the already established criteria for that specific item/service and will not require a separate review under EPSDT; some service requests may be denied using specific item/service criteria and need to be reviewed under EPSDT; and some will need to be referred to DMAS. Specific information regarding the methods of submission may be found at the contractor's website, DMAS.KePRO.com. Click on Virginia Medicaid. They may also be reached by phone at 1-888-VAPAUTH or 1-888-827-2884, or via fax at 1-877-OKBYFAX OR 1-877-652-9329.

Example of EPSDT Review Process:

- The following is an example of the type of request that is reviewed using EPSDT criteria: A durable medical equipment (DME) provider may request coverage for a wheelchair for a child who is 13 who has a diagnosis of cerebral palsy. When the child was 10, the child received a wheelchair purchased by DMAS. DME policy indicates that DMAS only purchases wheelchairs every 5 years. This child's spasticity has increased and he requires several different adaptations that cannot be attached to his current wheelchair. The contractor would not approve this request under DME medical necessity criteria due to the limit of one chair every 5 years. However, this should be approved under EPSDT because the wheelchair does ameliorate his medical condition and allows him to be transported safely.

The review process as described is to be applied across all non-waiver Medicaid programs for children. A request cannot be denied as not meeting medical necessity unless it has been submitted for physician review. DMAS or its contractor must implement a process for physician review of all denied cases.

When the service needs of a child are such that current Medicaid programs do not provide the relevant treatment service, then the service request will be sent directly to the DMAS Maternal and Child Health Division for consideration under the EPSDT benefti. Examples of non-covered services are inclusive of but are not limited to the following services: residential substance abuse treatment, behavioral therapy, specialized residential treatment not covered by the psychiatric services program. All service requests must be a service that is listed in (Title XIX Sec. 1905.*[42 U.S.C. 1396d]* (r)(5)).

NOTE: Effective November 1, 2012, EPSDT specialized services that are service authorized by Keystone Peer Review Organization (KEPRO), DMAS' service authorization contractor include:

Hearing Aids and Related Devices

Assistive Technology

Private Duty Nursing

Personal Care and Attendant Care Services

Requests for services **not service authorized by KEPRO** may be sent to:

EPSDT Service Authorization Coordinator

Fax: 804-452-5462 Phone: 804-786-6134

Medicaid Expansion

On January 1, 2019 Medicaid expansion became effective. Individuals eligible for Medicaid expansion are:

- Adults ages 19-64,
- Not Medicare eligible,
- Not already eligible for a mandatory coverage group,
- Income from 0% - 138% Federal Poverty Level (FPL), and
- Individuals who are 100% - 138% FPL with insurance from the Marketplace. The new expansion aid categories:

Aid Category	Description
AC 100	Caretaker Adult, Less than or equal to 100% of the Federal Poverty Level (FPL) and greater than LIFC
AC 101	Caretaker Adult, Greater than 100% FPL
AC 102	Childless Adult, Less than 100% FPL
AC 103	Childless Adult, Greater than 100% FPL
AC 106	Presumptive Eligible Adults Less than or equal to 133% FPL
AC 108	Incarcerated Adults

The Medicaid Expansion Benefit Plan includes the following services:

Covered Service
Doctor, hospital and emergency room services
Prescription drugs
Laboratory and x-ray
Maternity and newborn care
Behavioral health services including addiction and recovery treatment
Rehabilitative and habilitative services including physical, occupational, and speech therapies and equipment
Family planning
Transportation to appointments
Home Health

DME and supplies
Long Term Support Services (LTSS) to include Nursing Facility, PACE and Home and
Community Based Service
Preventive and wellness
Chronic disease management
Premium assistance for the purchase of employer-sponsored health insurance coverage, if cost effective
Referrals for job training, education and job placement

All of the services currently submitted and reviewed by KEPRO remain the same. There are no new expansion benefits that require service authorization by KEPRO.