~~CHAPTER IV~~

~~COVERED SERVICES AND LIMITATIONS~~

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CHAPTER IV
COVERED SERVICES AND LIMITATIONS

COVERAGE FOR RECIPIENTS RECEIVING RENAL DIALYSIS SERVICES

Medicaid coverage is secondary to Medicare for the treatment of end stage renal disease. Supervision of dialysis and kidney transplantation is covered by **Medicaid only when the patient is not eligible for Medicare benefits.** (Medicaid will withhold payment until a determination is made concerning the patient's Medicare eligibility.) If the recipient has Medicare, Medicare must be billed first; Medicaid will be responsible only for coinsurance and deductibles.

Professional staff in the Medicare-certified facility will have responsibility for the management of the treatment program and will determine the appropriate type of services needed; e.g., outpatient, home, or nursing facility treatments.

Dialysis centers enrolled in the Virginia Medicaid Program are responsible for submitting charges for outpatient and home dialysis services.

CLINICAL LABORATORY IMPROVEMENT AMENDMENT (CLIA)

Under the Clinical Laboratory Improvement Amendment (CLIA) of 1988, providers must have a CLIA certificate and identification number to bill for laboratory services. To obtain a CLIA certificate or to obtain information about CLIA, send a request to:

Virginia Department of Health
Office of Health Facility Regulation
3600 Centre Ste 216
3600 West Broad Street
Richmond, Virginia 23230

DMAS will deny laboratory claims of providers that bill for services outside of their CLIA type, reason 480 (provider not CLIA certified to perform procedure).

VACCINES FOR CHILDREN PROGRAM

The Vaccines for Children (VFC) Program provides routine childhood vaccinations free of charge to Medicaid-eligible children up to the age of 19. These vaccines will be provided by the Virginia Department of Health (VDH).

Requirement to Enroll in VFC

To participate, a provider must complete the enrollment and provider profile forms

provided by VDH. At this point, the provider is eligible to receive free vaccines under the VFC. Unless enrolled, the Department of Medical Assistance Services will not reimburse the provider for vaccines covered under VFC. DMAS will reimburse providers the administration fee for routine childhood vaccines that are available under VFC (up to the age of 19). DMAS will reimburse the provider an administration fee per injection.

Billing Codes for the Administration Fee

Providers must use Medicaid-specific billing codes when billing DMAS for the administration fee for free vaccines under VFC. These codes identify the VFC vaccine provided and will assist VDH with its accountability plan which the Health Care Financing Administration (HCFA) requires. The billing codes are:

Y0013	Diphtheria Tetanus & Pertussis
Y0014	Diphtheria Tetanus & Acellular Pertussis
Y0015	Tetanus Diphtheria - Adult
Y0016	Tetanus Diphtheria - Pediatric
Y0017	Combined Diphtheria Tetanus Pertussis & Haemophilus Influenzae b
Y0018	Haemophilus Influenzae b
Y0019	Hepatitis B - Adult
Y0020	Hepatitis B - Pediatric
Y0021	Oral Polio
Y0022	Inactivated Polio
Y0023	Measles Mumps & Rubella
Y0024	Measles Rubella
Y0025	Measles
Y0026	Mumps
Y0027	Rubella
Y0028	Varicella - Chickenpox
Y0029	Influenza
Y0030	Pneumococcal
Y0031	Hepatitis B - Adolescent
Y0032	Hepatitis B – Dialysis
Y0033	Comvax
Y0034	DTAP & HiB
Y0035	Hepatitis A

If the provider chooses to provide a single antigen vaccine, such as measles, mumps, or rubella, medical justification which documents the medical necessity of providing a single antigen vaccine when the combined antigen vaccine is available must be attached to the claim. Claims for measles, mumps, or rubella vaccines will automatically pend for review by DMAS staff. See the section on "Single Antigen Vaccines" below. DMAS does not reimburse for influenza and pneumococcal vaccines except when they are reasonable and necessary for the prevention of illness. The physician's treatment plan must have as its objective preventing the occurrence of more serious illness in an individual "at risk." This allows for the provision of influenza and/or pneumococcal vaccines when they are indicated as medically necessary. The medical treatment record must clearly indicate the valid medical reason(s) justifying the administration of these vaccines.

Reimbursement for Children Ages 19 and 20

Since DMAS policy provides coverage for vaccines for children up to the age of 21, and VFC provides coverage only up to the age of 19, there may be instances where the provider will provide immunizations to children who are ages 19 and 20. Bill Medicaid with the appropriate CPT/HCPCS code, and DMAS will reimburse the acquisition cost for these vaccines. DMAS will not reimburse an administration fee since these vaccines were not covered under the VFC Program to this age group.

Office Visits Billed in Conjunction With Immunizations

DMAS will reimburse physicians an appropriate minimal office visit (e.g., CPT/HCPCS code 99211), in addition to the administration fee or acquisition cost as appropriate (only for ages 19 and 20) when an immunization is the only service performed.

Single Antigen Vaccines

Single antigen vaccines (such as measles, mumps, and rubella) are available from the VFC contractor but must be ordered by the provider with special justification since the combined antigen vaccine (MMR) is available. This is consistent with DMAS policy to require medical justification for single antigen vaccines.

Pneumococcal and Influenza Vaccines

The VFC Program provides coverage for the pneumococcal and influenza vaccines for high-risk patients only. When ordering these vaccines through the health department, the provider must provide medical justification. DMAS will provide reimbursement for these vaccines only if they are reasonable and necessary for the prevention of illness. Medical justification does not need to be attached to the claim, but the physician's treatment plan on file in the patient's medical record must indicate that the vaccine was provided to prevent the occurrence of more serious illness in an individual "at risk."

Vaccines Provided Outside of the EPSDT Periodicity Schedule

Virginia Medicaid covers childhood immunizations under the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program based upon a periodicity schedule. This schedule was developed by the Advisory Committee on Immunization Practices (ACIP) and the American Academy of Pediatrics along with representatives from the American Academy of Family Physicians. See *Supplement B - EPSDT* for a copy of the immunization schedule. If the provider provides a vaccine to a child that falls outside of this immunization schedule and the vaccine does not meet the criteria for coverage under the VFC Program, DMAS cannot reimburse for immunizations under these conditions unless documentation is sent along with the claim to explain the circumstances under which the vaccine was provided. In addition to the attachment to the claim, use modifier 22 in Locator 24-D to bill DMAS for the acquisition cost.

Questions

For questions relating specifically to the VFC program, call the Virginia Department of Health Hotline at 1-800-568-1929. The VDH Hotline is available Monday through Friday from 7:00 a.m. to 5:00 p.m. For other questions, call the Medicaid HELPLINE.

NON-COVERED SERVICES

Some dialysis centers use intradialytic parenteral nutrition (IPDN) as an adjunct to dialysis.

Virginia Medicaid does not cover IDPN in the form of amino acids, vitamins, minerals, and other nutrients administered during the dialysis session.

COPAYMENTS

Recipients with Special Indicator C on their cards are required to share in the cost of each dialysis treatment. A $1.00 copayment for each treatment must be paid by the recipient to the dialysis center. However, **no copayment** is to be collected for service rendered to recipients under the following conditions:

- An emergency or life-threatening condition exists. If this condition exists, mark an "X" in Locator 24 I (Accidental Injury) on the HCFA-1500 (12-90);
- Any pregnancy-related service;
- Recipient is under 21 years of age;
- Recipient resides in a long-term care facility; or
- Recipient is in a hospice program.

If any of these conditions exist, no copayment will be deducted from the provider's calculated payment.

Services to recipients cannot be denied solely because of their inability to pay any applicable copayment charge. This does not relieve the recipient of the responsibility to pay nor does it prevent the provider from attempting to collect any applicable copayment from the recipient.

MEDICARE CATASTROPHIC COVERAGE ACT OF 1988
[Effective Date: January 1989]

The Medicare Catastrophic Coverage Act of 1988 and other legislation require State Medicaid Programs to expand the coverage of services to certain low income Medicare beneficiaries, known as Qualified Medicare Beneficiaries (QMBs).

QMB Coverage Only

Recipients in this group are eligible for Medicaid coverage of Medicare premiums and of deductible and coinsurance up to the Medicaid payment limit on allowed charges for all Medicare-covered services. They will receive Medicaid cards with the message "QUALIFIED MEDICARE BENEFICIARY - QMB - MEDICAID PAYMENT LIMITED TO MEDICARE COINSURANCE AND DEDUCTIBLE." The Medicare coinsurance is limited to the Medicaid fee when combined with the Medicare payment.

QMB Extended Coverage

Recipients in this group will be eligible for Medicaid coverage of Medicare premiums and of deductible and coinsurance on allowed charges up to Medicaid payment limits less the recipient copayment for all Medicare-covered services plus coverage of all other Medicaid-covered services listed in Chapter I of this manual. This group will receive Medicaid cards with the message "QUALIFIED MEDICARE BENEFICIARY - QMB - EXTENDED." These recipients are responsible for copay for pharmacy services, health department clinic visits, and vision services. Effective July 1, 1992, this group will also be responsible for copay for hospital and physician visits.

All Others

Recipients without either of these messages on their Medicaid cards will be eligible for those covered services listed in Chapter I of this manual.

CLIENT MEDICAL MANAGEMENT PROGRAM

As described in Chapters III and VI of this manual, the State may designate certain recipients to be restricted to specific physicians and pharmacies. When this occurs, it is noted on the Medicaid recipient's ID card. A Medicaid-enrolled physician who is not the designated primary provider may provide and be paid for services to these recipients only:

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

- On written referral from the primary physician, using the Practitioner Referral Form (DMAS-70). This also applies to covering physicians.

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

Renal dialysis clinics are excluded, which means that restricted recipients are not required to obtain a written referral from the designated primary care physician, and there are no special billing instructions for renal dialysis services. Clinic providers are encouraged, however, to coordinate treatment with the primary care physician whose name appears on the recipient's eligibility card, since other services and medications are monitored routinely by primary care providers.

PREAUTHORIZED SERVICES FOR RETROACTIVE ELIGIBILITY

For services requiring preauthorization, all preauthorization criteria must be met for the claim to be paid. For those services occurring in a retroactive eligibility period, after-the-fact authorizations will be performed by DMAS.