CHAPTER IV

COVERED SERVICES, LIMITATIONS, AND PAYMENT

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GENERAL INFORMATION

The provision of medically necessary artificial arms, legs, their necessary supportive devices, and breast prostheses to Medicaid-eligible members in the Commonwealth of Virginia requires service authorization prior to rendering service.

SERVICE AUTHORIZATION

Effective April 1, 2012, Service Authorization (Srv Auth) is required through DMAS' Service Authorization contractor. Refer to Chapter V of this manual for further information regarding service authorization, timely submittal of requests and service specific details.

COVERAGE AND LIMITATIONS

A. Prosthetic services shall mean the replacement of missing arms, legs, eyes, and breasts and the provision of an internal (implant) body part. Nothing in this regulation shall be construed to refer to orthotic services or devices or organ transplantation services. (12VAC30-50-210)

B. Artificial arms and legs, and their necessary supportive attachments, implants, and breasts are provided when prescribed by a physician or other licensed practitioner of the healing arts within the scope of their professional license as defined by state law. This service, when provided by an authorized vendor, must be medically necessary, and service authorized for the minimum applicable component necessary for the activities of daily living (ADLs).

C. Eye prostheses are provided when eyeballs are missing regardless of the age of the member or the cause of the loss of the eyeball. Eye prostheses are provided regardless of the function of the eye. Service authorization is not required, but post-payment review is conducted.

To obtain the required service authorization for coverage, the prosthetist will ask the prescribing practitioner to complete a DMAS Certificate of Need form (DMAS-4001). The prosthetist will then submit the Certificate of Need, a copy of the physician's prescription, and a completed Service Authorization Request form (DMAS-363) to DMAS' Service Authorization contractor. Refer to Chapter V titled "Service Authorization Information". The Appendix D includes an "Exhibits" section for the necessary forms.

NON-COVERED SERVICES

The following devices are not covered for adults:

- Orthotic Devices - Spinal
- Orthotic Devices - Cervical
- Orthotic Devices - Thoracic

- Orthotic Devices - Sacral
- Orthopedic Footwear
- Orthopedic Footwear Modifications
- Shoe Modifications
- Trusses
- Penile Prostheses

PAYMENT FOR SERVICES

General Information

The payment criteria established for prosthetic devices are designed to enlist the participation of a sufficient number of suppliers so that Medicaid-eligible persons receive prostheses at least to the extent that they are available to the general population.

Participation as a prosthetic provider is limited to those who accept the amount paid by the Virginia Medicaid Program as payment in full.

Payment for services will not exceed the amount indicated to be paid in accordance with the policy and methods described in the State Plan for Medical Assistance, and payment will not be made in excess of the upper limits described in 42 CFR § 447.304(a).

Federal requirements prohibit Medicaid from paying prosthetic device providers **more** than Medicare would allow for the same service.

Payment Methodology

Payment for prostheses is the lowest of Medicaid's fee schedule, the actual charge, or the Medicare allowance.

For Medicare crossover claims, the payment will be the deductible and co-insurance amounts computed by Medicare based on the Medicare-allowed charge, as reported on the Explanation of Medicare Benefits (EOMB) received from the Medicare carrier.

Cost Sharing

There are no Medicaid deductible or co-insurance amounts imposed for any prosthetic device provided to Medicaid members. As previously mentioned, Medicaid will pay the deductible and co-insurance amounts imposed on Medicaid members who are also Medicare beneficiaries and whose claims the Medicare carrier processes initially.

MEDICARE CATASTROPHIC COVERAGE ACT OF 1988

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

Qualified Medicare Beneficiaries (QMBs) are only eligible for Medicaid coverage of Medicare premiums and of deductible and co-insurance up to the Medicaid payment limit less the member's co-payment on allowed charges for all Medicare-covered services. Their Medicaid verification will provide the message "QUALIFIED MEDICARE BENEFICIARY-QMB-MEDICAID PAYMENT LIMITED TO MEDICARE COINSURANCE AND DEDUCTIBLE." The Medicare co-insurance is limited to the Medicaid fee when combined with the Medicare payment.

QMB Extended Coverage

Members in this group will be eligible for Medicaid coverage of Medicare premiums and of deductible and co-insurance up to the Medicaid payment limit on allowed charges for all Medicare-covered services plus coverage of all other Medicaid-covered services listed in Chapter I of this manual. Their Medicaid verification will provide the message "QUALIFIED MEDICARE BENEFICIARY-QMB EXTENDED." These members are responsible for the Medicaid co-payments.

All Others

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