
CHAPTER VI

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**CHAPTER VI
UTILIZATION REVIEW AND CONTROL**

INTRODUCTION

Under the provisions of federal regulations, the Medical Assistance program must provide for continuing review and evaluation of the care and services paid through Medicaid, including review of utilization of the services of providers and by recipients. Federal regulations of 42 CFR §§ 455-456 set forth requirements for detection and investigation of Medicaid fraud and abuse to maintain program integrity and require implementation of a statewide program of utilization control to ensure high quality care as well as the appropriate provision of services. This chapter provides information on utilization review and control requirements handled by the Department of Medical Assistance Services (DMAS).

FINANCIAL REVIEW AND VERIFICATION

The purpose of financial review and verification of services is to ensure that the provider bills only for those services that have been provided in accordance with DMAS policy and that are covered under the Virginia Medical Assistance programs and services. Any paid provider claim that cannot be verified at the time of review cannot be considered a valid claim for services provided, and is subject to retraction.

REVIEW AND EVALUATION OVERVIEW

The Department of Medical Assistance Services (DMAS) routinely conducts utilization review to ensure that the services provided to Medicaid recipients are medically necessary and provided by the appropriate provider. Participating Medicaid providers are responsible for ensuring that requirements, such as record documentation for services rendered, are met in order to receive payment from DMAS. Under the Participation Agreement with DMAS, the provider also agrees to give access to records and facilities to Virginia Medical Assistance Program representatives, the Attorney General of Virginia or his authorized representatives, and authorized federal personnel upon reasonable request.

Providers and recipients are identified for review either from systems-generated reporting using various sampling methodologies or by referrals and complaints from agencies or individuals. Provider reviews are initiated on a regular basis to meet federal requirements. To ensure a thorough and fair review, trained professionals employed by DMAS will review all cases utilizing available resources, including appropriate consultants, and make on-site reviews of medical records as necessary.

The use of statistical sampling is recognized as a valid basis for findings of fact in the context of Medicaid reimbursement. DMAS will utilize a scientific focus sample of paid claims for the audit period. Overpayments are calculated based upon review of claims requested during a specified time period.

Providers will be required to refund payments made by Medicaid if they are found to have billed Medicaid contrary to regulation or statute, failed to maintain any record or adequate documentation to support their claims, or billed for medically unnecessary services. In

addition, due to the provision of poor quality services or of any of the above problems, Medicaid may limit, suspend, or terminate the provider's participation agreement.

Corrective actions for recipients include education on the appropriate use of health care, restriction to designated providers for utilization control, recovery of misspent funds, and referral for further investigation of allegations of fraudulent activities. Loss of Medicaid coverage can result from a conviction of Medicaid fraud.

INPATIENT SERVICES

General Acute Care Hospital Audits

The Department of Medical Assistance Services (DMAS) is required to conduct routine utilization review audits on providers conducting inpatient services for Medicaid recipients within inpatient and acute care facilities. These audits are conducted to determine that the provider is in compliance with the regulations governing general acute care hospitals found in 42 CFR, Section 456.50-456.145. These audits can be performed either on-site or as a desk audit. The facility shall make all requested records available and shall provide an appropriate place for the auditors to conduct the review if conducted on-site.

DMAS staff will send the provider a written request for recipient records. Facilities must submit requested records within 30 days of the date on the Request for Records letter. If a facility fails to comply with the request for records, an overpayment to DMAS will be required. The facility may request one extension by contacting the reviewer prior to the 30 day deadline.

If an onsite is conducted, DMAS staff will send the provider a written request for recipient records. Facilities must have these records available for the reviewer as specified in the Request for Records letter. If a facility fails to comply with the request for records for the onsite audit, an overpayment to DMAS will be required. DMAS staff will not issue extensions for onsite audits.

Absence of any of required documentation for either freestanding facilities or acute care hospitals may result in retraction of payment. Providers will be required to refund payment if they are found to have billed Medicaid contrary to law or regulation, failed to maintain any record or adequate documentation to support their claims, or billed for medically unnecessary services. Refer to Chapter IV for the requirements

Appeals for Services Reviewed

Payment to providers may be denied when the provider has failed to comply with established federal and state regulations or policy guidelines.

If a provider disagrees with the results of the UR they may appeal the findings by filing a written notice of appeal with the DMAS Appeals Division within 30 days of the receipt of the final audit findings letter. The notice of appeal is considered filed when it is date

stamped by the DMAS Appeals Division. The notice must identify the issues being appealed and must be Sent to:

Appeals Division
Department of Medical Assistance Services
600 East Broad Street, 11th Floor
Richmond, VA 23219

The normal business hours of DMAS are from 8:00 a.m. through 5:00 p.m. on dates when DMAS is open for business. Documents received after 5:00 p.m. on the deadline date shall be untimely.

If the provider chooses not to appeal the said finding(s) and are unable to submit payment in full within 30 days of finding letter, they should immediately request an extended repayment plan. If a provider does not respond to this letter by repaying the amount in full, by requesting an extended repayment schedule, or by filing a notice of appeal, DMAS must take further action to collect.

CERTIFICATION AND RECERTIFICATION

The Medical Assistance Program recognizes the physician as the key figure in determining utilization of health services; the physician determines the appropriateness of admission to a hospital; orders tests, drugs, and treatments; and determines the length of stay. In recognition of this responsibility, Medicaid calls for substantiation of certain physician decisions as an element of proper administration and fiscal control. Medicaid requires that payment for certain covered services may be made to a provider of services only if there is a physician's certification concerning the necessity of the services furnished and, in certain instances, only if there is a physician's recertification as to the continued need for the covered services.

The provider of services is responsible for obtaining timely physician certification and recertification statements and for retaining them on file for verification, when needed by the intermediary or by this state agency. Providers are allowed some flexibility to determine the manner in which certification and recertification statements are obtained as long as the required information is included in the patient record and can be verified.

Admission Certification and Plan of Care

Federal regulations (42 CFR §456.60 and § 456.80) mandate that there must be an admission certification and plan of care to justify every Medicaid inpatient hospital admission. Compliance is monitored on a regular basis by Medicaid's utilization review staff. Noncompliance will result in reimbursement of the paid claim being recouped by Medicaid.

The certification (stating that inpatient services are needed by the patient) must be in writing and signed by an individual clearly identified as a physician (M.D.), doctor of osteopathy (D.O.), or dentist (D.D.S.). The certification must be completed, signed, and

dated within 24 hours of admission. Each certification and recertification statement is to be separately signed by a physician.

Certification and recertification statements may be provided on a separate form, or may be included in physician admission orders, progress notes, or other records a physician normally signs in caring for a patient, if the physician includes a statement indicating where the required information is contained in the patient's medical records. Alternatively, certification may be made with a stamp stating "Certified for Necessary Hospital Admission" which must be made an identifiable part of the patient records.

A written plan of care must be completed within 24 hours of admission for each Medicaid recipient. If the individual applies for Medicaid while in the hospital, the plan of care must be completed before payment for care can be authorized. The plan must be an identifiable part of patient records and must include:

- Diagnosis, symptoms, complaints, and complications indicating the need for admission;
- A description of the functional level of the individual;
- Any orders for medication, treatment, restorative or rehabilitative services, activities, social services, and diet;
- Plans to continue care as appropriate; and
- Tentative discharge plan.

An admission certification and plan of care form similar to the sample admission certification and plan of care in the "Exhibits" section is preferred in order to meet federal requirements in a uniform manner.

Recertification

Each recertification must be contemporaneously completed, signed, and dated by an individual clearly identified as a physician, physician assistant or nurse practitioner acting within the scope of practice as defined by state law and under the supervision of a physician. The individual must recertify for each patient that inpatient services in a hospital are needed. Recertification must be completed, signed, and dated at least every 60 days after certification.

Certification and Recertification for Recipient Receiving Retroactive Eligibility

If any individual receives services before his or her entitlement to Medical Assistance Program benefits, the timing of certification and recertification will be determined as if the date of entitlement was the date of admission. Example: If any individual is admitted to a hospital before entitlement, the date of entitlement will determine the timing of certification and recertification, not the date of admission. All required certification and recertifications must be obtained before the provider requests payment for any portion of the inpatient stay.

FRAUDULENT CLAIMS

Fraud means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself / herself or some other person. It includes any act that constitutes fraud under applicable federal or state law.

Since payment of claims is made from both state and federal funds, submission of false or fraudulent claims, statements, or documents or the concealment of a material fact may be prosecuted as a felony in either federal or state court. The program maintains records for identifying situations in which there is a question of fraud and refers appropriate cases to the Office of the Attorney General for Virginia, the United States Attorney General, or the appropriate law enforcement agency.

Provider Fraud

The provider is responsible for reading, understanding, and adhering to applicable state and federal regulations and to the requirements set forth in this manual. The provider is also responsible for ensuring that all employees are likewise informed of these regulations and requirements. The provider certifies by his/her signature or the signature of his/her authorized agent on each invoice that all information provided to DMAS is true, accurate, and complete. Although claims may be prepared and submitted by an employee, providers will still be held responsible for ensuring their completeness and accuracy.

Repeated billing irregularities or possible unethical billing practices by a provider should be reported to the following address, in writing, and with appropriate supportive evidence:

Supervisor, Hospital Utilization Review Unit
Program Integrity Division
Department of Medical Assistance Services
600 East Broad Street, 9th Floor
Richmond, Virginia 23219

Investigations of allegations of provider fraud are the responsibility of the Medicaid Fraud Control Unit in the Office of the Attorney General for Virginia. Provider records are available to personnel from that unit for investigative purposes. Referrals are to be made to:

Director, Medicaid Fraud Control Unit
Office of the Attorney General
900 East Main Street, 5th Floor
Richmond, Virginia 23219

UTILIZATION REVIEW ACTIVITIES

Introduction

In addition to the certification and recertification by the patient's own physician, as mentioned in Chapter IV, the hospital is required to have a utilization review plan which provides for review of all Medicaid patient stays and medical care evaluation studies of

admissions, durations of stay, and professional services rendered. The objective of the utilization review mechanism is the maintenance of high-quality patient care and the most efficient utilization of resources through an educational approach involving the study of patient care.

The objective of utilization review is to ensure that inpatient care is provided only when medically necessary and that the care meets quality standards.

Medicaid requires that effective utilization review be maintained on a continuing basis to ensure the medical necessity of the services for which Medicaid pays and to promote the most efficient use of available health facilities and services.

Utilization Review (UR) – General Requirements

The review will include the examination the following areas/items:

- A copy of the facility's Utilization Review Plan,
- A list of the Utilization Review Committee members and physician advisors,
- Written verification of Utilization Review Committee meetings for the year, to include the dates and list of attendees,
- One completed medical care evaluation study to include the objectives of the study, analysis of the results of the study, action(s) and/or recommendations to undertake,
- The topic of an on-going medical care evaluation study,
- Recipient medical records to include a copy of the certification for admission, admission face sheet, history and physical, discharge summary, physician's orders, physician's progress notes, copy of the applicable ER records and a copy of the utilization review worksheet. For psychiatric admissions, the independent team certification and a copy of the required medical, psychiatric and social evaluations are also required.
- Documentation of compliance with Deficit Reduction Act of 2005 (DRA)
- Written verification of provider's monthly search of the U.S. Department of Health and Human Services' Office of Inspector General (HHS-OIG) List of Excluded Individuals and Entities (LEIE)

Medical Records and Retention

The facility must recognize the confidentiality of recipient medical record information and provide safeguards against loss, destruction, or unauthorized use. Written procedures must govern medical record use and removal and the conditions for the release of information. The recipient's written consent is required for the release of information not authorized by law. Current recipient medical records and those of discharged recipients must be completed promptly. All clinical information pertaining to a recipient must be centralized in the recipient's clinical/medical record.

Records of inpatient services must be retained for not less than five years after the date of discharge. Records must be indexed at least according to the name of the recipient to facilitate the acquisition of statistical medical information and the retrieval of records for research or administrative action. The provider must maintain adequate facilities and equipment, conveniently located, to provide efficient processing of the clinical records (reviewing, indexing, filing, and prompt retrieval). **Refer to 42 CFR 482.24 for additional requirements.**

The facility must maintain medical records on all recipients in accordance with accepted professional standards and practice. The records must be completely and accurately documented, readily accessible, legible, and systematically organized to facilitate the retrieval and compilation of information.

All inpatient medical record entries must be fully signed, and dated (month, day, and year) including the title (professional designation) of the author. Documentation should be clear and legible. A required physician signature for DMAS purposes may include signatures, computer entry, or rubber-stamped signature initialed by the physician. These methods only apply to DMAS requirements. For more complete information, refer to the Medicaid *Physician Manual*. If a physician chooses to use a rubber stamp on documentation requiring his or her signature, the physician whose signature the stamp represents must provide the provider's administration with a signed statement to the effect that he or she is the only person who has the stamp and he or she is the only person who will use it. The physician must initial and completely date all rubber-stamped signatures at the time the rubber stamp is used.

Upon the transfer of ownership or closure of a service provider or facility, the current provider or facility is required to notify DMAS Provider Enrollment and the supervisor of the Hospital Utilization Review Unit in writing within 30 days of the effective date of the change. Information required concerning the change includes, but is not restricted to, the effective date of the change and who will have custody of the files/records.

Send notice to:

Department of Medical Assistance Services
Hospital Utilization Review Supervisor
600 E. Broad Street, 9th Floor
Richmond, Virginia 23219

Admission Review

The Virginia Medical Assistance Program delegates utilization review of inpatient hospital services for all Medicaid admissions to the local facilities' utilization review department. Medicaid requires 100 percent utilization review of Medicaid patients. The hospital must have a utilization review plan (42 CFR §§ 456.101 - 456.145) reflecting 100 percent review of Medicaid patients, approved by the Division of Licensing Certification, Department of Health (VDH), and DMAS or appropriate licensing agency in the state in which the institution is licensed. Staff will review the functions associated with approved hospital utilization review plans for compliance with 42 CFR §§ 456.101 to 456.145.

The hospital utilization review coordinator is required to approve the medical necessity, based on a list of admission criteria approved by the Utilization Review Committee, within one working day of admission. In the event of an intervening Saturday, Sunday, or holiday, a review must be performed the very next working day. This must be reflected in the hospital utilization review plan and the patient's record.

- If the admission is determined to be medically necessary, an initial stay review date must be assigned within the 50th percentile of norms approved by the Utilization Review Committee except in circumstances that are properly documented in the progress notes and reflected on the utilization review sheets. Continued or extended stay review must be assigned prior to or on the date assigned for the initial stay. If the facility's Utilization Review Committee has reason to believe that an inpatient admission was not medically necessary, it may review the admission at any time. However, the decision of a Utilization Review Committee in one facility is not binding upon the Utilization Review Committee in another facility.
- If the admission or continued stay is found to be medically unnecessary, the attending physician must be notified and be allowed to present additional information. If the hospital physician advisor still finds the admission or continued stay unnecessary, a notice of adverse decision must be made within one working day after the admission or continued stay is denied. Copies of this decision must be sent by the Utilization Review Committee's designated agent to the hospital administrator, attending physician, recipient or recipient's authorized representative, and Medicaid. Medicaid notification must be sent to:

Manager, Prior -Authorization Utilization Review
Division of Program Integrity
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

The role of the hospital Utilization Review Committee is to ensure that only medically necessary care is delivered. The hospital Utilization Review Committee must issue a written adverse determination letter to the recipient if, after following the regulatory steps of adverse determination, the Committee determines that the admission or continued stay is not medically necessary. For general hospitals, refer to 42 CFR §§ 456.121 to 456.126 and §§ 456.131 through 456.137. For mental hospitals, refer to 42 CFR §§ 456.236 through 456.238. These citations describe the review procedures required, including the adverse determination steps.

When communicating an adverse determination decision to a recipient, the hospital must clearly indicate, in a letter to the recipient, that the decision is based on the medical necessity review of the Utilization Review Committee at the hospital. Further, the adverse

determination letter must indicate that the attending physician has been notified of the decision and must advise the recipient that he or she will be responsible for payment after the effective date of the adverse determination. The letter must be signed by a representative of the hospital's Utilization Review Committee and by the recipient as an acknowledgment of the receipt of the notification.

There has been no modification to the hospital adverse determination process as the result of the hospital preauthorization process performed for DMAS by the PA Contractor (see Chapter IV). DMAS will not acknowledge adverse determination letters issued by hospitals unless they follow the guidelines detailed in this manual and in the Code of Federal Regulations. Further, hospitals may not hold any Medicaid recipient liable for any portion of the hospital bill unless the hospital Utilization Review Committee has communicated to the recipient its adverse decision based on medical necessity. The only exception to this would be for a non-Medicaid-covered service and the applicable copayments.

The hospital Utilization Review Committee's decision should in no way be confused with a preauthorization review decision rendered by the PA contractor. Hospitals may not rely on the PA contractor decision either to justify or deny an admission to or continued stay in the hospital. The responsibilities of the hospital Utilization Review Committee are independent of the authorization performed by the PA contractor.

Medical Care Evaluation Studies (MCES)

As part of their utilization review plan, hospitals must have one medical or patient care evaluation study in process and one completed each calendar year. Medical care evaluation studies must contain the elements mandated by 42 CFR §§ 456.141 through 456.145. Virginia Medicaid requires that each study must include:

- Objectives of the study;
- Results of the study;
- Evaluation of results; and
- Action plan or recommendations as indicated by study results.

ABORTIONS

As of July 1, 2010, induced (elective) abortions are covered by the Virginia Medical Assistance Program **only** upon the physician's certification that in his or her professional medical judgment the life of the member would be substantially endangered if the fetus were carried to term.

The policy statement does not pertain to the treatment of incomplete, missed, or septic abortions. Reimbursement for these types of abortions are covered as before.

The abortion certification (MAP-3006) must accompany each claim for an induced (elective) abortion. Note that, if a woman's life would be endangered by carrying the fetus to term, the attending physician must so certify.

A copy of the physician certification (MAP-3006) must be attached to each invoice related to the induced abortion (e.g., surgeon, hospital, anesthesiologist). (See “Exhibits” at the end of this chapter for a sample of this form.) Any claim submitted without the appropriate certification will be denied. All billing providers must secure a copy of the physician certification from the originating physician.

Reimbursement is available for those abortions performed during periods of **retroactive** eligibility if the physician certifies in writing on the MAP-3006 that, on the basis of his or her professional judgment, **the life of the mother would have been endangered** if the fetus had been carried to term. The certification must contain the name and address of the patient and the member ID number.

ICD-CM Abortion Procedure Codes

ICD-10-CM Abortion Procedure Codes for dates of service on or after 10/01/15

10A07ZZ, 10A08ZZ	Dilation and curettage for termination of pregnancy
10A07ZZ, 10A08ZZ	Aspiration curettage of uterus for termination of pregnancy
10A00ZZ-e 10A04ZZ	Hysterotomy to terminate pregnancy
10A07ZX	Intra-amniotic injection for abortion

ICD-9-CM Abortion Procedure Codes*

6901	Dilation and curettage for termination of pregnancy
6951	Aspiration curettage of uterus for termination of pregnancy
7491	Hysterotomy to terminate pregnancy
750	Intra-amniotic injection for abortion

Excludes: Insertion of prostaglandin suppository for abortion (9649) and (6993) insertion of laminaria.

*Note: The codes that define abortion procedures refer to legal abortions only. These procedures must meet specific criteria to receive federal matching funds. Any medical treatment as a result of an abortion is considered a medical service and not subject to funding restrictions.

HYSTERECTOMY

According to federal regulations, hysterectomy is not a sterilization procedure. Therefore, patients undergoing surgery that is not for, but results in, sterilization are not required to complete the sterilization consent form (DMAS-3004) or adhere to the required waiting

period. However, hysterectomies performed solely for the purpose of rendering an individual incapable of reproducing are not covered by Medicaid.

Conditions for Service

Payment may be made for hysterectomies as follows:

- **Medically Necessary** - A medically necessary hysterectomy may be covered only when the person securing the authorization to perform the hysterectomy has informed the individual or her representative, if applicable, orally and in writing **before the surgery** is performed that the hysterectomy will render the individual permanently incapable of reproducing, and the individual or her representative has signed a written Acknowledgment of Receipt of Hysterectomy Information Form (DMAS-3005). (See "Exhibits" at the end of this chapter for a sample of this form.) The Physician Statement must be completed and signed by the physician, and in this situation, Section A must be marked.

When a hysterectomy is performed as a consequence of abdominal exploratory surgery or biopsy, the Acknowledgment of Receipt of Hysterectomy Information Form is also required. Therefore, it is advisable to inform the patient or her representative prior to the exploratory surgery or biopsy. Again, Section A of the Physician Statement must be completed.

- **Emergency** - When a hysterectomy is performed on an emergency basis because of life-threatening circumstances, Section B of the Physician Statement must be marked and a description of the nature of the emergency must be included. The completed Physician Statement must be attached to each invoice related to the hysterectomy (e.g., surgeon, hospital, anesthesiologist). The patient does not have to sign this form. An example of this situation would be when the patient is admitted to the hospital through the emergency room for immediate medical care, and the patient is unable to understand and respond to information pertaining to the acknowledgment of the receipt of hysterectomy information due to the emergency nature of the admission.
- **Sterility** - If the patient is sterile prior to the hysterectomy, Section C of the Physician Statement must be marked and a statement regarding the cause of the sterility must be included. The completed Physician Statement must be attached to each invoice related to the hysterectomy (e.g., surgeon, hospital, anesthesiologist). The patient does not have to sign the form. (For example, this form would be used when the sterility was postmenopausal or the result of a previous surgical procedure.)

Claims Requirements

A copy of the form DMAS-3005 must be attached to each provider's invoice for a hysterectomy procedure if Medicaid is to consider the claim for payment. Failure to

provide the appropriate acknowledgment or certification will result in denial of the claim. Hospitals and other billing providers will need to secure from the originating provider a copy of the DMAS-3005 before submitting their claims to Virginia Medicaid. Any claim submitted without a properly executed DMAS-3005 or documentation showing emergency medical necessity will be denied.

ICD-CM Hysterectomy Procedure Codes

From ICD-10-CM Hysterectomy Procedure Codes for dates of service on or after 10/01/15:

0UT94ZZ: Laparoscopic supracervical hysterectomy

0UT90ZZ: Other and unspecified subtotal abdominal hysterectomy

0UT94ZZ, 0UTC4ZZ: Laparoscopic total abdominal hysterectomy

0UT90ZZ, 0UTC0ZZ: Other and unspecified total abdominal hysterectomy

0UT9FCZ, 0UTC4ZZ: Laparoscopically assisted vaginal hysterectomy (LAVH)

0UT97ZZ,0UT98ZZ,0UTC7ZZ,0UTC8ZZ : Other and unspecified vaginal hysterectomy

0UT94ZZ, 0UT44ZZ, 0UTC4ZZ: Laparoscopic radical abdominal hysterectomy

0UT90ZZ, 0UT40ZZ,0UTC0ZZ: Other and unspecified radical abdominal hysterectomy

0UT9FZZ,0UT44ZZ,0UTC4ZZ: Laparoscopic radical vaginal hysterectomy (LRVH)

0UT97ZZ,0UT98ZZ,0UT47ZZ,0UT48ZZ,0UTC7ZZ,0UTC8ZZ: Other and unspecified radical vaginal hysterectomy

0UT90ZZ,0UTC0ZZ,0UT20ZZ,0UT70ZZ,0UTG0ZZ,0TTB0ZZ,0TTD0ZZ,0DTP0ZZ : Pelvic evisceration

0UT90ZZ, 0UT94ZZ: Other and unspecified hysterectomy

ICD-9-CM Hysterectomy Procedure Codes

683 9 Partial or Subtotal (supracervical)(supravaginal) hysterectomy

684 9 Total abdominal hysterectomy

6851 Laparoscopically Assisted Vaginal hysterectomy (LAVH)

6859 Vaginal Hysterectomy (complete) (partial) (subtotal) (total)

686 9 Radical (modified) abdominal hysterectomy

687 9 Radical vaginal hysterectomy

688 Pelvic evisceration

689 Other and unspecified hysterectomy

6919 Other excision or destruction of uterus and supporting structures

-
- 6831 Classic Intrafascial SEMM hysterectomy (CISH), laparoscopically assisted (LASH)
 - 6841 Total Laparoscopic (TLH)
 - 6861 Laparoscopic (total) radical (TLRH)
 - 6871 Laparoscopic radical vaginal hysterectomy (LRVH)

Retroactive Coverage

Reimbursement is available for hysterectomies performed during periods of retroactive eligibility if the physician will certify on the DMAS-3005 that one of the following conditions was met:

- The physician informed the recipient before the operation that the procedure would make her sterile. In this case, the patient and the physician must sign the DMAS-3005.
- The recipient met one of the exceptions provided in the Physician Statement Section of the DMAS-3005. In this case, no recipient signature is required.

STERILIZATION

Human Reproductive Sterilization

Human reproductive sterilization is defined by DMAS as any medical treatment, procedure, or operation for the purpose of rendering an individual permanently incapable of reproducing. Sterilizations that are performed because pregnancy would be life-threatening to the mother (so-called "therapeutic" sterilizations) are included in this

definition. The term sterilization, as used in Medicaid regulations, means only human reproductive sterilization, as defined above.

Note: Treatment which is not for the purpose of, but results in, sterility (formerly referred to as secondary sterilization) does not require completion of the Sterilization Informed Consent Form. This applies for the purposes of Medicaid payment only. Informed consent and billing requirements associated with the performance of a hysterectomy are referred to later in this section.

Conditions of Coverage

The conditions under which sterilization procedures for both inpatient and outpatient services are payable by Medicaid conform to federal regulations.

A sterilization will be covered under Medicaid only if the following conditions are met:

- The individual is at least 21 years old at the time consent for sterilization is obtained.
Note: A patient must be 21 years old to give consent to a sterilization. This is a federal requirement for sterilizations only (see 42 CFR § 441.253) and

is not affected by any other state law regarding the ability to give consent to medical treatment generally. The age limit is an absolute requirement. There are no exceptions for marital status, number of children, or for a therapeutic sterilization.

- The individual is not a mentally incompetent individual. For Medicaid purposes, a mentally incompetent individual is a person who has been declared mentally incompetent by the federal, state, or local court of competent jurisdiction for any purpose, unless the individual has been declared competent for purposes that include the ability to consent to sterilization. The competency requirement is an absolute requirement. There are no exceptions.
- The procedure has not been court-ordered.
- The individual has voluntarily given informed consent in accordance with all the requirements prescribed in this section.
- The individual is able to understand the content and nature of the informed consent process as specified in this section. A patient considered mentally ill or mentally retarded may sign the consent form if it is determined by a physician that the individual is capable of understanding the nature and significance of the sterilizing procedure. This form is to be signed by the physician and witnessed.
- The individual is not institutionalized. For the purposes of Medicaid reimbursement for sterilization, an institutionalized individual is a person who is:
 - Involuntarily confined or detained under civil or criminal statute in a correctional or rehabilitative facility, including a mental hospital or other facility for the care and treatment of mental illness, or
 - Confined under a voluntary commitment in a mental hospital or other facility for the care and treatment of mental illness
- At least 30 days, but not more than 180 days, have passed between the date of informed consent and the date of the sterilization, except in the following instances:
 - Sterilization may be performed at the time of emergency abdominal surgery if the patient consented to the sterilization at least 30 days before the intended date of sterilization and at least 72 hours have passed after written informed consent was given and the performance of the emergency surgery.
 - Sterilization may be performed at the time of premature delivery if the following requirements are met: the written informed consent was given at least 30 days before the expected date of the delivery, and at least 72 hours have passed after written informed consent to be sterilized was given.

- A completed consent form must accompany all claims for sterilization services. This requirement extends to all providers: attending physicians or surgeons, assistant surgeons, anesthesiologists, and facilities. Only claims directly related to the sterilization surgery, however, require consent documentation. Claims for presurgical visits and tests or services related to post-surgical complications do not require consent documentation.

Informed Consent Process of Sterilization

The informed consent process may be conducted either by a physician or by the physician's designee.

An individual has given informed consent only if:

- The person who obtained consent for the sterilization procedure:
 - Offered to answer any questions the individual may have had concerning the sterilization procedure;
 - Provided the individual with a copy of the consent form; and
 - Provided orally all of the following information to the individual to be sterilized:
 - Advice that the individual is free to withhold or withdraw consent to the procedure at any time before the sterilization without affecting the right to future care or treatment and without loss or withdrawal of any federally funded program benefits to which the individual might be otherwise entitled;
 - A description of available alternative methods of family planning and birth control;
 - Advice that the sterilization procedure is considered to be irreversible;
 - A thorough explanation of the specific sterilization procedure to be performed;
 - A full description of the discomforts and risks that may accompany or follow performing the procedure, including an explanation of the type and possible effects of any anesthetic to be used;
 - A full description of the benefits or advantages that may be expected as a result of the sterilization; and
 - Advice that the sterilization will not be performed for at least 30 days, except under the circumstances of premature delivery or emergency abdominal surgery, in which case 72 hours must have passed between the informed consent and surgery; also, in the case of premature delivery, consent must have been given at least 30 days prior to the expected date of delivery.
- Suitable arrangements were made to ensure that the information specified above was effectively communicated to any individual who is to be sterilized.

- An interpreter was provided if the individual to be sterilized did not understand the language used on the consent form or the language used by the person obtaining consent.
- The individual to be sterilized was permitted to have a witness of his or her choice present when consent was obtained.
- The sterilization operation was requested without fraud, duress, or undue influence.
- All other state and local requirements were followed.
- The appropriate consent form was properly filled out and signed (see below).
- **Informed consent may not be obtained while the individual to be sterilized is:**
 - **In labor or within 24 hours postpartum or post-abortion**
 - **Seeking to obtain or obtaining an abortion**
 - "Seeking to obtain" means that period of time during which the abortion decision and the arrangements for the abortion are being made.
 - "Obtaining an abortion" means that period of time during which an individual is undergoing the abortion procedure, including any period during which preoperative medication is administered.
Note: DMAS prohibits the giving of consent to a sterilization at the same time a patient is seeking to obtain or obtaining an abortion. This does not mean, however, that the two procedures may never be performed at the same time. If a patient gives consent to sterilization, then later wishes to obtain an abortion, the procedures may be done concurrently. An elective abortion does not qualify as emergency abdominal surgery, and this procedure does not affect the 30-day minimum wait.
 - **Under the influence of alcohol or other substances that affect the individual's state of awareness**

Sterilization Consent Document

The only acceptable sterilization consent form is the DMAS-3004. An informed consent does not exist unless the Department of Medical Assistance Services Consent Form (DMAS-3004) is completed voluntarily by a person 21 years of age or over and in accordance with the following requirements. (See "Exhibits" at the end of this chapter for a sample of this form.). No payment will be made without the submission of this form completed, signed, and dated by the patient giving the consent, the person obtaining the consent, and the physician who performed the surgery. The date of the signature of the person obtaining an informed consent must be the same as the date of the signature of the person giving consent. Instructions for completing the form are shown the following page. The numbered items correspond to the numbers on the form as shown under "Exhibits."

Instructions for Completing the Consent Form (DMAS-3004)

<u>Ref.</u>	<u>Blank</u>	<u>Instructions</u>
<u>No.</u>		
1	Doctor or Clinic	This line may be prestamped. If the provider is a physician group, all names may appear (e.g., Drs. Miller and Smith); the professional group name may be listed (e.g., Westside Medical Group); or the phrase "and/or his/her associates" may be used.
2	Name of Operation	If the name of the operation is lengthy, an abbreviation may be used with an asterisk. The full name of the operation should be written out at the bottom of the form.
3	Month, Day, Year	Enter the patient's birth date. This information is required.
4	Patient name	Must be completed. The name used must be identical to the patient name appearing on the claim form.
5	Doctor	May be prestamped. If a group, all names may be listed, or the phrase "and/or his/her associates."
6	Name of Operation	Enter the name of the operation. If the name of the operation is lengthy, an abbreviation may be used with an asterisk. The full name of the operation must be written out at the bottom of the form.
7	Signature	The patient must sign here. If the patient is illiterate, the form of signature permitted is an "X," which should be countersigned by a witness.
8	Month, Day, Year	The patient's signature must be dated. The waiting period is calculated from this date.
<u>Ref.</u>		
<u>No.</u>	<u>Blank</u>	<u>Instructions</u>
9	Ethnic Designation	This information is voluntary and should be completed only by the patient.
10	Language	Indicate the language in which the patient was counseled, if other than English.
11	Interpreter's Signature	Must be signed if an interpreter was used.
12	Month, Day, Year	Interpreter's signature must be dated.
13	Name of Individual	Enter the patient's name here.

14	Name of Operation	If the name of the operation is lengthy, an abbreviation may be used with an asterisk. The full name of the operation must be written out at the bottom of the form.
15	Person Obtaining Consent	The person providing sterilization counseling may be a physician or the physician's designee (e.g., an office nurse). Once this section is completed, the patient should be given a copy of the form.
16	Month, Day, Year	Signature of the person obtaining consent must be dated.
17	Facility	May be prestamped
18	Address	May be prestamped.
20	Date of Operation	Enter the date of the operation.
21	Type of Operation	If the name of the operation is lengthy, an abbreviation may be used with an asterisk. The full name of the operation should be written out at the bottom of the form. Consent is not invalidated if the operation actually performed differs from the method of sterilization originally planned.
22- 23	Final Paragraphs	Cross-out the paragraph not used. The minimum waiting period is 30 days from the date consent was given, except in cases of premature delivery or emergency abdominal surgery.
24	Premature Delivery	If this box is checked, a date of expected delivery must be present in Item 25.
25	Individual's Expected Date of Delivery	Date estimated by the physician based on the patient's history and physical condition.
<u>Ref.</u> <u>No</u>	<u>Blank</u>	<u>Instructions</u>
26	Emergency Abdominal Surgery	Indicate the operation performed.
<u>Ref.</u> <u>No</u>	<u>Blank</u>	<u>Instructions</u>
27	Physician Signature	Must be completed after the sterilization operation, by the physician who has verified consent and who actually performs the operation. The purpose of obtaining consent "shortly before" the operation is to reaffirm consent. This may be done while the patient is in labor or after delivery. In this context, "shortly before" means up to 72 hours prior to the operation.

28 **Month, Day, Year** Physician's signature must be dated.

Use of the Consent Form

The consent form must be signed and dated by the following:

- The individual to be sterilized;
- The interpreter, if one is provided;
- The individual who obtains the consent; and
- The physician who will perform the sterilization procedure.

The person securing consent shall certify by signing the consent form that he or she:

- Advised the individual to be sterilized, before the individual to be sterilized signed the consent form, that no federal benefits may be withheld or withdrawn because of the decision not to be sterilized;
- Explained orally the requirements for informed consent to the individual to be sterilized as set forth on the consent form and in regulations; and
- Determined to the best of his or her knowledge and belief that the individual to be sterilized appeared mentally competent and knowingly and voluntarily consented to be sterilized.

The physician performing the sterilization shall certify by signing the consent form that:

- The physician, shortly before the performance of the sterilization, advised the individual to be sterilized that federal benefits shall not be withheld or withdrawn because of a decision not to be sterilized. (For Medicaid purposes, the phrase "shortly before" means a period within 72 hours prior to the time the patient receives any preoperative medication.);
- The physician explained orally the requirements for informed consent as set forth on the consent form;
- To the best of the physician's knowledge and belief, the individual to be sterilized appeared mentally competent and knowingly and voluntarily consented to be sterilized; and
- At least 30 days have passed between the date of the individual's signature on the consent form and the date the sterilization was performed, except in the following instances:
 - Sterilization may be performed at the time of emergency abdominal surgery if the physician certifies that the patient consented to the sterilization at least 30 days before he or she intended to be sterilized; that at least 72 hours have passed after written informed consent to be

sterilized was given; and the physician describes the emergency on the consent form; and

- Sterilization may be performed at the time of premature delivery if the physician certifies that the written informed consent was given at least 30 days before the **expected** date of the delivery. The physician shall state the expected date of the delivery on the consent form. At least 72 hours have passed after written informed consent to be sterilized was given.

The interpreter, if one is provided, shall certify that he or she:

- Transmitted the information and advice presented orally to the individual to be sterilized;
- Read the consent form and explained its contents to the individual to be sterilized; and
- Determined to the best of his or her knowledge and belief that the individual to be sterilized understood what the interpreter told the individual.

A copy of the signed consent form must be:

- Provided to the patient;
- Retained by the physician and the hospital in the patient's medical records; and;
- Attached to all claims for sterilization services. In addition, no sterilization procedure will be covered at all by Virginia Medicaid unless a copy of the Department of Medical Assistance Services Consent Form (DMAS-3004) is attached to the invoice submitted by each provider, including the surgeon, assistant surgeon, anesthesiologist, hospital, or outpatient clinic in order that each claim might be evaluated. **The DMAS-3004 is the only consent form that will be accepted by Medicaid, and no payment will be made without submission of this form by each provider involved in the sterilization procedure.** Only claims directly related to the sterilization surgery, however, require consent documentation. Claims for presurgical visits and tests or services related to postsurgical complications do not require consent documentation.

Claims for Service

Any claim submitted without a properly executed consent form will be denied. The originating physician is required to supply a copy of the DMAS-3004 to other billing providers.

Note: With the implementation of DRG payment methodology effective with admissions on or after January 1, 2000, for labor and delivery the facility can remove all associated charges for the sterilization when a properly executed DMAS-3004 form is not done. Do

not include the specific sterilization procedure code on the claim. This will allow payment for the labor and delivery.

ICD-10-CM Sterilization Procedure Codes
(for dates of service on or after 10/01/15)

0VTC0ZZ,0VTC4ZZ: Bilateral orchidectomy

0VTC4ZZ: Removal of both testes at same operative episode

0VT90ZZ,0VT94ZZ,0VTB0ZZ,0VTB4ZZ: Removal of remaining testis

0V5N0ZZ-0VTQ4ZZ: Male sterilization procedure, not otherwise specified

0VLN0CZ-0VLQ4ZZ : Ligation of vas deferens

0VLF0CZ-0VLH4ZZ: Ligation of spermatic cord

0VBN0ZZ-0VTQ4ZZ : Vasectomy

0UT20ZZ,0UT27ZZ,0UT28ZZ,0UT2FZZ: Other removal of both ovaries at same operative episode

OUT00ZZ-OUT0FZZ,0UT10ZZ-OUT1FZZ : Other removal of remaining ovary

0UT24ZZ: Laparoscopic removal of both ovaries at same operative episode

0UT04ZZ, OUT14ZZ: Laparoscopic removal of remaining ovary

0UT20ZZ, 0UT70ZZ: Other removal of both ovaries and tubes at same operative episode

0UT00ZZ, 0UT50ZZ,0UT10ZZ,0UT60ZZ: Other removal of remaining ovary and tube

0UT24ZZ, 0UT74ZZ: Laparoscopic removal of both ovaries and tubes at same operative episode

0UT04ZZ, 0UT54ZZ,0UT14ZZ,0UT64ZZ: Laparoscopic removal of remaining ovary and tube

0UL74ZZ, 0UL78ZZ: Bilateral endoscopic ligation and crushing of fallopian tubes

0UL74ZZ, 0UL78ZZ: Bilateral endoscopic ligation and division of fallopian tubes

0U514ZZ, 0U578ZZ, 0UL74CZ, 0L74DZ, 0UL74ZZ, 0UL78DZ, 0UL78ZZ: Other bilateral endoscopic destruction or occlusion of fallopian tubes

0UL70ZZ, 0UL73ZZ, 0UL77ZZ: Other bilateral ligation or crushing of fallopian tubes

0UL70ZZ, 0UL73ZZ, 0UL77ZZ: Other bilateral ligation or division of fallopian tubes

0U570ZZ-0UL7722: Other bilateral destruction or occlusion of fallopian tubes

0UT70ZZ, 0UT74ZZ, 0UT77ZZ, 0UT78ZZ, 0UT7FZZ: Removal of both fallopian tubes at same operative episode

0UT50ZZ-0UT6FZZ : Removal of remaining fallopian tube

ICD-9-CM Sterilization Procedure Codes

- 624 Bilateral orchidectomy
- 6241 Removal of both testes at same operative episode
- 6242 Removal of remaining testis
- 636 Vasotomy
- 637 Vasectomy and ligation of vas deferens
- 6370 Male sterilization procedure, not otherwise specified
- 6371 Ligation of vas deferens
- 6372 Ligation of spermatic cord
- 6373 Vasectomy
- 655 Bilateral oophorectomy
- 6551 Other removal of both ovaries at same operative episode
- 6552 Other removal of remaining ovary
- 6553 Laparoscopic removal of both ovaries at same operative episode
- 6554 Laparoscopic removal of remaining ovary
- 656 Bilateral salpingo-oophorectomy
- 6561 Other removal of both ovaries and tubes at same operative episode
- 6562 Other removal of remaining ovary and tube
- 6563 Laparoscopic removal of both ovaries and tubes at same operative episode
- 6564 Laparoscopic removal of remaining ovary and tube
- 662 Bilateral endoscopic destruction or occlusion of fallopian tubes
- 6621 Bilateral endoscopic ligation and crushing of fallopian tubes
- 6622 Bilateral endoscopic ligation and division of fallopian tubes
- 6629 Other bilateral endoscopic destruction or occlusion of fallopian tubes

- 663 Other bilateral destruction or occlusion of fallopian tubes
- 6631 Other bilateral ligation and crushing of fallopian tubes
- 6632 Other bilateral ligation and division of fallopian tubes
- 6639 Other bilateral destruction or occlusion of fallopian tubes
- 665 Total bilateral salpingectomy

- 6651 Removal of both fallopian tubes at same operative episode
- 6652 Removal of remaining fallopian tube

- 666 1 Excision or destruction of lesion of fallopian tube
- 6663 Bilateral partial salpingectomy not otherwise specified

Retroactive Coverage

Providers are reminded that sterilization is covered only if all applicable requirements are met for the operation performed. This includes:

- The time period required between the date of informed consent and the date of sterilization;
- The informed consent requirements for the individual to be sterilized; and

The certification requirements for signatures of the individual to be sterilized, the interpreter (if applicable), the person obtaining consent, and the physician who performed the sterilization procedure that must be present on the DMAS-3004. If a patient obtains retroactive Medicaid coverage, previously provided sterilization services cannot be billed unless the applicable requirements have been met. There are no exceptions made for retroactive eligibility in regard to the requirements for sterilization.

CLAIMCHECK/CORRECT CODING INITIATIVE (CCI)

The implementation of CCI edits was done January 1, 2009 for all physician and laboratory claims received on this date. ClaimCheck/CCI is part of the daily claims adjudication cycle on concurrent basis. The current claim will be processed to edit history claims. Any adjustments or denial of payments from the current or history claim(s) will be done during the daily adjudication cycle and reported on the providers weekly remittance cycle. All ClaimCheck/CCI edits are based on the following global claim factors: same recipient, same provider, same date of service or date of service is within established pre- or post-operative time frame. DMAS will recognize the following modifiers, when appropriately used as defined by the most recent Current Procedural Terminology (CPT), to determine the appropriate exclusion from the ClaimCheck/CCI process. The recipient's medical record **must** contain documentation to support the use of the modifier by clearly identifying the significant, identifiable service that allowed the use of the modifier. The Division of Program Integrity will monitor and audit the use of these modifiers to assure compliance. These audits may result in recovery of overpayment(s) if the medical record does not appropriately demonstrate the use of the

modifiers. DMAS has provided a listing of the modifiers, examples of common CCI and ClaimCheck edits and ClaimCheck edit error reason codes that can be found at our website www.DMAS.virginia.gov, under Provider Services, Claims and Billing. It is also included as an Exhibit at the end of this chapter.

The modifiers that currently bypass the ClaimCheck/CCI edits are:

- Modifier 24 – Unrelated E & M service by the same physician during the post-operative period

- Modifier 25 – Significant, separately identifiable E & M service on the same day by the same physician on the same day of the procedure or other services.
- Modifier 57 – Decision for Surgery
- Modifier 59 – Distinct Procedural Service
- Modifiers U1-U9 – State-Specific Modifiers

Reconsideration /Appeals

Providers that disagree with the action taken by a ClaimCheck edit may request a reconsideration of the process via email (ClaimCheck@dmas.virginia.gov) or by submitting a request to the following mailing address:

Payment Processing Unit, Claim Check
Division of Program Operations
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

There is a 30-day time limit from the date of the denial letter or the date of the remittance advice containing the denial for requesting reconsideration. A review of additional documentation may sustain the original determination or result in an approval or denial of additional day(s). Requests received without additional documentation will not be considered. Requests received after the 30 time limit will be denied as untimely.

OTHER UTILIZATION REVIEW ACTIVITIES

Ancillary Services for Denied Hospital Days

Medicaid will accept outpatient billings for the medically necessary ancillary services that would have been rendered on an outpatient basis but are provided during a denied inpatient stay. These outpatient billings are limited to those ancillary services performed for any inpatient denials within the first three days of hospitalization. These billings, for utilization review purposes, are to be sent to:

Manager, Payment Processing Unit
Division of Program Operations
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

Every effort must still be made to ensure that ancillary services are performed on an outpatient basis when appropriate

Review and Evaluation

DMAS may exempt, modify, or reapply one or more of the utilization review documentation requirements for claims submitted for specific hospitals as part of its ongoing hospital utilization review performance evaluation. At least once a year, DMAS staff will conduct desk audits to review selected documentation requirements and medical

records.. The purpose of the review of the medical records is to evaluate the necessity for and adequacy of the care provided and to audit compliance with state and federal regulations and policies. The provider will make all medical records available as requested for utilization review within the allowed timeframe.

During the review of the DRG validation, DMAS or a DMAS contractor will conduct Diagnosis Related Groups (DRGs) audits. DRG assignments will be validated. Correct diagnosis and procedure codes must be submitted on the claim and be supported in the recipient's medical record. Any inaccurate DRG coding assignment and billing practices will be identified and reported to DMAS and payment retracted.

In order to validate the prior-authorizations, DMAS Hospital Utilization Review Analysts will review information contained in the patient's medical record with that provided by to the PA Contractor during the prior-authorization process. This review is to ensure that the admission for medical/surgical cases and admission and length of stays for psychiatric cases are appropriate based on the patient's medical record.

All reviews will be done on a post payment basis; therefore, the current process of contacting the PA Contractor for prior authorization requests does not change. In addition, claims will not suspend pending review of the medical records, and the initial payment of the claims will not be affected.

REFERRALS TO THE CLIENT MEDICAL MANAGEMENT PROGRAM

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

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

Supervisor, Recipient Monitoring Unit
Division of Long Term Care and Quality Assurance
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

Telephone: (804) 786-6548

CMM Helpline: 1-888-323-0589 – When making a referral, provide the name and Medicaid number of the recipient and a brief statement regarding the nature of the

utilization problems. Hospitals continue to have the option of using the “Non-Emergency Use of the Emergency Room” Referral Form when reporting emergency room abuse.

Copies of pertinent documentation, such as emergency room records, are helpful when making written referrals. For a telephone referral, the provider should give his or her name and telephone number in case DMAS has questions regarding the referral.

EXHIBITS

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MEDICAID ADMISSION CERTIFICATION/PLAN OF CARE

HOSPITAL ADMISSION IS CERTIFIED NECESSARY FOR THE FOLLOWING REASON(S):

Horizontal lines for text entry.

ESTIMATED PERIOD OF HOSPITALIZATION

PLAN OF CARE:

Horizontal lines for text entry.

PLAN TO DISCHARGE		HOME WITH OFFICE FOLLOW-UP
		HOME WITH HOME HEALTH CARE
		EXTENDED CARE FACILITY
		OTHER (SPECIFY)

Horizontal lines for text entry.

PHYSICIAN'S SIGNATURE:

DATE:

Horizontal lines for text entry.

VIRGINIA MEDICAL ASSISTANCE PROGRAM

ACKNOWLEDGMENT OF RECEIPT OF HYSTERECTOMY INFORMATION
Abortion Certification

PATIENT ACKNOWLEDGMENT

Recipient Eligibility Number: _____

I, Doctor _____, certify that on the basis of my professional judgment the life of _____

_____ is permanently incapable of reproducing.

_____ of _____ (Member Name)

If Required: _____ (Interpreter's Signature) _____ (Date)

PHYSICIAN STATEMENT _____ would be substantially

endangered if the _____, certify that the hysterectomy performed _____ (Address) _____ on _____ (Recipient's Name) of _____ (City & State) _____ (Zip Code)

fetus was carried to term.

(X) MARK THE APPROPRIATE BLOCK.

This judgment is based on the following diagnosis and/or conditions:

A was not performed solely for the purpose of rendering the above mentioned recipient permanently incapable of reproducing nor was the hysterectomy done for medical purposes which by themselves do not mandate a hysterectomy.

B was performed under a life-threatening emergency situation which precluded explaining to her that the hysterectomy to be performed would render her permanently incapable of reproducing and obtaining an Acknowledgment of Receipt of Hysterectomy Information. The life-threatening emergency situation was _____

_____ (A Description of the Nature of the Emergency)

C was performed subsequent to the patient being sterile. This judgment is based on the following condition(s): _____

_____ (Physician's Signature) _____ (Date)

(A COPY OF THE COMPLETED CERTIFICATION MUST BE ATTACHED TO SIGNATURE FOR A HYSTERECTOMY PROCEDURE. THE SURGEON MUST PROVIDE COPIES TO OTHER PROVIDERS FOR THEIR USE WHEN BILLING MEDICAID.)

Signature

Address

Address

National Provider Identifier (NPI)

MAP-3006
Revision 06/30/2010