CHAPTER I

GENERAL INFORMATION

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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 Originally enacted by the Social Security amendments of 1965 (Public Law 89-97), Title XIX was approved on July 30, 1965.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 (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 updated and maintained by the DMAS Policy Division. 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. Due to these changes, additional selected low-income groups are eligible for Medicaid based 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.

In 2018, Virginia 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~~such as 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~~ obtain medical care within the guidelines of specified State and federal laws and regulations. Medicaid provides access to a wide range of medically necessary services or procedures for eligible members. The determination of medical necessity may be made by managed care organizations, the Utilization Review Committee in certain facilities, a peer review organization, DMAS professional staff or DMAS contractors.

Covered Services

DMAS provides comprehensive health care services which are discussed in this and other Provider Manuals.

A detailed list of covered service codes is available to providers in the procedure fee file and CPT search page, which is located at https://www.dmas.virginia.gov/for-providers/rates-and-rate-setting/. This website and search function provides detailed information about a full list of health care procedure codes with information about rates, service authorization requirements, covered/non-covered designation, and more. Please refer to the Frequently Asked Questions located at this link for an explanation of the characters in each field of the procedure fee file. The fee file is updated three times per week.

If members have questions about covered/non-covered services, please direct them to the Member Handbooks that are available at this link.

~~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.

- Behavioral Health services, including:
  - Early Intervention/Screening Brief Intervention and Referral to Treatment (ASAM 0.5)
  - Case Management (Substance Use, Mental Health and Treatment Foster Care)
  - Peer Recovery Support Services
  - Opioid Treatment Programs and Office-Based Addiction Treatment (includes substance use care coordination)
  - Outpatient Psychiatric and Outpatient Substance Use (ASAM 1.0) Services
  - Intensive In-Home

  - Therapeutic Day Treatment
  - Psychosocial Rehabilitation
  - Mental Health Skill Building Services
  - Multisystemic Therapy
  - Functional Family Therapy
  - Applied Behavior Analysis
  - Assertive Community Treatment
  - Mental Health and Substance Use (ASAM 2.1) Intensive Outpatient
  - Mental Health and Substance Use (ASAM 2.5) Partial Hospitalization
  - Mobile Crisis Response
  - Community Stabilization
  - 23-Hour Crisis Stabilization
  - Residential Crisis Stabilization Unit
  - Residential Treatment Services (Therapeutic Group Home, Psychiatric Residential Treatment Facility, ASAM levels 3.1, 3.3, 3.5 and 3.7)
  - Inpatient Psychiatric Services and Medically Managed Intensive Inpatient (ASAM Level 4.0) in a general acute care hospital. Inpatient services in Freestanding Psychiatric Hospitals are also covered for individuals below age 21 and individuals age 65 and older.

- Blood glucose monitors and test strips for pregnant women

- Building Independence (BI) Waiver – The CMS-approved HCBS § 1915(c) waiver whose purpose is to provide support in the community for individuals eighteen (18) years of age or older who have a Developmental Disability (DD), meet the ICF/IID level of care criteria, and who live in their own homes/apartments with BI waiver supports. Services may be complemented by non-waiver funded rent subsidies and/or other types of support. The Building Independence Waiver is administered collaboratively by the Department and DBHDS. A complete listing of all allowable services under the BI Waiver may be found in Chapter 4 of the DD Waiver Manual Covered Services and Limitations.

- 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

- Clinic services

- Commonwealth Coordinated Care Plus (CCC Plus) Waiver- The CMS- approved HCBS § 1915(c) waiver that covers a range of community support services offered to older adults, individuals who have a disability, andindividuals who are chronically ill or severely impaired, having experienced loss of a vital body function, and who require substantial and ongoing skilled nursing care. A complete listing of all allowable services under the CCC Plus Waiver may be found in Chapter 4 of the CCC Plus Waiver Manual Covered Services and Limitations.

- Community developmental disability services

- Community Living Waiver - The CMS-approved HCBS §1915(c) waiver whose purpose is to provide services and supports in the community rather than in an Intermediate Care Facility for Individuals with Intellectual Disability (ICF/IID). Participants include individuals up to six (6) years of age who are at developmental risk and individuals age six (6) and older who have Developmental Disability (DD) and meet the ICF/IID level of care criteria. Residential services and additional supports for adults and some children with exceptional medical and/or behavioral support needs are included in this waiver. A complete listing of all allowable services under the CL Waiver may be found in Chapter 4 of the DD Waiver Manual Covered Services and Limitations.

- Contraceptive supplies, drugs and devices

- Dental services

- Diabetic test strips

- Doula services

- 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 provide 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.

- Early intervention services – Coverage available for children up to age three and includes developmental supports and services that are performed in natural environments, including home and community based settings in which children without disabilities participate, to the maximum extent possible. Services are designed to meet the developmental needs of an infant or toddler with a developmental delay and the needs of the family related to enhancing the child's development, as identified by the Individualized Family Service Plan (IFSP) team, in any one or more of the following areas: physical development, cognitive development,

communication development, social or emotional development, and adaptive development

- 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 12 months after the pregnancy ends (limitations applicable to all covered services apply to this group as to all other member groups)

- Eye refractions

- Family and Individual Support Waiver - The CMS-approved home- and community-based §1915(c) waiver whose purpose is to provide services and supports in the community rather than in an Intermediate Care Facility for Individuals with Intellectual Disability (ICF/IID). Participants include individuals up to six (6) years of age who are at developmental risk and individuals age six (6) and older who have a Developmental Disability (DD) and meet the ICF/IID level of care criteria. This waiver supports children and adults living with families, friends, or in their own homes, including supports for those with some medical or behavioral needs. A complete listing of all allowable services under the FIS Waiver may be found in Chapter 4 of the DD Waiver Manual Covered Services and Limitations.

- Federally Qualified Health Center services

- Gender dysphoria treatment 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

- 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)

- Maternity care – coverage includes prenatal and postpartum services

- 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

- 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.

- 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 loss of eyeball regardless of age of the member or the cause of the loss of the eyeball.

- 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 patient costs furnished in connection with participation in a qualifying clinical trial (see Exhibits)

- 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, dental exams, immunizations, smoking cessation, and nutritional counseling services for eligible adult members.

- 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

- 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

General Exclusions

Payment cannot be made under the Medicaid Program for certainnon-covered 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 services.

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, ocular 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

MANAGED CARE PROGRAMS

Coverage for the vast majority of Medicaid enrolled individuals is provided through one of the DMAS managed programs, Medallion 4.0 or Commonwealth Coordinated Care Plus (CCC Plus). Medallion 4.0 and CCC Plus programsDMAS contracts with the same six managed care organizations (MCOs) that, and all MCOs offer full coverage statewide. Through the MCOs, the managed care program In addition, both CCC Plus and Medallion 4.0 provides access to services that help keep people healthy as well as

services that focus on improving health outcomes. The MCOs also provide care coordination services to all enrolled members. For more information on the current health plans, please visit www.dmas.virginia.gov https://dmas.virginia.gov/for-providers/managed-care/cardinal-care-managed-care/ .

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.

Enrollment in managed care is mandatory for most members. Individuals awaiting newly enrolled in managed care enrollment will receive coverage through the DMAS fee-for-service program for a brief period (approximately 15-45 days) until they are enrolled in managed care. Additionally, some Medicaid services for managed care enrolled individuals are covered through fee-for-service; these are referred to as managed care carved-out services. Detailed Additional 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 https://www.dmas.virginia.gov/for-providers/managed-care/cardinal-care-managed-care/, under Managed Care Benefits.

Once enrolled in managed care, members have up to 90 days to request a change in their plan MCO for any reason. Members also have the ability to change their planMCOs during their the annual open enrollment period. Open enrollment dates varies vary by population and program geographic region, . For the MAGI Adult (expansion) population, open enrollment is from November 1 through December 31 each year. For CCC Plus, open enrollment is from October 1 through December 18 each year. For Medallion 4.0 open enrollment varies by program region. and are as follows:
1. Roanoke/Allegheny and Southwest Regions: December 19 through February 28.
2. Tidewater Region: February 19 through April 30.
3. Central Region: April 19 through June 30.
4. Northern Virginia Region: June 19 through August 31.
5. Charlottesville/Western Halifax Regions: August 19 through October 31.

(See the 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 providers. 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~~ assistance with managed care programs.

- ~~Medallion 4.0 and CCC Plus~~ Cardinal Care Virginia Managed Care programs

  Maximus has designed a mobile app for managed care enrollment for the ~~Medallion 4.0~~ Virginia Managed Care 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~~ Virginia Managed Care 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 individuals enrolled in ~~a~~ managed care ~~enrolled individual~~, providers must contract with and adhere to~~follow~~ their respective contract(s) with the managed care plan(s). 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 MCOs directly. MCO contact information for contracting and credentialing is available on the DMAS website at https://www.dmas.virginia.gov/for-providers/managed-care/cardinal-care-managed-care/.

- 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 The 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 member remains enrolled in the MCO plan but the carved-out services are covered and reimbursed by DMAS, not the MCO, 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 coverageProviders must be verified verify the individual's eligibility and managed care enrollment before treatment isservices are provided. Medallion and CCC PlusManaged care members will have a MCO-specific identification card and a Medicaid card, and must present the cards at the time of service. Medallion and CCC Plus MCO Managed care 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 state that, should the individual decide to accept services that have been denied payment by the MCO/Medicaid, 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.

DMAS offers providers several mechanisms by which to verify a member's eligibility. Verification by phone can be obtained by calling 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 can also available be verified online using the web-based Automated Response System (ARS) in the Provider Portal – please log in to the Portal and click on DMAS Identity, Credentials, and Access Management. 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 member's transition between fee-for-service Medicaid and the MCO managed care 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:

- In the absence of a written agreement stating otherwise, tThe Member's 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 to reimburse for authorized services without interruption until the Contractor MCO completes its utilization review process to determine medical necessity of continued services or to transition services to a network provider;.

- DMAS shall assume responsibility for all covered services authorized by the member's previous MCO which are rendered after the effective date of dis-enrollment to the fee-for-service system, if the member otherwise remains eligible for the service(s), and if the provider is a Medicaid provider;.

- If the prior authorized service is an inpatient stay, the claim should be handled as follows:
  - 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. In the absence of an agreement with the out-of-network provider, the MCO must require out-of-network providers to coordinate with the MCO for payment and ensure the cost to the member is no greater than it would be if the services were furnished within the MCO's network. The MCO must reimburse out-of-network providers at the fee-for-service rate in effect on the date of service. For CCC Plus Waiver and home health services, the rate must include the Northern Virginia differential.

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 XXISCHIP 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. Please consult the procedure fee file to determine whether a service is covered for an individual who is covered by FAMIS.

If members have questions about covered/non-covered services in FAMIS, please direct them to the Member Handbooks that are available at this link.

The following services are covered for FAMIS enrollees:

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

- Behavioral Health services for the treatment of mental health and substance use disorders, including the following:
  - Case Management
  - Peer Recovery Support Services
  - Opioid Treatment Programs and Office-Based Addiction Treatment (includes substance use care coordination)
  - Screening Brief Intervention and Referral to Treatment (SBIRT) (ASAM 0.5)
  - Outpatient Psychiatric and Outpatient Substance Use (ASAM 1.0) Services
  - Psychosocial Treatment, including individual psychotherapy, group therapy, family therapy, and other types of counseling services
  - Tobacco Cessation screening, counseling, and pharmacotherapies
  - Intensive In-Home
  - Therapeutic Day Treatment
  - Multisystemic Therapy
  - Functional Family Therapy
  - Applied Behavior Analysis
  - Assertive Community Treatment
  - Mental Health and Substance Use (ASAM 2.1) Intensive Outpatient
  - Mental Health and Substance Use (ASAM 2.5) Partial Hospitalization
  - Mobile Crisis Response
  - Community Stabilization
  - 23-Hour Crisis Stabilization
  - Residential Crisis Stabilization Unit
  - Inpatient Psychiatric Services and Medically Managed Intensive Inpatient Substance Use Treatment Services (ASAM Level 4.0) in a general acute care hospital. Does not include services furnished in a state-operated mental hospital, services furnished by IMDs, or residential services or other 24-hour therapeutically planned structural services with the exception of residential crisis stabilization unit services
- Blood lead testing
- Chiropractic with benefit limitations
- Clinic services (including health center services) and other ambulatory health care services
- 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 services (365 days per confinement; includes ancillary 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 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)
- 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
- Prescription drugs (mandatory generic program)
- 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)

No Member Copays, Fees, or Premiums for FAMIS members

FAMIS does not have enrollment fees or yearly or monthly premiums. Effective April 1, 2022, FAMIS members do not have co-payments in fee- for-service or managed care, pursuant to the 2022 Special Session I Appropriations Act, which permanently removed co-pays. In compliance with federal law, Native Americans and Alaska Natives do not

have any co-payments.

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.

SOURCES OF INFORMATION FOR FEE-FOR-SERVICE PROVIDERS

Providers may obtain information about Member eligibility, claims status, payment status, service limits, service authorization status, and remittance advice from one of two DMAS systems: an online automated response system, or Medicall (a telephone-based automated voice response system). Providers enrolled with an MCO will need to contact their contracted MCO for claims status, payment status, service limits, service authorization status and remittance advices.

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.

The Automated Response System (ARS) offers Medicaid and FAMIS providers twenty-four-hour-a-day, seven-day-a-week online access to current member eligibility information, service limits, claim status, service authorizations, and provider payment history. This web-enabled tool allows providers to access current information quickly and conveniently.

The ARS can be accessed through the provider portal. Please visit the portal for information on registration and use of the ARS.

Medicall Automated Voice Response System

Toll-free numbers are available 24-hours-per-day, seven days a week, to obtain current member eligibility information, service limits, claim status, service authorizations, and provider payment history. The numbers are: 1-800-772-9996 or 1-800-884-9730.

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.

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 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
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 (prior to July, 2012)

- Managed Care Organization provider name and assignment dates

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

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

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

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

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

PROVIDER CHECK LOG

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

CLAIMS STATUS

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

- For inpatient care, press 01.

- For long-term care, press 02.

- For outpatient hospital, home health or rehabilitation services, press 03.

- For personal care, press 04.

- For practitioner (physician CMS-1500 billing), press 05.

- For pharmacy, press 06.

- For independent labs (outpatient lab services), press 08.

- For Medicare crossover, press 09.

- For dental, press 11.

- For transportation, press 13.

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

SERVICE AUTHORIZATION INFORMATION

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

SERVICE LIMITS INFORMATION

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

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

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

PRESCRIBING PROVIDER ID

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

The Automated Response System (ARS)

GENERAL INFORMATION

The Automated Response System (ARS) offers Medicaid and FAMIS providers twenty-four-hour-a-day, seven-day-a-week Internet access to current member eligibility information, service limits, claim status, service authorizations, and provider payment history. This web-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	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