FREQUENTLY ASKED QUESTIONS

1. **Q:** What file format should I access, CSV or TXT?

   A: Depending on the software available on your computer, the user may use the CSV or TXT format. Both formats contain the same data. The TXT version may be preferable for loading into a database application. The CSV version opens easily in an Excel spreadsheet file.

2. **Q:** How long will the files take to download?

   A: Download time is determined by the size of the file and the internet connection.

3. **Q:** Will the Procedure Fee File tell me if a procedure needs prior authorization (PA)?

   A: Yes, it will identify a numeric value for the field PA_TYPE, one of the following:
   00 No PA required
   01 Always needs a PA
   02 Only needs PA if service limits are exceeded
   03 Always needs PA, with per frequency

4. **Q:** How do I know what the current rate is for each CPT code?

   A: Option 1 - Using the CPT Search Function (Numeric CPT Codes ONLY)

   Type the numeric CPT code into the CPT Code box without making any changes to the other boxes. Click Search. The resulting records will show the current rate for this CPT code.

   Option 2 - Using the CSV Files (Numeric CPT Codes and Alpha-Numeric HCPCS Codes)

   Choose the appropriate CSV or HCPC file to download based on the code in question. In the downloaded file, filter on the code that you are searching for, then filter on Rate End Date (END DATE) equal to 12/31/9999. This will show you the current rate for the CPT code.

5. **Q:** What does an “IC” rate mean in the procedure fee file?

   A: IC is an abbreviation for Individual Consideration. These procedure codes cannot be priced due to a lack of benchmark pricing data. If the procedure code is covered, providers may be required to send additional information with their claim. The claim will pend and be reviewed manually.

6. **Q:** How do I determine if a code is covered using the information on the website?

   A: Option 1 - Using the CPT Search Function (Numeric CPT Codes ONLY)

Type the numeric CPT code into the CPT Code box without making any changes to the other boxes. Click Search.

- If a result is not found, then the code is not in our system and is not currently covered by Virginia Medicaid.
- If a result is found, scroll all the way to the right of the results and look at the Flag Code field. If any of the Flag Codes listed are equal to 999, then the code is not currently covered by Virginia Medicaid.
- If a result is found and there is no 999 listed in the Flag Code field, then the code is covered by Virginia Medicaid.

Option 2 - Using the CSV Files (Numeric CPT Codes and Alpha-Numeric HCPCS Codes)

Choose the appropriate CSV or HCPC file to download based on the code in question. In the downloaded file, filter on the code that you are searching for.

- If a result is not found, then the code is not in our system and is not currently covered by Virginia Medicaid.
- If a result is found, scroll to the right of the document until you get to the flag code fields (FLAG CDE 1 - FLAG CDE 10). If any of these fields has an unexpired 999 flag (unexpired meaning the corresponding END DTE field is equal to 12/31/9999), then the code is not currently covered by Virginia Medicaid.
- If a result is found and does not have an unexpired 999 flag, then the code is covered by Virginia Medicaid.

7. **Q:** How do I use the CPT search function?

   A: To look up the current rate for a numeric CPT code, type the code into the CPT Code box without making any changes to the other boxes. Click Search.

   To look up the rate on a specific date for a numeric CPT code, type the code into the CPT Code box and type the date into the Service Date box without making any changes to the Flag Code box. Click Search.

   To look up the complete history of rates for a numeric CPT code, type the code into the CPT Code box and remove the date in the Service Date box without making any changes to the Flag Code box. Click Search.

   To look up a specific numeric CPT code-flag code combination, type the code into the CPT box, type the date you are interested in into the Service Date box, and select the flag code you are interested in checking in the Flag Code box. Click Search. If the flag code and CPT code combination exists, the results will be displayed. If the flag code and CPT code combination does not exist, no results will be displayed.

8. **Q:** How often is the information found in the CPT search function/Procedure Fee Files updated?

   A: DMAS will update the search function and files three times per week on Monday, Wednesday, and Friday.

9. **Q:** How do I know what information is on the Procedure Fee Files?

   A: The Medical, Dental, and Revenue Procedure Fee Files contain the rate history for procedure and revenue codes and associated program and claim processing information. The DMAS Procedure Fee File is posted in three separate files: Medical, Dental, and Revenue. For easier downloading and due to its size, the Medical file is further separated into four parts. The range of codes is listed for each part.

   The Procedure Fee Files are historical and fields identifying the effective and end dates should be used to match the date of service with the rate.

   The rates listed on the Procedure Fee Files may be the same as or different from those paid to providers as some providers enrolled with Virginia Medicaid are paid a percentage of the total rate listed.

   The columns with fee amounts can be defined either as dollar or number fields in order to see decimal places. The procedure code fields must be defined as text or else leading zeros will be dropped. Each file has a header record identifying the data in each column. Each user should refer to their own software manual or the Help function in their software packages for further instructions on opening, importing, saving, and/or resizing files.

   A list of each field in the Procedure Fee Files and its definition is shown below. The fields are listed in the order that they occur in the files.

PROCEDURE RATE FILE LAYOUTS AND DEFINITIONS

MEDICAL / DENTAL / REVENUE Procedure Rate File

Field	Definition
Procedure Code	Code used to identify a specific dental, medical, revenue, or ICD procedure.
Procedure Code Description	Abbreviated description of the procedure code in lay terminology.
Procedure Code Type	Identifies a record on the Procedure File as being dental, medical, revenue, or ICD procedure.
Procedure Code Type Description	0 Dental 1 Medical 2 Revenue 4 ICD-9-CM Procedures 5 ICD-10-CM Procedures A Aids Waiver B Children's Mental Health Waiver C CDPAS D Early Intervention E Elderly & Disabled Waiver F Treatment Foster Care H High Intensity I IFFDS M Mental Retardation R Rental S Special T Tech Waiver X Mental Health Clinic and Select DD Waivers Services
Procedure Code Begin Date	Effective date of coverage for a procedure code.
Procedure Code End Date	Ending date of coverage for a procedure code.
Minimum Age	Minimum age of the enrollee to which a procedure is restricted.
Maximum Age	Maximum age of the enrollee to which a procedure is restricted.
Sex	F Restricted to females M Restricted to males
Prior Authorization (PA) Type	00 No PA required 01 Always needs PA 02 Only needs PA if services limits are exceeded 03 Always needs PA, with per frequency
Prior Authorization (PA) Begin Date	Effective date of the PA type.
Prior Authorization (PA) End Date	Ending date of the PA type.
Category	Code representing the type of organization or department that divides the State of Virginia into various region codes. Each organization breaks the State in a different way.

Category Description	0000	None
	0004	LTC PHP/PACE - Sentara Lifecare
	0006	Medallion
	0007	Medallion II (1996)
	0008	Options (1994-5)
	0009	Options (1995-6)
	0010	Hospital Facilities
	0011	DSS Local Offices
	0012	DSS QC Regions
	0013	DMAS Fraud & Investigations
	0014	DSS Regional Offices
	0015	Planning Districts
	0017	Pharmacy Pricing Regions
	0018	Client Medical Management (CMM)
	0019	State Institutions
	0020	Out of State
	0021	Health Departments
	0022	DMAS
	0023	DSS/DMAS Report Distribution
	AGE	Age-Based Rates (<21 or >20) for Health Clinics, Practitioners, EPSDT, Lab
	AIDE	Nurse’s Aide
	AW	AIDS Waiver
	CAP0	Capitation Region Type
	CCCP	Commonwealth Coordinated Care - Plus
	CMM	Client Medical Management Caseloads
	DEN	Dental Geographic Area of Service (GAS) Codes (1970)
	DME	Durable Medical Equipment
	DTRN	DBHDS Transportation
	HH	Home Health
	HHRB	Home Health Rehabilitation
	HO	Hospice
	LPN	Licensed Practical Nurse
	MD1	Day Treatment and Partial Hospitalization
	MHAS	Mental Health Assessment
	MHC	Mental Health Clinics
	PCCM	Managed Care Region Type
	PT1	Provider Type 60 versus All Others
	PT2	Provider Type 72 Therapy Pricing
	REG	Regular
	RN	Registered Nurse
	RPR	DME Replacement
	SAB	Substance Abuse
	TDO	Adolescent
	TRN	Transportation
	WAV	Non AIDS Waiver Waivered Services

Inpatient/Outpatient Indicator	IP Inpatient OP Outpatient
Maximum Rate	Amount allowable to be paid to a physician for a procedure or service.
Rate Effective Date	Effective date of associated procedure amount.
Rate End Date	Ending date of the associated procedure amount.
Professional Component (PC) Rate **	Professional component to be paid to a physician for a procedure or service.
Professional Component (PC) Rate Effective Date **	Effective date of associated procedure amount.
Professional Component (PC) Rate End Date **	Ending date of the associated procedure amount.
Technical Component (TC) Rate **	Technical component to be paid to a physician for a procedure or service.
Technical Component (TC) Rate Effective Date **	Effective date of associated procedure amount.
Anesthesiology Base Units 1-5 **	A method of charging Virginia Medicaid for anesthesia services where the base unit represents the level of intensity for anesthesia procedure services that reflects all activities except time. These activities include usual preoperative and postoperative visits, the administration of fluids and/or blood incident to anesthesia care, and monitoring procedures. (Note: The payment amount for anesthesia services is based on a calculation using base units, time units, and the conversion factor.)
Anesthesiology Base Units 1-5 Begin Date **	Effective date for Virginia Medicaid anesthesiology base units.
Anesthesiology Base Units 1-5 End Date **	Ending date for Virginia Medicaid anesthesiology base units.

** Only in MEDICAL Procedure Rate File

Flag Code 1-10	Code	Description
	26	Professional/Technical Component Not Payable for Procedure
	7Q	Psychiatrist - DOE
	7R	Licensed Clinical Psychologist - DOE
	7S	School Psychologist - DOE
	9	E & D Waiver (Personal Care, Adult Day, Respite Care)
	90	Pregnancy, Preventative Services & Court-Ordered Medical Care Paid (Bypass TPL)
	91	Pregnancy, Preventative Services & Court-Ordered Office Visit Paid (Bypass TPL)
	999	Not covered by Virginia Medicaid
	A	Ventilator Depended Services - Waiver
	AP1-9	Ambulatory Service Facility Fee 1-9
	AS1-9	Ambulatory Service Center 1-9
	C1	Copay May Apply (Currently $1.00)
	CF	Clinic Fee for Service
	CM	Elderly Case Management
	CP	Copay May Apply
	CS	FAMIS Only
	CT	Other Procedure Code Required
	CV	Clinic Visit Encounter (HCPCS & Dental)
	E	AIDS Waiver
	F	Regular Assisted Living - Waiver
	FA	Full Assessment
	FD	Family Planning with Diagnosis, Copay May Apply
	FP	Family Planning, Copay Does Not Apply
	FS	FAMIS SPO
	FW	Family Planning Waiver
	G	Elderly Study - Waiver
	I	EPSDT Routine Immunization
	J	Intensive Assisted Living - Waiver
	LB	Lab Procedure (CLIA)
	MP	PPMP Procedure (CLIA)
	OC	HMO
	Q	CDPAS (Consumer Directive Personal Attendant Services)
	R	IFDDS
	RD	Reduce if not in physician's office
	RF	Use Recipient's FIPS Rather Than the Provider's FIPS for pricing
	S	EPSDT Screening
	SA	Short Assessment
	SLH	State and Local Hospitals
	ST	STD Tests for FP Waiver
	T	Alzheimer's Waiver
	TDO	Temporary Detention Order
	VAC	Vaccine
	WV	Wavered Lab Procedure as Defined by CLIA

Flag Code 1-10 Service/Receipt Indicator	R Date of Receipt S Date of Services
Flag Code 1-10 Begin Date	Effective date of flag.
Flag Code 1-10 End Date	Ending date of flag.