CHAPTER I

GENERAL INFORMATION

CHAPTER I
TABLE OF CONTENTS

CHAPTER I
GENERAL INFORMATION

INTRODUCTION

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 Originally enacted by the Social Security amendments of 1965 (Public Law 89-97), Title XIX was approved on July 30, 1965.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 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.

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, and to persons who are aged, blind, and disabled.

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:

- AIDS Waiver services - Individuals who are HIV+ and symptomatic and meet the criteria for a nursing facility or hospital level of care can be authorized to receive case management, personal care, private duty nursing, and respite care.
- Adult Care Residence Intensive Assisted Living Waiver services
- 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 Mental Retardation Services
- Consumer directed personal attendant services
- Contraceptive capsules including the insertion and removal
- Contraceptive injections
- Dental services, limited to members under 21 years of age in fulfillment of the treatment required under the EPSDT Program
- 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
- Dental services for individuals under 21 years of age
- 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.

- Elderly and Disabled 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, and respite care.
- 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 Technology-Assisted or AIDS 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
- Family planning services and supplies (for individuals of child-bearing age)
- 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)
- 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 – Mental Retardation 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 mental retardation community services
    - Mental Health:
        - Crisis stabilization
        - Mental health support
        - Intensive community treatment
        - Intensive in-home services for children and adolescents
        - Therapeutic day treatment for children and adolescents
        - Day treatment/partial hospitalization

- Psychosocial rehabilitation
- Crisis intervention
- Case management

- Substance Abuse Services:

  - 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

- Mental Retardation Community Services Waiver:

  - Residential support services
  - Day support services
  - Habilitation services
  - Therapeutic consultation
  - Supported employment
  - Environmental modifications
  - Assistive technology
  - Nursing services
  - Personal assistance
  - Respite care
  - Crisis stabilization
  - Crisis supervision

- Mental Hospital Services for the Aged (65 Years and Older)
- 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.

- Papanicolau 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
- Physical therapy and related rehabilitative services
- 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.
- Psychological testing for persons with mental retardation 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 exams and immunizations for foster care children (EPSDT is not required)
- 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
- Technology-assisted waiver services - Individuals under the age of 21 who require both a medical device and ongoing medical care to avert death or disability can be authorized to receive private duty nursing and respite care.

- Telemedicine for selected services - limited to certain types of providers.
- 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
- Dental services for members 21 years of age and over, except for limited oral surgery covered as defined by Title XVIII (Medicare) and by DMAS for all members
- 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
- Interpreter services for members who are deaf or hard of hearing
- 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
- Medical care provided in freestanding psychiatric hospitals except through EPSDT
- Personal comfort items
- Physician hospital services for non-covered hospital stays
- Preventive medical care – Other than preventive care services provided under EPSDT and screening mammograms, pap smears, screening for colorectal cancer and PSA tests. Preventive care such as routine physicals and immunizations, well-child examinations, preschool examinations, camp physicals, and work permit examinations are not covered. Routine exams and immunizations for foster children are covered when arranged by the appropriate local Department of Social Services.
- Private duty nursing services – Other than for children 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 and mammograms are covered for women over 30. Screening services for colorectal cancer are covered according to medical guidelines, and also PSA tests.
- Services determined not to be reasonable and/or medically necessary
- Services to persons under age 65 in mental hospitals (except under the EPSDT coverage)
- Smoking cessation programs
- 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, and air cleaners
- Transsexual surgery
- 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:

SERVICE	COPAY AMOUNT
Inpatient Hospital	$100.00 per admission
Outpatient hospital clinic	3.00 per visit
Clinic visit	1.00 per visit
Physician office visit	1.00 per visit
Other Physician service	3.00 per service
Eye examination	1.00 per examination
Prescription	1.00 per prescription (generic) 3.00 per prescription (brand-name) (effective July 1, 2003)
Home health visit	3.00 per visit
Rehabilitation therapy services (PT, OT, Speech/Language) service	3.00 per service

For purposes of copays, a visit is defined as a patient encounter in the same place of treatment, by the same provider on the same day regardless of the number of procedures performed. The encounter may be direct or indirect.

Special Indicator Code (Copayment Code)

The Special Indicator Code indicates the status of copayments or eligibility for certain additional services. After July 2003, providers will be notified of the member's copayment status as a part of eligibility verification. 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 Clients - 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 clients.
- No copayments apply for any emergency services for any client, with one exception for clients in Client Medical Management with a pharmacy restriction. Please refer to the Client Medical Management exhibit in Chapter 1 for more information on this exception.

Services to a member cannot be denied solely because of his or her inability to pay an applicable copayment charge. This does not relieve the member of the responsibility to pay nor does it prevent the provider from attempting to collect any applicable copayment from the member.

MEDICAL COVERAGE FOR SPECIFIED 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) 371-8891. 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.

MANAGED CARE PROGRAMS

The Virginia Department of Medical Assistance Services (DMAS) provides Medicaid to individuals through three programs. Fee-for-Service (FFS), the standard Medicaid program, and two managed care programs: MEDALLION and Medallion II. The MEDALLION program is administered by DMAS. MEDALLION is a Primary Care Case Management (PCCM) program. Members in the specified eligibility categories who live in these localities must enroll in the MEDALLION program and seek their services through a contracted primary care case manager (PCP). Members in the specified eligibility categories in Medallion II localities must enroll with one of the Medicaid-contracted managed care organizations (MCOs) available in those localities. Members who live in an area where both the MEDALLION and Medallion II programs operate simultaneously can choose under which managed care program they wish to participate.

Members who receive any of the following services shall meet the criteria for exclusion from the Medallion II Program. Once the Contractor determines that an member is receiving these services and notifies the Department, the Department will begin the process to exclude the member. Until the Department has excluded the member, the Contractor is responsible for covering Medallion II services for that member. However, in no event is the Contractor responsible for provision of the following services, which will be reimbursed by the Department:

- Services for members with mental retardation and related conditions, including case management, who are participants in the Home and Community Based Services are carved out as set forth in 12 VAC 30-50-450, 12 VAC 30-120-211 through 30-120-21.

- Inpatient mental health services rendered in a State psychiatric hospital, as set forth in 12 VAC 30-50-230 through 12 VAC 30-50-250.

- Hospice services defined as those services allowed under the provisions of Medicare law and regulations as they relate to hospice benefits and as specified in 42 C.F.R., Part 418 and as set forth in 12 VAC 30-50-270.

- Skilled nursing facility care, as set forth in 12 VAC 30-50-130.

- Individuals who are enrolled in DMAS authorized Therapeutic Foster Care (TFC) or Residential Treatment Facility (RTF) programs, as authorized by the Department.

- If upon authorization for TFC case management services, it is determined by the prior authorization contractor that the client is enrolled in an MCO, the prior authorization agent will notify the MCO Unit by facsimile, confirming E-mail, with documentation necessary to identify the member and approved admission date. MCO enrollment will end one day before the authorized admission date to the service. The MCO Unit will annually review the prior authorization files to determine discharge from TFC case management services. When upon discharge from TFC case management services, it is determined that the client is eligible to participate in Medallion II, the member will be entered into the pre-assignment process for MCO enrollment. Foster care children enrolled in TFC case management who are in the custody of Richmond City Department of Social Services will be enrolled in managed care but TFC-CM services are carved out of the MCO contract.

MEDALLION II

Medallion II members receive primary and acute care services through mandatory enrollment in a managed care organization (MCO). Medallion II first began January 1, 1996 in the Tidewater area. Over the past decade, the program has expanded seven times. Currently, DMAS contracts with seven MCOs to administer quality health care to its members. They are: Virginia Premier Health Plan, Optima Family Care, Southern Health/CareNet, Anthem Healthkeepers Plus, Anthem Peninsula Health Care, Anthem Priority Health Care and AMERIGROUP Community Care. 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 except for certain carved-out services. Covered services include but are not limited to, inpatient and outpatient hospital, physician, pharmacy, transportation, durable medical equipment, and laboratory services. **While enrolled in a MCO, DMAS will NOT pay for services provided to MCO members EXCEPT for those services carved-out specifically from the MCO contracts.** These specific carved-out services are listed below. In these cases, the client remains enrolled in the MCO but the specific carved-out service is reimbursed by

DMAS, if the service is appropriate and in compliance with State and Federal Medicaid rules. For non-MCO services, the member must present his or her plastic ID card.
The following services are Medallion II carved-out services:

- The Department shall cover community mental health rehabilitative services, emergency services (crisis), intensive outpatient, day treatment and SA case management services for Medicaid/FAMIS Plus members. Transportation and pharmacy services necessary for the treatment of substance abuse services, including carved out services are the responsibility of the Contractor. Inpatient substance abuse treatment is not covered.

- School health services. The Contractor shall not be required to cover school health services or services rendered in a nursing facility. The Contractor shall not deny medically necessary outpatient or home setting therapies based on the fact that the child is also receiving therapies in a school. (Reference Article I. Definitions section for additional details.)

- Targeted case management services provided to seriously mentally ill adults and emotionally disturbed children; youth at risk of serious emotional disturbance; individuals with mental retardation; individuals with mental retardation and related conditions participating in home- and community-based care waivers; the elderly; and members of Auxiliary Grants as provided in 12 VAC §§ 30-50-420 through –470.

- Investigations by local health departments to determine the source of lead contamination in the home as part of the management and treatment of eligible children who have been diagnosed with elevated blood lead levels, as set forth in 12 VAC 30-50-227.

- Abortions as set forth in 12 VAC 30-50-180 and 42 C.F.R. § 441.203 and § 441.206.

- Dental Services as set forth in 12 VAC 30-50-190.

- Specialized infant formula and medical foods for individuals under age 21.

- Private duty nursing (PDN) services when provided through HCBS waivers covered in 12VAC30-50-170, 12 VAC 30-120-10 through 30-120-259.

- Personal care services.

- Services provided under the home and community-based Medicaid waivers (AIDS, Individual and Family Developmental Disabilities Supports, Mental Retardation, Elderly or Disabled with Consumer Direction, Day Support, or Alzheimer's, or as may be amended from time to time) as set forth in 12VAC30-120-370. These individuals shall receive acute and primary medical services via the MCO and shall receive waiver services and related

transportation to waiver services via the fee-for-service program.

- Early Intervention Services as described in 12VAC 30-50-131 and 12VAC 30-50-430.

- Therapeutic Foster Care Case Management Services for foster care children.

Long term care services provided under the §1915(c) home and community-based waivers (excluding Technology Assisted Waiver) including transportation to such authorized waiver services. The following services must be reimbursed by the MCO regardless of whether the provider is in or out of the MCO's network:

- Emergency and Post-Stabilization Services - an emergency medical condition is defined as a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to body functions, or serious dysfunction of any bodily organ or part.

- Family Planning services - the MCO shall cover all family planning services that include services and supplies for individuals of child-bearing age that delay or prevent pregnancy, but does not include services to treat infertility or to promote fertility.

Insurance coverage must be verified before treatment is provided. Medallion II clients will have a MCO identification card and a Medicaid card. Also, Medallion II clients and MCO providers must adhere to the MCO's requirements regarding referrals and prior authorizations. Prior 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 prior authorizations are obtained. If the MCO denies authorization for a service, the member may exercise his right to appeal to the MCO and/or directly to DMAS. A provider may bill a member only when, prior to rendering services, the provider has the client sign a statement indicating: 1) the client has been informed that their MCO/Medicaid will not pay for the service; 2) the provider is accepting the client as a private pay patient, not as a Medicaid patient; and 3) the services being provided are the financial responsibility of the patient. Failure to confirm Medicaid eligibility and insurance 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.

The managed care programs focus on coordinated care, primary care case management,

improving health outcomes, and improving provider access. Members who have questions regarding the managed care programs can contact the Managed Care Helpline at 1-800-643-2273. Additional information on the programs can also be obtained through the DMAS website at www.dmas.virginia.gov.

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 clients enrolled in MCOs, the following procedures are used:

- The Contractor (the member's current 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 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 Contractor (the member's current MCO) shall continue prior authorized services without interruption until the Contractor completes its utilization review process to determine medical necessity of continued services or to transition services to a network provider;
- DMAS shall assume responsibility for all covered services authorized by the member's previous MCO which are rendered after the effective date of dis-enrollment to the fee-for-service system, if the member otherwise remains eligible for the service(s);
- If the prior authorized service is an inpatient stay, the claim should be handled as follows:
    - 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.
    - 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.
- If services have been prior-authorized using a provider who is out of network, the member's current MCO may elect to reauthorize (but not deny) those services using an in-network provider.

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 and 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.

Home and Community-Based Care Services Information

Except for billing issues, all questions pertaining to home and community-based care waiver services should be directed to DMAS. The telephone number is:

(804) 225-4222

Community-Based Care Services assistance is available Monday through Friday from 8:00 a.m. to 5:00 p.m., except on holidays.

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 profession 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.

Updates to this manual will be accompanied by an update transmittal memorandum. These updates will have an identifying code and sequential identification numbers assigned for each calendar year, e.g., H 1-99. The transmittal memorandum identifies the new page number(s) to be added and/or the page(s) to be replaced, and it will provide any other pertinent information regarding the update being made.

To be an effective tool, the manual must be properly maintained. Updates should be promptly filed, according to the following procedures:

An Update Control Log has been provided in the back of this manual. The transmittal log numbers run consecutively from 1-44. When an update package is received or downloaded and printed, put the updated pages in the appropriate place in the manual and enter the release date in the next blank space in the Update Control Log. The release date is the date

of issue by DMAS. File the transmittal letter immediately after the Update Control Log. If the Update Control Log indicates missing transmittals, contact the HELPLINE to request copies of these transmittals, or download them from www.dmas.state.va.us. (See the section titled "Sources of Information.")

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.**

Providers have the right to appeal adverse actions. Time frames for completing cases remanded by DMAS hearing officers are established in accordance with the "reasonable promptness" standard of Title 42 C.F.R. §§ 431.220(a)(1) and 431.241. The time frames for the following entities are effective for decisions issued on and after February 16, 1996:

Local Department of Social Services	30 days
Local Health Departments	30 days
Department of Mental Health, Mental Retardation and Substance Abuse Services	30 days
Nursing Facilities	30 days
Medicaid Disability Unit	45 days
DMAS Divisions	30 days

Chapter II of this manual contains the details for the reconsideration of adverse actions.

EXHIBITS

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

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
- Managed Care Organization provider name and assignment dates

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

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

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

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

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

PROVIDER CHECK LOG

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

CLAIMS STATUS

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

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

For claims status, the From date cannot be more than 365 days in the past. The Thru date cannot be more than 31 days later than the From date. After keying the member

identification number and the From and Thru date(s) of service, MediCall will provide the status of each claim up to and including five claims. MediCall will prompt for any additional claims or return to the main menu.

SERVICE AUTHORIZATION INFORMATION

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

SERVICE LIMITS INFORMATION

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

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

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

PRESCRIBING PROVIDER ID

Only enrolled Pharmacy providers can access this choice. When prompted, the caller should enter the license number of the prescriber. MediCall will return the first six letters of the prescriber's last name and Medical Assistance provider number. If the prescriber is not active in Virginia Medicaid, you will receive a message that the number is not on file.

The Automated Response System (ARS)

GENERAL INFORMATION

The Automated Response System (ARS) offers Medicaid and FAMIS providers twenty-four-hour-a-day, seven-day-a week Internet access to current member eligibility information, service limits, claim status, service authorizations, and provider payment history. This we-enabled 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	087	Henrico	177	Spotsylvania
003	Albemarle	089	Henry	179	Stafford
005	Alleghany	091	Highland	181	Surry
007	Amelia	093	Isle of Wight	183	Sussex
009	Amherst	095	James City	185	Tazewell
011	Appomattox	097	King and Queen	187	Warren
013	Arlington	099	King George	191	Washington
015	Augusta	101	King William	193	Westmoreland
017	Bath	103	Lancaster	195	Wise
019	Bedford	105	Lee	197	Wythe
021	Bland	107	Loudoun	199	York
023	Botetourt	109	Louisa		
025	Brunswick	111	Lunenburg		
027	Buchanan	113	Madison		
029	Buckingham	115	Mathews		
031	Campbell	117	Mecklenburg		
033	Caroline	119	Middlesex		
035	Carroll	121	Montgomery		
036	Charles City	125	Nelson		
037	Charlotte	127	New Kent		
041	Chesterfield	131	Northampton		
043	Clarke	133	Northumberland		
045	Craig	135	Nottoway		
047	Culpeper	137	Orange		
049	Cumberland	139	Page		
051	Dickenson	141	Patrick		
053	Dinwiddie	143	Pittsylvania		
057	Essex	145	Powhatan		
059	Fairfax	147	Prince Edward		
061	Fauquier	149	Prince George		
063	Floyd	153	Prince William		
065	Fluvanna	155	Pulaski		
067	Franklin	157	Rappahannock		
069	Frederick	159	Richmond		
071	Giles	161	Roanoke		
073	Gloucester	163	Rockbridge Area		
075	Goochland	165	Rockingham		
077	Grayson	167	Russell		
079	Greene	169	Scott		
081	Greensville	171	Shenandoah		
083	Halifax	173	Smyth		
085	Hanover	175	Southampton		

CITIES

510	Alexandria	683	Manassas
515	Bedford	685	Manassas Park
520	Bristol	690	Martinsville
530	Buena Vista	700	Newport News
540	Charlottesville	710	Norfolk
550	Chesapeake	720	Norton
560	Clifton Forge	730	Petersburg
570	Colonial Heights	735	Poquoson
580	Covington	740	Portsmouth
590	Danville	750	Radford
595	Emporia	760	Richmond
600	Fairfax	770	Roanoke
610	Falls Church	775	Salem
620	Franklin	780	South Boston
630	Fredericksburg	790	Staunton
640	Galax	800	Suffolk
650	Hampton	810	Virginia Beach
660	Harrisonburg	820	Waynesboro
670	Hopewell	830	Williamsburg
678	Lexington	840	Winchester
680	Lynchburg	976	Central Processing Unit for FAMIS

STATE MENTAL HEALTH FACILITIES

983	Southern Virginia Mental Health Institute
984	Southwestern Virginia Training Center
985	Southeastern State Hospital
986	Northern Virginia Training Center
987	Virginia Treatment Center
988	Northern Virginia Mental Health Institute
989	Southside Virginia Training Center
990	Central Virginia Training Center
991	Western State Hospital
992	Southwestern State Hospital
993	Piedmont State Hospital
994	Eastern State Hospital
995	DeJarnette Sanatorium
996	Hiram Davis Hospital
997	Catawba State Hospital
998	Blue Ridge Sanatorium

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 431.54(e-f) and state regulations as set forth in 12 VAC 30-130-800 through 12 VAC 30-130-820.

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 and is not to be confused with the MEDALLION program that automatically assigns eligible groups of members to primary care providers for primary case management. 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 use of health care;
- 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 36 months. Assignment to both a physician and pharmacy is made with few exceptions. Members with dual eligibility for Medicaid and Medicare may be enrolled with only a pharmacy restriction since Medicare is the primary insurance for physician services.

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 *Medicaid provider 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.

Changes in the Designated Provider's Medicaid ID Number

If a designated provider receives a new Medicaid ID number, he or she must notify the CMM staff prior to the effective date of the change if CMM members are to be reassigned to the new number.

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) well-child 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/MR 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 form 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-9-CM 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 modeled after procedures for payment of the MEDALLION management fees. 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 (08-05) 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.

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
CLIENT MEDICAL MANAGEMENT PROGRAM

PRACTITIONER REFERRAL FORM

Recipient's Name: _____ DMAS#: _____

Referred to: _____ Date: _____

Purpose of Referral (check one):

_____ Physician covering in absence of primary health care provider for (specify period of absence for up to 90 days) _____

_____

_____ See one time only for _____

_____ See as needed for on-going treatment of _____

_____

(Referral for on-going treatment must be renewed at 90 day intervals.)

This recipient is restricted to me as his/her primary health care provider. Please refer to the billing chapter in your Medicaid Provider Manual for billing information. **This form must be part of your medical record. For reimbursement, a copy must be attached to every claim submitted on behalf of this recipient.**

If you wish to refer this patient to another source who will be billing Medicaid, you must obtain another referral form for that physician from me.

These referral provisions do not apply while the recipient is an inpatient in a hospital.

_____
Signature of Primary Health Care Provider

_____
Name of Primary Health Care Provider

Provider ID#: _____

Address: _____

_____

_____

Telephone #: (_____) _____

(Instructions on Back)

DMAS-70 4/89

REFERRAL PHYSICIAN'S COPY

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

CLIENT MEDICAL MANAGEMENT PROGRAM
RECIPIENT/PRIMARY PROVIDER AGREEMENT

PHYSICIAN

DATE: _____

RECIPIENT NAME:_____**DMAS#**: _____

I. My choice for primary physician is given below. I understand that Medicaid will pay for covered outpatient physician services provided by my primary physician. Other physicians will be paid only when my primary physician makes a medical referral or is unable to provide services in a medical emergency requiring immediate treatment.

RECIPIENT SIGNATURE: _____ **DATE**: _____

TELEPHONE NUMBER: _(___)_____

II. PRINT NAME AND ADDRESS OF PHYSICIAN: _____

_____

I agree to undertake primary health care and make appropriate referrals to specialists for the recipient named above.

PHYSICIAN'S SIGNATURE: _____ **DATE**: _____

PHYSICIAN'S DMAS ID#: _____ **TELEPHONE NUMBER**: _(____)_____
(Use Virginia Medicaid Provider Billing Number)

MAIL/FAX BY _____ **TO:** _____

RECIPIENT MONITORING UNIT
DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
600 EAST BROAD STREET, SUITE 1300
RICHMOND, VIRGINIA 23219

INSTRUCTIONS

1. You must sign the form in Section I. If the form is for a child, the parent or guardian must sign.

2. The physician you select must be enrolled as an individual physician with Medicaid and bill on the HCFA 1500 invoice or other acceptable media using his/her own Medicaid provider number. The physician can tell you if these requirements are met.

3. If the physician agrees to be your primary physician, ask him/her to **sign and date the form and write in the Medicaid provider number.**

4. Be sure the physician's name and the office address are **PRINTED** clearly in Section II.

5. When Sections I and II are completed, return the form to our office in the enclosed postage paid envelope. The form may also be **FAXED** to **(804) 371-8891.**

6. Any questions can be directed to the Recipient Monitoring Unit in Richmond, **(804) 786-6548** or toll free **1-888-323-0589**.

(03/03)

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

CLIENT MEDICAL MANAGEMENT PROGRAM
RECIPIENT/PRIMARY PROVIDER AGREEMENT

PHARMACY

DATE: _____

RECIPIENT NAME:_____**DMAS#:** _____

I. My choice for designated pharmacy is given below. I understand that Medicaid will pay for covered outpatient pharmacy services from my designated pharmacy. Other pharmacies will be paid only when my designated pharmacy does not stock or cannot supply medications in a medical emergency requiring immediate treatment.

RECIPIENT SIGNATURE: _____ **DATE**: _____

TELEPHONE NUMBER: (___) _____

II. PRINT NAME AND ADDRESS OF PHARMACY:_____

_____

I agree to monitor the drug utilization and provide all outpatient pharmaceutical needs for the recipient named above.

PHARMACY REPRESENTATIVE'S SIGNATURE: _____**DATE:** _____

PHARMACY'S DMAS ID#: _____ **TELEPHONE NUMBER**: _____
(Use Virginia Medicaid Provider Billing Number)

MAIL/FAX BY _____ **TO:** _____

RECIPIENT MONITORING UNIT
DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
600 EAST BROAD STREET, SUITE 1300
RICHMOND, VIRGINIA 23219

INSTRUCTIONS

1. You must sign the form in Section I. If the form is for a child, the parent or guardian must sign.

2. The community pharmacy you select must be a Medicaid provider that bills on the Pharmacy Claim Form or other acceptable media. The pharmacist can tell you if the pharmacy meets these requirements.

3. If the pharmacist agrees to be your designated provider, ask him/her to **sign and date the form and write in the pharmacy's National Provider Identifier.**

4. Be sure the name and address of the pharmacy is **PRINTED** clearly in Section II.

5. When Section I and II are completed, return the form to our office in the enclosed postage paid envelope. The form may also be **FAXED** to **(804) 371-8891.**

6. Any questions can be directed to the Recipient Monitoring Unit in Richmond. Call toll-free to the CMM Helpline **(1-888-323-0589)** or call **(804) 786-6548** in the Richmond Metro area**.**

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
CLIENT MEDICAL MANAGEMENT PROGRAM (CMM)

CMM PROVIDER AFFILIATION FORM

PLEASE TYPE or PRINT

SECTION I: General Information

Provider Name: _____ **Provider Number:** _____

Business Name: _____ **IRS ID number** _____

Street Address*:** _____ **Contact Person:** _____

Telephone Numbers: _____ **Contact Phone**: _____

24-hour Access: **(Required)** _____ **Email:** _____

Office Hours: _____ **FAX:** _____

(*****The address *must* be a physical street address.)**

SECTION II: Service Locations

Please list all Medicaid provider identification numbers issued to you.

Medicaid Number	**Medicaid Number**
_____	_____
_____	_____
_____	_____

SECTION III: Affiliations

Please list the names and Medicaid numbers of those associated physicians or nurse practitioners at the location listed in Section I who are to be affiliated for business and billing purposes. Use the back of this form if more space is needed.

Name	**Medicaid Number**
_____	_____
_____	_____
_____	_____
_____	_____

DO NOT WRITE BELOW THIS SPACE

RETURN FORM TO:

Recipient Monitoring Unit
Department of Medical Assistance Services
600 E. Broad Street, Suite 1300
Richmond, Virginia 23219

Affiliation group to include provider numbers listed in Sections II and III.

OFFICE USE ONLY

Affiliation Group number assigned by system ☐

FIPS Code _____

Affiliation Group Number assigned by RMU _____

RMU Signature_____

Date _____