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 Originally enacted by the Social Security amendments of 1965 (Public Law 89-97), Title XIX was approved on July 30, 1965.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 most vulnerable citizens using the health care delivery system already in place within the state.

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.

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, 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 obtaining medical care within the guidelines of specified State and federal laws and regulations. Medicaid provides access to a wide range of medically necessary and appropriate 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.

General Exclusions

Payment cannot be made under the Medicaid Program for non-covered items and services, and Virginia Medicaid will not reimburse providers for these services. Providers must contact the participating MCO or use the procedure fee file and CPT search page to determine whether a code is covered. Prior to rendering the service, the provider must advise the member that they will be billed for non-covered services, and the member must consent. The member consent must be in writing, dated, and signed in order to be valid.

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.

MANAGED CARE

Coverage for the vast majority of Medicaid enrolled individuals is provided through the DMAS managed care program. DMAS contracts with managed care organizations (MCOs) that all offer full coverage statewide. Through the MCOs, the managed care program 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, please visit https://dmas.virginia.gov/for-providers/managed-care/cardinal-care-managed-care/ .

Enrollment in managed care is mandatory for most members. Individuals newly enrolled in Medicaid 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.

Once enrolled in managed care, members have up to 90 days to request a change in their MCO for any reason. Members also have the ability to change MCOs during the annual open enrollment period. Open enrollment dates vary by geographic 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 which provides information to help 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 contact information for assistance with managed care programs.

- Cardinal Care Virginia Managed Care programs

  DMAS has a mobile app for enrollment for the 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 Cardinal 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 Virginia Managed Care enrollment website at: https://virginiamanagedcare.com/ or call 1-800-643-2273 or TTY: 1-800-817- 6608.

MCO Provider Reimbursement

In accordance with 42 CFR 438. 602, to be reimbursed for services provided to individuals enrolled in managed care, providers must enroll and maintain enrollment with DMAS, as described in Chapter 2. Providers must also contract with the MCO and adhere to their respective contract(s) with the MCO. MCOs are prohibited from paying any network providers who are not enrolled with DMAS. The MCO may utilize different prior authorization, billing, and reimbursement guidelines

than those described for Medicaid fee-for-service individuals.

MCOs also have the option to pay out-of-network, "non-par" providers. In the absence of an agreement between the MCO and the non-par provider, the MCO must pay non-par providers at the prevailing DMAS rate in existence on the date of service. This reimbursement is considered payment in full to the non-par provider. For more information, please contact the individual's MCO directly.

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.

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 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.** The member must present his or her Medicaid plastic ID card when receiving carved-out services.

Eligibility and MCO Enrollment Verification

Providers must verify the individual's eligibility and managed care enrollment before services are provided. Managed care members will have a MCO-specific identification card and a Medicaid card, and must present the cards at the time of service. 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, and the member has consented. The notice must also 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 and the member cannot be billed.

DMAS offers providers several mechanisms by which to verify a member's eligibility. Verification by phone can be obtained by calling the MCO's enrollment verification system or the DMAS Medicall line at 1-800-772-9996 or 1-800-884-9730. Eligibility

information can also 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.

Continuity of Care

The Department attempts to make the member's transition between fee-for-service and managed care seamless whenever possible. As a result, there is a process to ensure that Medicaid 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, the member's MCO shall assume responsibility for all managed care contract covered services authorized by either the Department or a previous MCO which are rendered after the MCO enrollment effective date. 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 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.
  - If the provider contracts with the MCO under a diagnosis related group (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 SCHIP 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 or non-emergency medical transportation. 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.

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.

Automated Response System (ARS)

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.

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.