

MANUAL TITLE: ALL MANUALS

CHAPTER 1, GENERAL INFORMATION

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CHAPTER I
GENERAL INFORMATION

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CHAPTER I GENERAL INFORMATION

INTRODUCTION

The Virginia Medicaid Provider Manual describes the role of the provider in the Virginia Medical Assistance Program (Medicaid). To provide a better understanding of the Medicaid Program, this manual explains Medicaid rules, regulations, procedures, and reimbursement and contains information to assist the provider in answering inquiries from Medicaid members.

The manual can also be an effective training and reference tool for provider administrative personnel, since it conveys basic information regarding the Medicaid Program, covered and non-covered services, and billing procedures. Proper use of the manual will result in a reduction of errors in claims filing and, consequently, will facilitate accurate and timely payment.

In addition to the Medicaid Program, other programs administered by the Department of Medical Assistance Services (DMAS) include the Family Access to Medical Insurance Security (FAMIS) program, the State and Local Hospitalization (SLH) program, and the Uninsured Medical Catastrophe Fund. If you have any questions concerning the Medicaid Program or any of the other programs listed above, please contact the provider "HELPLINE" at:

804-786-6273	Richmond Area
1-800-552-8627	All other areas

PROGRAM BACKGROUND

In 1965, Congress created the Medical Assistance Program as Title XIX of the Social Security Act, which provides for federal grants to the states for their individual Medical Assistance programs. Originally enacted by the Social Security amendments of 1965 (Public Law 89-97), Title XIX was approved on July 30, 1965. This enactment is popularly called "Medicaid" but is officially entitled "Grants to States for Medical Assistance Programs." The purpose of Title XIX is to enable the states to provide medical assistance to eligible indigent persons and to help these individuals if their income and resources are insufficient to meet the costs of necessary medical services. Such persons include dependent children, the aged, the blind, the disabled, pregnant women, and needy children.

The Medicaid Program is a jointly administered federal/state program that provides payment for necessary medical services to eligible persons who are unable to pay for such services. Funding for the Program comes from both the federal and state governments. The amount of federal funds for each state is determined by the average per capita income of the state as compared to other states.

Virginia's Medical Assistance Program was authorized by the General Assembly in 1966 and is administered by the Virginia Department of Medical Assistance Services (DMAS). The Code of Federal Regulations allows states flexibility in designing their own medical assistance programs within established guidelines. Virginia Medicaid's goal is to provide health and medical care for the Commonwealth's poor and needy citizens using the health care delivery system already in place within the state.

In 2003, the Virginia General Assembly changed the name of the Medicaid program covering most children to FAMIS Plus. The change in name was intended to facilitate a coordinated program for children's health coverage including both the FAMIS (Family Access to Medical Insurance Security Plan) and FAMIS Plus programs. All covered services and administrative processes for children covered by FAMIS Plus remain the same as in Medicaid.

While the Virginia Medicaid Program is administered by DMAS, the eligibility determination process is performed by local departments of social services through an interagency agreement with the Virginia Department of Social Services.

The *State Plan for Medical Assistance* for administering the Medicaid Program was developed under the guidance of the Advisory Committee on Medicare and Medicaid appointed by the Governor of the Commonwealth of Virginia. The State Plan is maintained through continued guidance from the Board of Medical Assistance Services, which approves amendments to the *State Plan for Medical Assistance* with policy support from the Governor's Advisory Committee on Medicare and Medicaid. Members of the Governor's Advisory Committee and the Board of Medical Assistance Services are appointed by the Governor.

Individuals originally became eligible for Medicaid because of their "categorical" relationship to two federal cash assistance programs: Aid to Families with Dependent Children (AFDC) and Supplemental Security Income (SSI). However, congressional mandates in the late 1980s resulted in dramatic changes in Medicaid eligibility provisions. ~~Due to these changes, New individuals, in~~ additional selected low-income groups, are eligible for Medicaid ~~solely based~~ on the relationship of their incomes to the Federal Poverty Guidelines. New Federal Poverty Guidelines are published annually in the *Federal Register* and become effective upon publication.

~~On June 7, 2018, Governor Northam approved the state budget that~~ In 2018, Virginia expanded eligibility to include the Modified Adjusted Gross Income (MAGI) adult

group, also known as the Medicaid Expansion covered group. The MAGI adult group includes adults between the ages of 19 and 64, who are not eligible for or enrolled in Medicare, and who meet income eligibility rules. After receiving the necessary approvals from the Centers for Medicare and Medicaid Services (CMS), DMAS began enrolling individuals in the MAGI adult group on January 1, 2019.

Medicaid is a means-tested program. Applicants' income and other resources must be within program financial standards, and different standards apply to different population groups, with children and pregnant women, the MAGI adult group, and persons who are aged, blind, or disabled. Reference Chapter III of this manual for detailed information on groups eligible for Medicaid.

GENERAL SCOPE OF THE PROGRAM

The Medical Assistance Program (Medicaid) is designed to assist eligible members in securing medical care within the guidelines of specified State and federal regulations. Medicaid provides access to medically necessary services or procedures for eligible members. The determination of medical necessity may be made by the Utilization Review Committee in certain facilities, a peer review organization, DMAS professional staff or DMAS contractors.

Covered Services

The following services are provided, **with limitations** (certain of these limitations are set forth below), by the Virginia Medicaid Program:

- BabyCare - Prenatal group patient education, nutrition services, and homemaker services for pregnant women and care coordination for high-risk pregnant women and infants up to age two.
- Behavioral Health services, including:
 - Early Intervention/Screening Brief Intervention and Referral to Treatment (ASAM 0.5)
 - Case Management (Substance Use, Mental Health and Treatment Foster Care)
 - Peer Recovery Support Services
 - Opioid Treatment Programs and Office-Based Addiction Treatment (includes substance use care coordination)
 - Outpatient Psychiatric and Outpatient Substance Use (ASAM 1.0) Services
 - Intensive In-Home
 - Therapeutic Day Treatment
 - Psychosocial Rehabilitation
 - Mental Health Skill Building Services

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- Multisystemic Therapy
 - Functional Family Therapy
 - Applied Behavior Analysis
 - Assertive Community Treatment
 - Mental Health and Substance Use (ASAM 2.1) Intensive Outpatient
 - Mental Health and Substance Use (ASAM 2.5) Partial Hospitalization
 - Mobile Crisis Response
 - Community Stabilization
 - 23-Hour Crisis Stabilization
 - Residential Crisis Stabilization Unit
 - Residential Treatment Services (Therapeutic Group Home, Psychiatric Residential Treatment Facility, ASAM levels 3.1, 3.3, 3.5 and 3.7)
 - Inpatient Psychiatric Services and Medically Managed Intensive Inpatient (ASAM Level 4.0) in a general acute care hospital. Inpatient services in Freestanding Psychiatric Hospitals are also covered for individuals below age 21 and individuals age 65 and older.
- Blood glucose monitors and test strips for pregnant women
 - Building Independence (BI) Waiver – The CMS-approved HCBS § 1915(c) waiver whose purpose is to provide support in the community for individuals eighteen (18) years of age or older who have a Developmental Disability (DD), meet the ICF/IID level of care criteria, and who live in their own homes/apartments with BI waiver supports. Services may be complemented by non-waiver funded rent subsidies and/or other types of support. The Building Independence Waiver is administered collaboratively by the Department and DBHDS. A complete listing of all allowable services under the BI Waiver may be found in Chapter 4 of the DD Waiver Manual Covered Services and Limitations.
 - Case management services for high-risk pregnant women and children up to age 1 (as defined in the State Plan and subject to certain limitations)
 - Christian Science sanatoria services
- Clinical psychology services
- Clinic services
 - Commonwealth Coordinated Care Plus (CCC Plus) Waiver- The CMS-approved HCBS § 1915(c) waiver that covers a range of community support services offered to older adults, individuals who have a disability, and individuals who are chronically ill or severely impaired, having experienced loss of a vital body function, and who require substantial and ongoing skilled

nursing care. A complete listing of all allowable services under the CCC Plus Waiver may be found in Chapter 4 of the CCC Plus Waiver Manual Covered Services and Limitations.

- -Community developmental disability services
- Community Living Waiver - The CMS-approved HCBS §1915(c) waiver whose purpose is to provide services and supports in the community rather than in an Intermediate Care Facility for Individuals with Intellectual Disability (ICF/IID). Participants include individuals up to six (6) years of age who are at developmental risk and individuals age six (6) and older who have Developmental Disability (DD) and meet the ICF/IID level of care criteria. Residential services and additional supports for adults and some children with exceptional medical and/or behavioral support needs are included in this waiver. A complete listing of all allowable services under the CL Waiver may be found in Chapter 4 of the DD Waiver Manual Covered Services and Limitations.
- Contraceptive supplies, drugs and devices
- Dental services
- Diabetic test strips
- Durable medical equipment and supplies
- Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT)
 - For individuals under age 21, EPSDT must include the services listed below:
 - Screening services, which encompass all of the following services:
 - Comprehensive health and developmental history
 - Comprehensive, unclothed physical exam
 - Appropriate immunizations according to age and health history
 - Laboratory tests (including blood lead screening)
 - Health education
 - Home health services
 - Eyeglasses for all members younger than 21 years of age according to medical necessity

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- Hearing services
 - Inpatient psychiatric services for members under age 21
 - Environmental investigations to determine the source of lead contamination for children with elevated blood lead levels
 - Other medically necessary diagnostic and treatment services identified in an EPSDT screening exam, not limited to those covered services included above
 - Skilled nursing facilities for persons under 21 years of age
 - Transplant procedures as defined in the section “transplant services”
 - All states are required to offer EPSDT to all Medicaid-eligible individuals under age 21 to determine any physical and mental defects that they may have and to provide health care, treatment, and other measures to correct or ameliorate the defects or chronic conditions discovered. The services available under EPSDT are not limited to those available in the Medicaid State Plan for Medical Assistance. Services requiring preauthorization under the State Plan for Medical Assistance will continue to require pre-authorization. DMAS reserves the right to utilize medical necessity criteria for non-State Plan services under EPSDT.
- ~~• Commonwealth Coordinated Care Plus (CCC Plus) Waiver services - Individuals who meet the criteria for a nursing facility level of care can be authorized to receive adult day health care, personal care (agency directed or consumer directed) services, Respite Care and Skilled Respite Care services, Personal Emergency Response System (PERS), Services Facilitation services, Transition Coordination, and Transition services~~
- Emergency hospital services
 - Emergency services for aliens
 - Enteral nutrition (EN) - Coverage is limited to circumstances in which the nutritional supplement is the sole source of nutrition except for individuals authorized through the CCC Plus Waiver or through EPSDT, is administered orally or through a nasogastric or gastrostomy tube, and is

necessary to treat a medical condition. Coverage of oral administration does NOT include the provision of routine infant formula.

- Extended services for pregnant women, pregnancy-related and postpartum services for ~~60 days~~ 12 months after the pregnancy ends (limitations applicable to all covered services apply to this group as to all other member groups)
- Eye refractions
- ~~• Plan First (family planning services) – Medicaid fee for service program for men and women who meet the eligibility criteria. Plan First includes coverage of those services necessary to prevent or delay a pregnancy. It shall not include services to promote pregnancy such as infertility treatments. Family planning does not include counseling about, recommendations for or performance of abortions, or hysterectomies or procedures performed for medical reasons such as removal of intrauterine devices due to infections.~~
- Family and Individual Support Waiver - The CMS-approved home- and community-based §1915(c) waiver whose purpose is to provide services and supports in the community rather than in an Intermediate Care Facility for Individuals with Intellectual Disability (ICF/IID). Participants include individuals up to six (6) years of age who are at developmental risk and individuals age six (6) and older who have a Developmental Disability (DD) and meet the ICF/IID level of care criteria. This waiver supports children and adults living with families, friends, or in their own homes, including supports for those with some medical or behavioral needs. A complete listing of all allowable services under the FIS Waiver may be found in Chapter 4 of the DD Waiver Manual Covered Services and Limitations.
- Federally Qualified Health Center services
- Gender dysphoria treatment services
- Home and Community-Based Care Waiver services
- Home health services
- Hospice services for individuals certified as terminally ill (defined as having a medical prognosis that life expectancy is six months or less)
- ~~• Family and Individual Support Waiver~~

- ~~• Gender dysphoria treatment services~~
- Inpatient care hospital services
- ~~• Inpatient Psychiatric Hospital Services for Individuals under 21 years of age (medically needy are not covered)~~
- Intensive rehabilitation services
- Intermediate care facility – Individuals with Intellectual Disabilities Services (medically needy members are not covered)
- Laboratory and radiograph services
- ~~• Legend and Non-legend drugs are covered with some limitations or exclusions. (See the Pharmacy Manual for specific limitations and requirements)~~
- ~~• Mental health, with limitations, covered under mental health and intellectual disability community services listed below:~~
- ~~• Behavioral Health services, including:~~
 - ~~• Early Intervention/Screening Brief Intervention and Referral to Treatment (ASAM 0.5)~~
 - ~~• Case Management (Substance Use, Mental Health and Treatment Foster Care)~~
 - ~~• Peer Recovery Support Services~~
 - ~~• Opioid Treatment Programs and Office-Based Addiction Treatment (includes substance use care coordination)~~
 - ~~• Outpatient Psychiatric and Outpatient Substance Use (ASAM 1.0) Services~~
 - ~~• Intensive In Home~~
 - ~~• Therapeutic Day Treatment~~
 - ~~• Psychosocial Rehabilitation~~
 - ~~• Mental Health Skill Building Services~~
 - ~~• Multisystemic Therapy~~
 - ~~• Functional Family Therapy~~
 - ~~• Applied Behavior Analysis~~
 - ~~• Assertive Community Treatment~~
 - ~~• Mental Health and Substance Use (ASAM 2.1) Intensive Outpatient~~
 - ~~• Mental Health and Substance Use (ASAM 2.5) Partial Hospitalization~~
 - ~~• Mobile Crisis Response~~
 - ~~• Community Stabilization~~
 - ~~• 23 Hour Crisis Stabilization~~
 - ~~• Residential Crisis Stabilization Unit~~

~~Residential Treatment Services (Therapeutic Group Home, Psychiatric Residential Treatment Facility, ASAM levels 3.1, 3.3, 3.5 and 3.7)~~
~~Inpatient Psychiatric Services and Medically Managed Intensive Inpatient (ASAM Level 4.0) in a general acute care hospital. Inpatient services in Freestanding Psychiatric Hospitals are also covered for individuals below age 21 and individuals age 65 and older.~~

~~• Mental Health:~~

~~•~~

- ~~• Crisis stabilization~~
- ~~• Mental health support~~
- ~~• Assertive community treatment~~
- ~~• Intensive in-home services for children and adolescents~~
- ~~• Therapeutic day treatment for children and adolescents~~
- ~~• Partial hospitalization Program~~
- ~~• Intensive Outpatient Program~~
- ~~• Psychosocial rehabilitation~~
- ~~• Crisis intervention~~
- ~~• Case management~~

~~• Substance Use Disorder:~~

- ~~• Residential treatment for pregnant and postpartum women~~
- ~~• Day treatment for pregnant and postpartum women~~
- ~~• Crisis Intervention~~
- ~~• Intensive Outpatient~~
- ~~• Day Treatment~~
- ~~• Case Management~~
- ~~• Opioid Treatment~~
- ~~• Outpatient Treatment~~

~~• Community Living Waiver~~

- Nurse-midwife services
- Nursing facility services
- Occupational therapy
- “Organ and disease” panel test procedures for blood chemistry tests
- Optometry services

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- Outpatient hospital services
 - Over-the-counter alternatives to certain classes of legend drugs. Upon a doctor's prescription or order, a pharmacy may provide and Medicaid will cover a drug that no longer requires a prescription to dispense. See the Pharmacy Manual for specific limitations and requirements.
 - Papanicolaou smear (Pap) test
 - Payment of deductible and coinsurance up to the Medicaid limit less any applicable payments for health care benefits paid in part by Title XVIII (Medicare) for services covered by Medicaid.
 - Physician services
 - Plan First (family planning services) – Medicaid fee-for-service program for men and women who meet the eligibility criteria. Plan First includes coverage of those services necessary to prevent or delay a pregnancy. It shall not include services to promote pregnancy such as infertility treatments. Family planning does not include counseling about, recommendations for or performance of abortions, or hysterectomies or procedures performed for medical reasons such as removal of intrauterine devices due to infections.
 - Podiatry services
 - Prostate specific antigen (PSA) test (1998)
 - Prostheses limited to artificial arms, legs, and the items necessary for attaching the prostheses, which must be pre-authorized by the DMAS central office. Also breast prostheses for any medically necessary reason and ocular prostheses for reason for loss of eyeball regardless of age of the member or the cause of the loss of the eyeball.
 - ~~Psychiatric Hospitals for the Aged (65 Years and Older)~~
 - Psychological testing for persons with intellectual disability as part of the evaluation prior to admission to a nursing facility (January 1, 1989)
 - Reconstructive surgery - post-mastectomy (1998)
 - Rehabilitation services (physical therapy – effective 1969; other rehabilitation services – effective 1986)

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- Renal dialysis clinic services
 - Routine patient costs furnished in connection with participation in a qualifying clinical trial (see Exhibits)
 - Routine preventive medical and dental exams and immunizations, sensory and developmental screenings and immunizations are covered for all eligible members under the age of 21
 - Routine preventive and wellness services, including annual wellness exams, immunizations, smoking cessation, and nutritional counseling services for the MAGI Adult (Medicaid Expansion) covered group.
 - Rural Health Clinic services
 - School-based services
 - Services for individuals age 65 and older in institutions for mental diseases
 - Specialized nursing facility services
 - Speech-language therapy services
 - ~~CCC Plus Waiver services – For children and adults who are chronically ill or severely impaired, needing both a medical device to compensate for the loss of a vital body function and require substantial and ongoing skilled nursing care to avert further disability or to sustain their lives. Authorized services include Private Duty Nursing, Private Duty Respite Care services, Personal Care (Adults Only), Assistive Technology, Environmental Modifications and Transition services.~~
 - Telemedicine for selected services.
 - Tobacco Cessation screening, counseling and pharmacotherapies.
 - Transplant services: kidney and corneal transplants, heart, lung, and liver transplants, without age limits; under EPSDT, liver, heart, lung, small bowel and bone marrow transplants and any other medically necessary transplant procedures that are not experimental or investigational, limited to persons under 21 years of age. Coverage of bone marrow transplants for individuals over 21 years of age is allowed for a diagnosis of lymphoma or breast cancer, leukemia, or myeloma.
 - Transportation services related to medical care

- ~~Treatment Foster Care Case Management~~

General Exclusions

Payment cannot be made under the Medicaid Program for certain items and services, and Virginia Medicaid will not reimburse providers for these non-covered services. Members have been advised that they may be responsible for payment to providers for non-covered services. Prior to the provision of the service, the provider must advise the member that he or she may be billed for the non-covered service. The provider may not bill the member for missed or broken appointments, which includes transportation services arranged by the member who is not at the pickup point or declines to get into the vehicle when the provider arrives.

Examples of such non-covered services are as follows:

- Abortions, except when the life or health of the mother is substantially endangered
- Acupuncture
- Artificial insemination or in vitro fertilization
- Autopsy examinations
- Cosmetic surgery
- Courtesy calls - visits in which no identifiable medical service was rendered
- Custodial care
- DESI drugs (drugs considered to be less than effective by the Food and Drug Administration)
- Domestic services (except for those approved as part of personal care services or homemaker services under BabyCare or EPSDT)
- Experimental medical or surgical procedures
- Eyeglass services for members age 21 and over

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- Fertility Services - Services to promote fertility are not covered. However, if there is a disease of the reproductive system that requires treatment to maintain overall health, the medical procedure will be covered
 - Free services - Services provided free to the general public cannot be billed to Medicaid; this exclusion does not apply where items and services are furnished to an indigent individual without charge because of his or her inability to pay, provided the provider, physician, or supplier bills other patients to the extent that they are able to pay
 - Items or services covered under a workers' compensation law or other payment sources
 - Meals-on-Wheels or similar food service arrangements and domestic housekeeping services which are unrelated to patient care
 - Medical care provided by mail or telephone (not including telemedicine)
 - Medical care provided in freestanding psychiatric hospitals except through EPSDT and SUD waiver, or for individuals aged 65 and over
 - Personal comfort items
 - Physician hospital services for non-covered hospital stays
 - Private duty nursing services – Other than for children under an appropriate waiver or EPSDT and adults under the appropriate waiver
 - Procedures prohibited by State or federal statute or regulations
 - Protheses (other than limbs, and the items necessary for attaching them, and breast protheses)
 - Psychological testing done for purposes of educational diagnosis or school admission or placement
 - Routine foot care
 - Screening services: Exceptions: Pap smears, mammograms, and PSA tests consistent with the guidelines published by the American Cancer Society.

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- Services determined not to be reasonable and/or medically necessary
 - Services to persons -age 21 to 65 in mental hospitals
 - Sterilizations when the patient is under age 21 or legally incompetent
 - Supplies and equipment for personal comfort, such as adult diapers except when provided as durable medical equipment, "Lifecall" systems (except under the EDCD, DD, and Intellectual Disability Waivers), and air cleaners
 - Unkept or broken appointments
 - Unoccupied nursing facility beds except for therapeutic leave days for nursing facility patients
 - Weight loss programs

MEMBER COPAYS

~~**COPAYS ARE THE SAME FOR CATEGORICALLY NEEDY MEMBERS, QUALIFIED MEDICARE BENEFICIARIES (QMBS), AND MEDICALLY NEEDY MEMBERS. COPAYS AND THEIR AMOUNTS ARE EXPLAINED IN CHAPTER III OF THIS MANUAL.**~~

MANAGED CARE PROGRAMS

Coverage for the vast majority of Medicaid enrolled individuals is provided through one of the DMAS managed care programs, Medallion 4.0 or Commonwealth Coordinated Care Plus (CCC Plus). Medallion 4.0 and CCC Plus programs contract with the same six managed care organizations (MCOs), and all MCOs offer coverage statewide. In addition, both CCC Plus and Medallion 4.0 provide services that help keep people healthy as well as services that focus on improving health outcomes. For more information on the current health plans, please visit www.dmas.virginia.gov.

Medallion 4.0 serves as the delivery system for children, pregnant women, and individuals in the MAGI Adult Group who are not determined to be "medically complex." CCC Plus provides a higher acuity of care coordination services and serves as the delivery system that provides coverage for individuals who are aged, blind or disabled, or who are dually eligible for Medicare and Medicaid, or who receive long-term services and supports, or individuals in the MAGI adult group determined to be "medically complex." "Medically complex" is defined as individuals

who have complex medical and/or behavioral health condition and a functional impairment, or an intellectual or developmental disability.

Individuals awaiting managed care enrollment will receive coverage through the DMAS fee-for-service program for a brief period (approximately 15-45 days) until they are enrolled in managed care. Additionally, some services for managed care enrolled individuals are covered through fee-for-service; these are referred to as managed care carved-out services. Detailed information about managed care-excluded populations and carved out services for Medallion 4.0 and CCC Plus is available on the DMAS website at <http://www.dmas.virginia.gov>, under Managed Care Benefits.

Once enrolled in managed care, members have up to 90 days to change their plan for any reason. Members also have the ability to change their plan during their annual open enrollment period. Open enrollment varies by population and program. For the MAGI Adult (expansion) population, open enrollment is from November 1 through December 31 each year. For CCC Plus, open enrollment is from October 1 through December 18 each year. For Medallion 4.0 open enrollment varies by program region. (See Managed Care Enrollment Broker section below for additional information.)

Managed Care Enrollment Broker (Maximus)

DMAS contracts with an enrollment broker, Maximus, which provides information to help Medallion and CCC Plus members select or change health plans. Members can find out which health plans contract with their primary care provider (PCP) or other provider. Providers should also let their members know which Medicaid health plans they accept. Members may use the following Maximus contact information for the Medallion 4.0 and CCC Plus managed care programs.

- Medallion 4.0
Maximus has designed a mobile app for managed care enrollment for the Medallion 4.0 program. The app is available to download in the Apple App Store and Google Play for both iPhone and Android users.

To get the free mobile app, search for Virginia Managed Care on the Apple App Store or Google Play and download. After downloading the app, members will log in using a two-step identification process, Medicaid ID, and social security number, or social security number and date of birth; non-members can log-in as guests.

Similar to the website, the main capabilities of the app allow members to view their profile, compare health plans, enroll in a health plan, change health plans, and search for providers and health plan information. For more

information, members can also visit the Medallion 4.0 enrollment website at: <https://virginiamanagedcare.com/> or call 1-800-643-2273 or TTY: 1-800-817-6608.

- CCC Plus
Members can visit the enrollment website for the CCC Plus managed care program at <https://cccplusva.com/> to view the health plan comparison chart and to choose or change their health plan. Members can also call the CCC Plus Helpline at 1-834374-9159 or TTY 1-800-817-6608 for more information.

MCO Provider Reimbursement

In order to be reimbursed for services provided to a managed care enrolled individual, providers must follow their respective contract with the managed care plan. The managed care plan may utilize different prior authorization, billing, and reimbursement guidelines than those described for Medicaid fee-for-service individuals. For more information, please contact the individual's managed care plan directly. Providers interested in contracting with the plans should also contact the MCO directly. MCO contact information for contracting and credentialing is available on the DMAS website:

- Medallion 4.0 The managed care helpline for the Medallion program is 800-6432273 and the web address is <https://www.virginiamanagedcare.com/>
- CCC Plus (<http://www.dmas.virginia.gov/#/cccplusinformation> See "Medical Provider Update October 2017")

DMAS reimburses the health plans a monthly capitated fee for each member. These fees are preset, and are determined by demographics such as patient's age, sex, program designation, and locality of residence. Each MCO is responsible for developing its own network of providers and for ensuring that its delivery system has an adequate number of facilities, locations, and personnel available and accessible to provide covered services for its members. Providers who contract with a MCO must meet the MCO's contracting requirements.

Medicaid-contracted MCOs must provide all the services covered by Medicaid, at least within an equal amount, duration, and scope as Medicaid, except for certain "carved-out services." "Carved-out" means that the client remains enrolled in the MCO plan but the carved-out services are covered and reimbursed by DMAS within DMAS program guidelines. **DMAS will NOT provide reimbursement for services provided to MCO enrolled members EXCEPT for those services carved-out specifically from the MCO contracts.** Carved-out services vary by program and are listed in the CCC Plus and Medallion 4.0 Contracts, available on the DMAS

Website, in the Managed Care Benefits section. The member must present his or her Medicaid plastic ID card when receiving carved-out services.

Eligibility and MCO Enrollment Verification

Medicaid eligibility and managed care enrollment coverage must be verified before treatment is provided. Medallion and CCC Plus members will have a MCO identification card and a Medicaid card. Medallion and CCC Plus MCO providers must adhere to their contract with the MCO regarding referrals, prior authorization, and billing requirements. Service authorization from the member's MCO is required for any out-of-network services, *except for emergency and family planning services*. The provider is responsible for ensuring that proper referrals and service authorizations are obtained. If the MCO denies authorization for a service, the member may exercise his right to appeal to the MCO. Members can also appeal to DMAS after first exhausting the MCO's appeal process. A provider may bill a member only when the provider has provided advanced written notice to the member, prior to rendering services that their MCO/Medicaid will not pay for the service. The notice must also share that the provider is accepting the member as a private pay patient, not as a Medicaid patient and the services being provided are the financial responsibility of the patient. Failure to confirm Medicaid eligibility and MCO coverage can result in a denial of payment.

To verify eligibility, call the MCO's enrollment verification system or the DMAS MediCall line at 1-800-772-9996 or 1-800-884-9730 (outside of Richmond), or (804) 965-9732 or (804) 965-9733 for Richmond and the surrounding counties. Eligibility information is also available using the web-based Automated Response System (ARS). When using the DMAS MediCall line or the ARS system, MCO information, if applicable, follows Medicaid eligibility information.

Continuity of Care

The Department attempts to make the transition between fee-for-service Medicaid and the MCO seamless whenever possible. As a result there is a process to ensure that the Medicaid information and authorization information is transferred and honored. In order to assure continuity of care for members enrolled in MCOs, the following procedures are used:

- The Member's MCO shall assume responsibility for all managed care contract covered services authorized by either the Department or a previous MCO, which are rendered after the MCO enrollment effective date, in the absence of a written agreement otherwise. For on-going services, such as home health, outpatient mental health, and outpatient rehabilitation therapies, etc., the member's MCO shall continue authorized services without interruption until the Contractor completes its utilization review process to determine

medical necessity of continued services or to transition services to a network provider;

- DMAS shall assume responsibility for all covered services authorized by the member's previous MCO which are rendered after the effective date of disenrollment to the fee-for-service system, if the member otherwise remains eligible for the service(s), and if the provider is a Medicaid provider;
- If the prior authorized service is an inpatient stay, the claim should be handled as follows:
 - If the provider contracts with the MCO under a per diem payment methodology, the financial responsibility shall be allocated between the member's current MCO and either DMAS or the new MCO. In the absence of a written agreement otherwise, the member's current MCO and DMAS or the new MCO shall each pay for the period during which the member is enrolled with the entity.
 - If the provider contracts with the MCO under a DRG payment methodology, the MCO is responsible for the full inpatient hospitalization from admission to discharge, including any outlier charges.
- If services have been authorized using a provider who is out of network, the member's MCO may elect to reauthorize (but not deny) those services using an in-network provider.

FAMILY ACCESS TO MEDICAL INSURANCE SECURITY (FAMIS) PLAN

Section 4901 of the Balanced Budget Act of 1997 (BBA) amended the Social Security Act (the Act) by adding a new title XXI, the State Children's Health Insurance Program (SCHIP). Title XXI provides funds to states to enable them to initiate and expand the provision of child health assistance to uninsured, low-income children in an effective and efficient manner.

Virginia's Title XXI program is known as FAMIS and is a comprehensive health insurance program for Virginia's children from birth through age 18 who are not covered under other health insurance and whose income is over the Medicaid income limit and under 200 percent of the Federal Poverty Level. FAMIS is administered by DMAS and is funded by the state and federal government.

FAMIS Covered Services

FAMIS covered services are somewhat different- from Medicaid covered services. One of the key differences is that most children enrolled in the FAMIS Program are

not eligible for EPSDT treatment services. Children who are eligible for the FAMIS program must enroll with a Managed Care Organization (MCO). Although FAMIS enrollees receive well child visits, they are not eligible for the full EPSDT treatment benefit.

The following services are covered for FAMIS enrollees:

- Abortion only if necessary to save the life of the mother
- ~~Behavioral therapies including, but not limited to, applied behavior analysis;~~
 - ~~Assistive technology~~
 - ~~Blood lead testing~~
 - ~~Chiropractic with benefit limitations~~
 - ~~Clinic services (including health center services) and other ambulatory health care services~~
 - ~~Community Mental Health Rehabilitation Services (CMHRS) including Behavioral Health services for the treatment of mental health and substance use disorders, including the following:~~
 - ~~Case Management~~
 - ~~Peer Recovery Support Services~~
 - ~~Opioid Treatment Programs and Office-Based Addiction Treatment (includes substance use care coordination)~~
 - ~~Screening Brief Intervention and Referral to Treatment (SBIRT) (ASAM 0.5)~~
 - ~~Outpatient Psychiatric and Outpatient Substance Use (ASAM 1.0) Services~~
 - ~~Psychosocial Treatment, including individual psychotherapy, group therapy, family therapy, and other types of counseling services~~
 - ~~Tobacco Cessation screening, counseling, and pharmacotherapies~~
 - ~~Intensive in-h/In-Home services~~
 - ~~Therapeutic Day Treatment~~
 - ~~_____~~
 - ~~Multisystemic Therapy~~
 - ~~Functional Family Therapy~~
 - ~~Applied Behavior Analysis~~
 - ~~Assertive Community Treatment~~
 - ~~Mental Health and Substance Use (ASAM 2.1) Intensive Outpatient~~
 - ~~Mental Health and Substance Use (ASAM 2.5) Partial Hospitalization~~
 - ~~_____~~
 - ~~Therapeutic day treatment~~
 - ~~Mental health crisis intervention~~ Mobile Crisis Response
 - Community Stabilization
 - 23-Hour Crisis Stabilization
 - Residential Crisis Stabilization Unit

-
- Inpatient Psychiatric Services and Medically Managed Intensive Inpatient Substance Use Treatment Services (ASAM Level 4.0) in a general acute care hospital. Does not include services furnished in a state-operated mental hospital, services furnished by IMDs, or residential services or other 24-hour therapeutically planned structural services with the exception of residential crisis stabilization unit services
 - Blood lead testing
 - Chiropractic with benefit limitations
 - Clinic services (including health center services) and other ambulatory health care services
 - Dental services (includes diagnostic, preventive, primary, orthodontic, prosthetic and complex restorative services)
 - Durable medical equipment, prosthetic devices, hearing aids, and eyeglasses with certain limitations
 - Disposable medical supplies
 - Early Intervention services including targeted case management
 - Emergency hospital services
 - Family planning services, including coverage for prescription drugs and devices approved by the U.S. Food and Drug Administration for use as contraceptives
 - Gender dysphoria treatment services
 - Home and community-based health care services (includes nursing and personal care services, home health aides, physical therapy, occupational therapy, and speech, hearing, and inhalation therapy)
 - Hospice care including care related to the treatment of the child's condition with respect to which a diagnosis of terminal illness has been made
 - ~~Inpatient substance abuse treatment services, with the following exceptions: services furnished in a state-operated mental hospital, services furnished in IMDs, or residential services or other 24-hour therapeutically planned structural services~~
 - ~~Inpatient services (365 days per confinement; includes ancillary services)~~
 - ~~Inpatient acute mental health services in general acute care hospital only. Does not include those (a) services furnished in a state-operated mental hospital, (b) services furnished by IMDs, or (c) residential services or other 24-hour therapeutically planned structural services~~
 - Maternity services including routine prenatal care
 - Medical formula, enteral/medical foods (sole source, specialized formula – not routine infant formula)
 - Nurse practitioner services, nurse midwife services, and private duty nursing services are covered. Skilled nursing services provided for special education students are covered with limitations
 - Organ transplantation

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- ~~• Outpatient mental health services, other than services furnished in a state-operated mental hospital~~
 - ~~• Outpatient substance abuse treatment services, other than services furnished in a state-operated mental hospital. These include intensive outpatient, partial hospitalization, medication assisted treatment, care coordination, case management, multi-systemic therapy, functional family therapy, and peer support services~~
 - Outpatient services, including emergency services, surgical services, clinical services, and professional provider services in a physician's office or outpatient hospital department
 - ~~• Outpatient diagnostic tests, X-rays, and laboratory services covered in a physician's office, hospital, independent and clinical reference lab (including mammograms);~~
 - ~~• Prescription drugs (mandatory generic program) and over the counter (optional for managed care)~~
 - ~~Peer support services~~
 - Physician services, including services while admitted in the hospital, or in a physician's office, or outpatient hospital department
 - Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders
 - Prescription drugs (mandatory generic program)
 - School based health services
 - Skilled nursing facility
 - Surgical services
 - Transportation - professional ambulance services only to medically necessary covered services (fee-for-service members have routine access to and from providers of covered medical services)
 - Vision services
 - Well-child care, including visits, laboratory services as recommended by the American Academy of Pediatrics Advisory Committee, and any immunizations as recommended by the Advisory Committee on Immunization Practice (ACIP)

No Member Copays, Fees, or Premiums for FAMIS members

FAMIS does not have enrollment fees or yearly or monthly premiums. Effective April 1, 2022, FAMIS members do not have co-payments in fee-for-service or managed care, pursuant to the 2022 Special Session I Appropriations Act, which permanently removed co-pays. In compliance with federal law, Native Americans and Alaska Natives do not have any co-payments. However, children who are enrolled in a MCO must pay co-payments for some covered services. There are no co-payments required for preventative services such as well-child care, immunizations, or dental

~~care. The chart below shows the co-payment amounts for some basic FAMIS services for children who are enrolled in a MCO, based on co-pay status.~~

~~NOTE: Native Americans and Alaskan Natives do NOT have any co-payments.~~

SERVICE*	Co-pay Status 1	Co-pay Status 2
Outpatient Hospital or Doctor	\$2 per visit	\$5 per visit
Prescription Drugs	\$2 per prescription	\$5 per prescription
Inpatient Hospital	\$15 per admission	\$25 per admission
Non-emergency use of Emergency Room	\$10 per visit	\$25 per visit
Yearly Co-payment Limit per Family	\$180	\$350

~~*Other co-payments may apply to other services.~~

EMERGENCY MEDICAID SERVICES FOR ALIENS

Section 1903v of the Social Security Act (42 U.S.C. 1396b) requires Medicaid to cover emergency services for specified aliens when these services are provided in a hospital emergency room or inpatient hospital setting. (See Chapter III for details on eligibility.)

The medical conditions subject to this coverage may include, but are not limited to, the following:

- Cerebral vascular attacks
- Traumatic injuries
- Childbirth
- Acute coronary difficulties
- Emergency surgeries (i.e., appendectomies)
- Episodes of acute pain (etiology unknown)
- Acute infectious processes requiring intravenous antibiotics
- Fractures

To be covered, the services must meet emergency treatment criteria and are limited to:

- Emergency room care
- Physician services

-
- Inpatient hospitalization not to exceed limits established for other Medicaid members
 - Ambulance service to the emergency room or hospital
 - Inpatient and outpatient pharmacy services related to the emergency treatment

Hospital outpatient follow-up visits or physician office visits related to the emergency care are not included in the covered services.

~~CLIENT MEDICAL MANAGEMENT (CMM)~~

~~The Client Medical Management Program (CMM) for members and providers is a utilization control and case management program designed to promote proper medical management of essential health care and, at the same time, promote cost efficiency. The basis for CMM member and provider restriction procedures is established through federal regulations in 42 CFR 431.54(e-f) and state regulations as set forth in 12 VAC 30-130-800 through 12 VAC 30-130-820. (See the "Exhibits" section at the end of this chapter for detailed information on the CMM Program.)~~

~~Providers may refer Medicaid patients suspected of inappropriately using or abusing Medicaid services to DMAS's Recipient Monitoring Unit. Referred members will be reviewed by DMAS staff to determine if the utilization meets regulatory criteria for restriction to a primary physician and/or pharmacy in the Client Medical Management Program.~~

~~Referrals may be made by telephone or in writing. The number for the Recipient Monitoring Unit is (804) 786-6548 or toll-free (888) 323-0589. Referrals can also be faxed to (804) 371-8891. Office hours are 8:15 a.m. — 5:00 p.m., Monday through Friday except state holidays. Voice mail receives after hours referrals.~~

~~Written referrals should be mailed to:~~

~~—— Lead Analyst, Recipient Monitoring Unit
—— Division of Program Integrity
—— Department of Medical Assistance Services
—— 600 East Broad Street, Suite 1300
—— Richmond, Virginia 23219~~

~~When making a referral, provide the member's name and Medicaid number and a brief statement regarding the nature of the utilization problems. Copies of pertinent documentation, such as emergency records, would be 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.~~

SOURCES OF INFORMATION

MediCall Automated Voice Response System

Toll-free numbers are available 24-hours-per-day, seven days a week, to confirm member eligibility status, claim status and check status. The numbers are:

1-800-772-9996	Toll-free throughout the United States
1-800-884-9730	Toll-free throughout the United States
(804) 965-9732	Richmond and Surrounding Counties
(804) 965-9733	Richmond and Surrounding Counties

Providers access the system using their Virginia Medicaid provider number as identification. Specific instructions on the use of the verification systems are included in "Exhibits" at the end of this chapter.

Automated Response System (ARS)

Providers may use the Internet to verify member eligibility and perform other inquiry functions. Inquiries can be submitted in real-time. Specific instructions on the use of the ARS are included in "Exhibits" at the end of this chapter.

HELPLINE

A toll-free "HELPLINE" is available to assist providers in interpreting Medicaid policy and procedures and in resolving problems with individual claims. The HELPLINE numbers are:

- (804)786-6273 Richmond Area & out-of-state long distance
- 1-800-552-8627 In-state long distance (toll free)

The HELPLINE is available Monday through Friday from 8:00 a.m. to 5:00 p.m., except on holidays.

The Virginia Medicaid provider number must accompany all provider inquiries (both written and via the HELPLINE). All provider information and data are filed by provider number. This number will expedite recovery of the requested information.

Do not use these HELPLINE numbers for member eligibility verification and eligibility questions. Local departments of social services are responsible for supplying information to members, and members who have questions about the Medicaid Program should be directed to their local departments of social services.

If MediCall is not available, the data will also be unavailable to the HELPLINE (when the system is down).

The Medicaid HELPLINE and MediCall numbers are for provider use only and should not be given to members.

ELECTRONIC FILING REQUIREMENTS

The Virginia MMIS is HIPAA-compliant and, therefore, supports all electronic filing requirements and code sets mandated by the legislation.

The Virginia MMIS will accommodate the following Electronic Data Interchange (EDI) transactions according to the specifications published in the ASC X12 Implementation Guides version 4010A1.

- 837P for submission of professional claims
- 837I for submission of institutional claims
- 837D for submission of dental claims
- 276 & 277 for claims status inquiry and response
- 835 for remittance advice information for adjudicated (paid and denied) □ 270 & 271 for eligibility inquiry and response
- 278 for prior authorization request and response.

Although not mandated by HIPAA, DMAS has opted to produce an unsolicited 277 transaction to report information on pended claims.

If you are interested in receiving more information about utilizing any of the above electronic transactions, your office or vendor can obtain the necessary information at our fiscal agent's website: <https://www.viriniamedicaid.dmas.virginia.gov/wps/portal>.

PROVIDER MANUAL UPDATES

This manual is designed to accommodate new pages as further interpretations of the law and changes in policy and procedures are made. Accordingly, revised pages or sections will be issued by the Department of Medical Assistance Services (DMAS) as needed.

NOTICE OF PROVIDER RESPONSIBILITY

The provider is responsible for reading and adhering to the policies and regulations explained in this manual and for ensuring that all employees do likewise. The

provider also certifies by his or her personal signature or the signature of an authorized agent on each invoice that all information provided to the Department of Medical Assistance Services is true, accurate, and complete. Satisfaction and payment of any claim will be from federal and State funds, and any provider who submits false claims, statements, or documents may be prosecuted under applicable federal or State laws.

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EXHIBITS

<u>Routine patient costs furnished in connection with participation in a qualifying clinical trial</u>	<u>2</u>
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ROUTINE PATIENT COSTS FURNISHED IN CONNECTION WITH PARTICIPATION IN A QUALIFYING CLINICAL TRIAL

Covered Items and Services

DMAS covers routine patient costs furnished in connection with participation in a qualifying clinical trial. Routine patient costs are defined as any item or service provided under a qualifying clinical trial: 1) to prevent, diagnose, monitor, or treat complications resulting from participation in the qualifying clinical trial, to the extent that the provision of such items or services to the beneficiary would otherwise be covered outside the course of participation in the qualifying clinical trial under the state plan or waiver; and/or 2) required solely for the provision of the investigational item or service that is the subject of the qualifying clinical trial, including the administration of the investigational item or service. Examples of routine costs include otherwise covered physician services or laboratory or medical imaging services that assist with prevention, diagnosis, monitoring or treatment of complications arising from clinical trial participation.

Non-covered Items and Services

Items and services considered experimental or investigational and not otherwise covered outside of the clinical trial are not covered. This includes the experimental or investigational drug, item, or service that is the subject of the qualifying clinical trial. Other non-covered items and services include items and services provided to the beneficiary solely to satisfy data collection and analysis for the qualifying clinical trial that are not used in the direct clinical management of the beneficiary.

Qualifying Clinical Trial

A qualifying clinical trial is defined as a clinical trial in any clinical phase of development that is conducted in relation to the prevention, detection, or treatment of any serious or life-threatening disease or condition. The clinical trial must also be one or more of the following:

- A study or investigation that is approved, conducted, or supported (including by funding through in-kind contributions) by one or more of the following:
 - The National Institutes of Health (NIH)
 - The Centers for Disease Control and Prevention (CDC)
 - The Agency for Health Care Research and Quality (AHRQ)
 - The Centers for Medicare & Medicaid Services (CMS)
 - A cooperative group or center of any of the entities described above or the Department of Defense or the Department of Veterans Affairs
 - A qualified non-governmental research entity identified in the guidelines issued by the NIH for center support grants
- A clinical trial, approved or funded by any of the following entities, that has been reviewed and approved through a system of peer review that the Secretary determines comparable to the system of peer review of studies and investigations used by the NIH, and that assures unbiased review of the highest scientific standards by qualified individuals with no interest in the outcome of the review:
 - The Department of Energy

- The Department of Veterans Affairs
- The Department of Defense
- A clinical trial that is one conducted pursuant to an investigational new drug exemption under section 505(i) of the Federal Food, Drug, and Cosmetic Act or an exemption for a biological product undergoing investigation under section 351(a)(3) of the Public Health Service Act; or
- A clinical trial that is a drug trial exempt from being required to have one of the exemptions in the prior bullet.

Determination for Coverage

Determination for coverage of routine patient costs furnished in connection with a member's participation in a qualifying clinical trial shall:

- Be expedited by DMAS and completed within 72 hours (equivalent to three business days) of receiving a fully populated "Medicaid Attestation Form on the Appropriateness of the Qualified Clinical Trial" form published by CMS;
- Be made without limitation on the geographic location of where the clinical trial is conducted or based on the network affiliation of the principal investigator or provider treating the beneficiary in connection with the clinical trial;
- Be based on attestation of the principal investigator or provider regarding the appropriateness of the qualifying clinical trial; and
- Not require the submission of protocols of the qualifying clinical trial or any other documentation that may be proprietary.

Service Authorization

All SA requirements that apply to services provided outside of a clinical trial also apply to services that meet the definition of routine patient costs furnished in connection with a member's participation in a qualifying clinical trial. For services requiring authorization, the "Medicaid Attestation Form on the Appropriateness of the Qualified Clinical Trial" form must be included in the SA request. If a routine patient cost furnished in connection with a member's participation in a qualifying clinical trial does not require a SA outside of a clinical trial, a SA is not required in the context of a clinical trial.

Claims for Services

All claims for routine patient costs furnished in connection with a member's participation in a qualifying clinical trial must include the following:

- HCPCS Modifier Q0 (investigational clinical service provided in a clinical research study that is in an approved clinical research study) or Q1 (routine clinical service provided in a clinical research study that is in an approved clinical research study); AND
- ICD-10 diagnosis code Z00.6 (encounter for examination for normal comparison and control in clinical research program) in the primary or secondary position; AND

The "Medicaid Attestation Form on the Appropriateness of the Qualified Clinical Trial" form, included as an attachment.

THE VIRGINIA MEDICAL ASSISTANCE MEDICALL SYSTEM GENERAL INFORMATION

The Virginia Medical Assistance MediCall System offers Medicaid providers twenty-four-hour-a-day, seven-day-a-week access to current member eligibility information, check status, claims status, prior authorization information, service limit information, pharmacy prescriber identification number cross reference, and information to access member eligibility and provider payment verification via the Internet. MediCall is an enhancement to the previous Medicaid Audio Verification Response System (AVRS).

Not only does MediCall offer providers flexibility in choosing the time of day for their inquiries, but it also makes efficient use of staff time. A valid provider number and a touchtone telephone are required to access MediCall.

To reach an operator while using the member eligibility verification feature of MediCall, key

“0” at any prompt within the Member Eligibility menu. Operator assisted calls are limited to three name searches per call. The operator will not be able to return the caller to MediCall for further inquiries. Operators are available from 8:30 a.m. to 4:30 p.m. Eastern time, Monday through Friday except for state holidays.

MediCall prompts the caller throughout the inquiry, giving and receiving only essential, pertinent information. The data provided is the most up-to-date information available, direct from the Medicaid eligibility, claims and remittance databases. If the caller waits too long to respond to a system prompt, the call will be disconnected.

System downtime will be scheduled during non-peak hours. If the caller dials MediCall during this time, the caller will be informed that the system is unavailable. System downtime is typically scheduled for:

—2:00 a.m. to 4:00 a.m. Daily
2:00 a.m. to 6:30 a.m. Thursday
—————10:00 p.m. Saturday to 6:00 a.m. Sunday

The telephone numbers are:

1-800-772-9996
1-800-884-9730

Toll-free throughout the United States
Toll-free throughout the United States

(804) 965-9732	Richmond and Surrounding Counties
(804) 965-9733	Richmond and Surrounding Counties

If you have any questions regarding the use of MediCall, contact the Medicaid Provider "HELPLINE." The HELPLINE is available Monday through Friday from 8:30 a.m. to 4:30 p.m., except State holidays, to answer questions. The HELPLINE numbers are:

1-804-786-6273	Richmond Area and out of state long distance
1-800-552-8627	In state long distance (toll-free)

HOW TO USE THE SYSTEM

To access MediCall, the provider must have a currently active Medicaid provider number. The provider's number is verified before access to MediCall is authorized.

Responses by the caller to MediCall are required within a specified period of time. If the time limit is exceeded, the call will be disconnected. The caller should have the following information available before calling:

- 10 digit National Provider Identifier (NPI) or Atypical Provider Identifier (API)
- Member Medicaid Number (12 digits) or Social Security Number (9 digits) **and** Date of Birth (8 digits) in month, day, century and year format (mmddyyyy) (necessary for member eligibility verification and claims status)
- From and Thru Date(s) of Service in month, day, century and year format (mmddyyyy) (necessary for member eligibility verification and claims status). The caller will have the following limits when entering dates of service:
 - The caller does not have to enter a **Thru** date of service if services were rendered on a single day. Pressing the # key prompts the system to continue.
 - Future month information is only available in the last week of the current month.
 - Inquiries cannot be on dates of service more than one year prior to the date of inquiry.

After dialing the MediCall number, the system will ask for the NPI or API. Enter the 10 digit number and select from the following options:

- Press “1” for member eligibility verification.
- Press “2” for claims status.
- Press “3” for recent check amounts.
- Press “4” for service authorization information.
- Press “5” for service limit information.

MEMBER ELIGIBILITY VERIFICATION

Enter the From and Thru dates of service. **The service dates for member eligibility verification cannot span more than 31 days.** When the dates of service have been entered, MediCall will verify the information and respond by speaking the first six letters of the last name and the member's Medicaid number for confirmation.

Remain on the line to obtain important member information that might affect payment, such as:

- Special Indicator Codes (Copayment)
- Client Medical Management Information Including Pharmacy/Physician Telephone Number
- Medicare Eligibility
- Other Insurance Coverage
- Special Coverage (QMB, QMB--Extended)
- "MEDALLION" Participation (prior to July, 2012)
- Managed Care Organization provider name and assignment dates

At this point, MediCall will prompt the caller for the next action. The caller may ask for additional dates of service on this member, or may inquire on another member.

The caller may check up to **three** dates of service for each member and inquire on up to **three** members per call.

If the caller is using a Social Security Number instead of the member ID number, the dates of service will relate to the first member ID reported. If multiple open records exist for the same Social Security Number, you will be advised to contact the local

department of social services. You will be given a 3-digit city/county code of the appropriate agency and a 5-digit caseworker code. A cross-reference list of the city/county codes is provided as an exhibit to this chapter.

The caller will receive a "not eligible" response if the future dates about which he or she inquires are beyond the information on file.

A response, "not eligible," will be given if the member is not eligible for all days within the time span entered.

PROVIDER CHECK LOG

The most recent check information is presented by invoice type. This inquiry permits the provider to receive check dates and amounts from the most recent three remittances.

CLAIMS STATUS

For claims status information, the MediCall system will prompt the provider to choose the among the following invoice types (additional information in italics).

- For inpatient care, press 01.
- For long-term care, press 02.
- For outpatient hospital, home health or rehabilitation services, press 03.
- For personal care, press 04.
- For practitioner (physician CMS-1500 billing), press 05.
- For pharmacy, press 06.
- For independent labs (outpatient lab services), press 08.
- For Medicare crossover, press 09.
- For dental, press 11.
- For transportation, press 13.

For claims status, the From date cannot be more than 365 days in the past. The Thru date cannot be more than 31 days later than the From date. After keying the member identification number and the From and Thru date(s) of service,

MediCall will provide the status of each claim up to and including five claims. MediCall will prompt for any additional claims or return to the main menu.

SERVICE AUTHORIZATION INFORMATION

The From and Thru dates for prior authorization cannot span more than 365 days. When the 12-digit member ID number and the 8-digit from and through dates of service have been entered, you will be prompted to enter the 11-digit prior authorization number, if known. If you do not know the prior authorization number, then press the pound (#) key. MediCall will verify prior authorization data on file. The system will prompt you to return additional prior authorization data for the same member and dates, enter new dates for the same member, another prior authorization number for the same member or to enter another member ID number to begin a new inquiry.

SERVICE LIMITS INFORMATION

Service limits can be obtained by service type or procedure code:

- For occupational therapy, press 1. For physical therapy, press 2 For speech therapy, press 3.
- For home health aide, press 4.
- For home health skilled nursing, press 5.
- For DME purchases, press 6 and for DME rentals, press 7.

For occupational therapy, speech therapy or physical therapy the MediCall system will return non-school based and school based service limits separately.

PRESCRIBING PROVIDER ID

Only enrolled Pharmacy providers can access this choice. When prompted, the caller should enter the license number of the prescriber. MediCall will return the first six letters of the prescriber's last name and Medical Assistance provider number. If the prescriber is not active in Virginia Medicaid, you will receive a message that the number is not on file.

The Automated Response System (ARS)

GENERAL INFORMATION

The Automated Response System (ARS) offers Medicaid and FAMIS providers twenty-four-hour-a-day, seven-day-a-week Internet access to current member eligibility information, service limits, claim status, service authorizations, and provider payment history. This web-enabled tool helps provide cost-effective care for members, and allows providers to access current information quickly and conveniently.

The ARS can be accessed through the Virginia Medicaid Web portal at www.virginiamedicaid.dmas.virginia.gov. Please visit the portal for information on registration and use of the ARS.

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CITY/COUNTY CODES

(The Three-Digit Numerical Identifier
of the Local Social Services/Welfare Agency Currently Handling the Case)

If two or more member records using the same SSN are active on the same date of service, inquirers are prompted to contact the Social Services agency for resolution.

COUNTIES

001	Accomack	049	Cumberland	097	King and Queen
003	Albermarle	051	Dickenson	099	King George
005	Alleghany	053	Dinwiddie	101	King William
007	Amelia	057	Essex	103	Lancaster
009	Amherst	059	Fairfax	105	Lee
011	Appomattox	061	Fauquier	107	Loudoun
013	Arlington	063	Floyd	109	Louisa
015	Augusta	065	Fluvanna	111	Luneburg
017	Bath	067	Franklin	113	Madison
019	Bedford	069	Frederick	115	Mathews
021	Bland	071	Giles	117	Mecklenburg
023	Botetourt	073	Gloucester	119	Middlesex
025	Brunswick	075	Goochland	121	Montgomery
027	Buchanan	077	Grayson	125	Nelson
029	Buckingham	079	Greene	127	New Kent
031	Campbell	081	Greensville	131	Northampton
033	Caroline	083	Halifax	135	Nottoway
035	Carroll	085	Hanover	137	Orange
037	Charlotte	087	Henrico	139	Page
041	Chesterfield	089	Henry	141	Patrick
043	Clarke	091	Highland	143	Pittsylvania
045	Craig	093	Isle of Wight	145	Powhatan
047	Culpeper	095	James City	147	Prince Edward
149	Prince George	167	Russell	179	Stafford
153	Prince William	169	Scott	181	Surry
155	Pulaski	171	Shenandoah	183	Sussex
157	Rappahannock	173	Smyth	185	Tazewell
159	Richmond	175	Southampton	187	Warren
161	Roanoke	177	Spotsylvania	191	Washington
193	Westmoreland	195	Wise	197	Wythe
199	York				

CITIES

510	Alexandria	620	Franklin	710	Norfolk
515	Bedford	630	Fredericksburg	720	Norton
520	Bristol	640	Galax	730	Petersburg
530	Buena Vista	650	Hampton	735	Poquoson
540	Charlottesville	660	Harrisonburg	740	Portsmouth
550	Chesapeake	670	Hopewell	750	Radford
570	Colonial Heights	678	Lexington	760	Richmond
580	Covington	680	Lynchburg	770	Roanoke
590	Danville	683	Manassas	775	Salem
595	Emporia	685	Manassas Park	780	South Boston
600	Fairfax	690	Martinsville	790	Staunton
610	Falls Church	700	Newport News	800	Suffolk
810	Virginia Beach	820	Waynesboro	830	Williamsburg
840	Winchester				
976	Central Processing Unit for FAMIS				

STATE MENTAL HEALTH FACILITIES

- 983 Southern Virginia Mental Health Institute
- 985 Southeastern State Hospital
- 986 Northern Virginia Training Center
- 987 Virginia Treatment Center
- 988 Northern Virginia Mental Health Institute
- 990 Central Virginia Training Center
- 991 Western State Hospital
- 992 Southwestern State Hospital
- 993 Piedmont State Hospital
- 994 Eastern State Hospital
- 996 Hiram Davis Hospital
- 997 Catawba State Hospital

~~CLIENT MEDICAL MANAGEMENT INTRODUCTION~~

~~The Client Medical Management Program (CMM) for members and providers is a utilization control and case management program designed to promote proper medical management of essential health care and, at the same time, promote cost efficiency. The basis for CMM member and provider restriction procedures is established through federal regulations in 42 CFR 456.3 and state regulations as set forth in 12 VAC 30-130-800 through 12 VAC 30130-810.~~

~~MEMBER RESTRICTION~~

~~Utilization Review and Case Management~~

~~Federal regulations allow states to restrict members to designated providers when the members have utilized services at a frequency or amount that is not medically necessary. Restricted members are identified and managed by the Recipient Monitoring Unit (RMU) in the Division of Program Integrity.~~

~~CMM enrollment is based upon review of the individual member's utilization patterns. All Medicaid members except MCO members and institutionalized long-term care residents are eligible for utilization review by RMU staff. If the member's utilization patterns meet the criteria for enrollment in CMM, the member is notified to select designated primary providers. Examples of inappropriate utilization are:~~

- ~~• Emergency room use for medical problems that could be treated in a physician's office;~~
- ~~• Using more than one physician and/or pharmacy to receive the same or similar medical treatment or prescriptions; and~~
- ~~• A pattern of non-compliance which is inconsistent with sound fiscal or medical practices.~~

~~Each CMM member is assigned a case manager in the Recipient Monitoring Unit to assist both members and providers with problems and questions related to CMM. The case manager is available to:~~

- ~~• Resolve case problems related to CMM procedures and provider assignments;~~
- ~~• Counsel the member on the appropriate access to healthcare;~~
- ~~• Approve/deny requests for provider changes; and~~
- ~~• Complete a utilization review prior to the end of the enrollment period to determine if CMM restriction should be extended.~~



Member Enrollment Procedures

~~Members identified for CMM enrollment receive a letter explaining the member/provider relationships under medical management. The letter includes the Member/Primary Provider Agreement forms (see the sample forms at the end of this section) with directions for completing and returning the form to the Recipient Monitoring Unit. Members are given thirty (30) days to select their primary providers by obtaining their signatures on the form. The provider's signature indicates agreement to participate as the CMM provider for the member. DMAS reviews member requests for specific providers for appropriateness and to ensure member accessibility to all required medical services.~~

~~Members also have thirty (30) days from the receipt of the restriction notice to appeal enrollment in CMM. Assignment to designated providers is not implemented during the appeal process.~~

~~CMM enrollment is for 24 months. Assignment to both a physician and pharmacy is made with few exceptions.~~

~~When members do not return choices to the Recipient Monitoring Unit or have difficulty in finding providers, RMU staff will select providers for them. RMU staff contact providers directly to request participation as a CMM provider for the member and follow-up by mailing or faxing the agreement form for the provider's signature.~~

~~When completed agreement forms are received, the member is enrolled in CMM effective the first of the next month in which a restricted Medicaid card can be generated. Both members and selected providers are notified by mail of the enrollment date.~~

~~Members enrolled in the Client Medical Management can be identified through the process of eligibility verification. A swipe of the Medicaid ID card will return the names and telephone numbers of the primary care physician and designated pharmacy. The dates of assignment to each provider are also included. This information is also available through the MediCall System and the web-based Automated Response System (ARS). Instructions for both resources are provided in this chapter.~~

~~Each CMM member also receives an individual Medicaid coverage letter with the name(s) and address of the designated primary health care provider and/or designated pharmacy printed on the front each time there is a change in providers.~~

Designated Primary Care Physicians (PCP)

~~Any physician enrolled in Medicaid as an individual practitioner may serve as a designated primary care physician (PCP) except when:~~

- ~~• The physician's practice is limited to the delivery of emergency room services; or~~
- ~~• The physician has been notified by DMAS that he or she may not serve as a designated provider, covering provider, or referral provider for restricted members.~~

~~Federally Qualified Community Health Centers (FQHCs) and Rural Health Clinics (RHCs) may serve as PCPs also. Other provider types such as ambulatory care centers may be established as designated providers as needed but only with the approval of DMAS.~~

~~Primary care physicians are responsible for coordinating routine medical care and making referrals to specialists as necessary. The PCP must arrange 24-hour coverage when they are not available and explain to their assigned members all procedures to follow when the office is closed or when there is an urgent or emergency situation.~~

~~The provider's NPI number is used for billing and referral purposes.~~

Designated Pharmacies

~~Any pharmacy enrolled as a community pharmacy billing on the Pharmacy Claim Form or other acceptable media may serve as a designated pharmacy unless the pharmacy has been notified by DMAS that it may not serve as a designated provider.~~

~~Designated pharmacies must monitor the member's drug regimen. The pharmacist should fill prescriptions from the PCP, referred physicians, and emergency prescriptions. Referrals can be confirmed by reviewing the member's copy of the referral form or by contacting the PCP's office. Close coordination between the PCP and the pharmacist, particularly if a medication problem has been identified, is a very important component of the program.~~

Changing Designated CMM Providers

~~The member or designated provider may initiate a request for a change of a designated provider by contacting the Recipient Monitoring Unit. Designated providers requesting a change must notify the member in addition to contacting RMU. If the designated provider requests the change and the member does not select a new provider by the established deadline, RMU shall select for them.~~

~~All changes must be preauthorized by DMAS RMU staff. The member's RMU case manager may contact the provider before making a final decision on the change request to try to resolve questions or issues and avoid unnecessary changes. If DMAS denies a member's request, the member shall be notified in writing and given the right to appeal the decision. Changes are allowed for:~~

- ~~1. Relocation of the member or provider;~~
- ~~2. Inability of the designated provider to meet the routine medical/pharmaceutical needs of the member; or~~
- ~~3. Breakdown of the relationship between the provider and member.~~

~~Provider changes can occur any time of the month because the effective date is the date the new provider signs the Member/Primary Provider Agreement form. When a new provider is assigned, RMU mails a letter to the member confirming the effective date of the change. The letter instructs the member to show the letter with the Medicaid identification card. Letters go to the affected providers also. All verification inquiries will return the new primary provider from the date it is entered into the computer system.~~

~~A PCP No Longer in Practice~~

~~If a provider leaves the practice or retires, he or she must notify CMM so that the restricted member can be reassigned to a new PCP.~~

~~Covered Services and Limitations~~

~~Under CMM, DMAS will pay for covered outpatient medical and/or pharmaceutical services only when they are provided (1) by the designated providers, (2) by physicians seen on written referral from the PCP, (3) by covering providers linked with the designated provider in a CMM Affiliation Group, or (4) in a medical emergency. A medical emergency means that a delay in obtaining treatment may cause death or serious impairment of the health of the member. Payment for covered outpatient services will be denied in all other instances (unless the covered services are excluded from Client Medical Management Program requirements), and the member may be billed for the services.~~

~~All services should be coordinated with the designated provider. The CMM PCP referral does not override Medicaid service limitations. All DMAS requirements for reimbursement, such as pre-authorization, still apply as indicated in each provider manual.~~

~~Physician Services~~

~~A Medicaid-enrolled physician who is not the PCP may provide and be paid for outpatient services to these members only:~~

- ~~• In a medical emergency situation in which a delay in the treatment may cause death or result in lasting injury or harm to the member.~~
- ~~• On written referral from the PCP using the Practitioner Referral Form (DMAS-70). This also applies to covering physicians who have not been affiliated with the PCP.~~
- ~~• When they are a part of a CMM provider affiliation group that includes the PCP.~~
- ~~• For other services covered by DMAS which are excluded from the Client Medical Management Program requirements.~~

~~Services Excluded from PCP Referral~~

~~These services should be coordinated with the primary health care provider whose name appears on the member's eligibility card, but they are excluded from special billing instructions for the Client Medical Management Program.~~

~~Covered services that do not need a referral include:~~

- ~~Early and Periodic Screening, Diagnosis, and Treatment Program (EPSDT) well-child exams and screenings (members under age 21);~~
- ~~Immunizations (member under age 21);~~
- ~~Family planning services;~~
- ~~Expanded prenatal services, including prenatal group education, nutrition services, and homemaker services for pregnant women and care coordination for high-risk pregnant women and infants;~~
- ~~Dental services (members under age 21);~~
- ~~Services provided under Home and Community-Based Care Waivered Services;~~
- ~~Hospice services;~~
- ~~Renal dialysis services;~~
- ~~Routine vision care services (routine diagnostic exams for members of all ages and eyeglasses for members under age 21). Medical treatment for diseases of the eye and its appendages still requires a written referral;~~
- ~~Audiology services;~~
- ~~Podiatry services;~~
- ~~Prosthetic services;~~
- ~~MH/ID community rehabilitative services;~~
- ~~Psychiatric diagnostic and therapeutic services (limited sessions of outpatient treatment);~~
- ~~Inpatient hospital services;~~
- ~~Life-threatening medical emergencies; and~~
- ~~School-based services.~~

~~CMM Provider Affiliation Groups~~

~~Physician affiliation groups allow covering physicians to see each other's patients without a written referral. GMM affiliations may be set up for physicians within a practice or for the single practitioner who arranges coverage by a physician not sharing office space. Affiliations can be open-ended or for a specified period of time (such as when the PCP is away from the office for days or weeks). CMM affiliations may include physicians, Rural Health Clinics, Federally Qualified Health Clinics (FQHC), and nurse practitioners.~~

~~Affiliations are not member-specific. This means that once provider numbers are affiliated, claims will pay for all GMM members who receive services from a member of an affiliation group that includes the member's PCP on the date of service.~~

~~The PCP requests affiliation by completing the CMM Provider Affiliation Form (see sample form at the end of this section) and returning it to the Recipient Monitoring Unit (RMU). The form is used to set up a new affiliation group or to update a group. Providers are responsible for notifying DMAS when a new provider joins the group or a provider leaves the group to ensure claims are processed correctly. Contact the Recipient Monitoring Unit at (804) 786-6548 in Richmond, or toll-free at 1-888-323-0589, to request a form.~~

~~Emergency Room Services~~

~~Outpatient hospital emergency room services for restricted members are limited to reimbursement for medical emergencies. Emergency hospital services means that the threat to the life or health of the member necessitates the use of the most accessible hospital facility available that is equipped to furnish the services. Reimbursement may be conditional upon the review of the emergency-related diagnosis or trauma ICD diagnosis codes and the necessary documentation supporting the need for emergency services. Additional guidelines for payment of medical services provided in the outpatient hospital emergency room setting are listed in Chapter IV "Covered Services" in this manual.~~

~~CMM clients must have a written PCP referral in order for non-emergency services provided in the emergency room to be reimbursed at an all-inclusive rate. The PCP must use the Practitioner Referral Form, DMAS-70. Payment will be denied without a referral unless there is a life-threatening emergency. Non-emergency services provided without a PCP referral become non-covered services, and the member is responsible for the full cost of the emergency room visit.~~

~~CMM also requires a PCP referral form for:~~

- ~~• Reimbursement to CONSULTING physicians who treat a CMM client in the emergency room setting, and~~
- ~~• Reimbursement for any follow-up outpatient or office consultations resulting from an ER visit.~~

~~Emergency Pharmacy Services~~

~~Prescriptions may be filled by a non-designated pharmacy only in emergency situations (e.g., insulin or cardiac medications) when the designated pharmacy is closed or the designated pharmacy does not stock or is unable to obtain the drug.~~

~~Provider Reimbursement and Billing Instructions~~

~~Management Fees~~

~~Each physician, FQHC, or Rural Health Clinic that serves as a CMM primary care provider (PCP) receives a monthly case management fee of \$5.00 for each assigned CMM member. Payment is made through a monthly remittance process. PCPs receive a monthly report listing the CMM members assigned the previous month for whom payment is made.~~

~~PCP and Designated Pharmacy Providers~~

~~DMAS pays for services rendered to CMM members through the existing fee-for-service methodology. Designated providers (PCP's and pharmacies) bill Medicaid in the usual manner, but non-designated providers who are not affiliated with the CMM provider must follow special billing instructions. Complete instructions for the CMS 1500 (08-05) and UB-04 billing invoices as well as Point-of-Sale (POS) billing can be found in the billing instruction chapter of this manual.~~

~~Affiliated Providers~~

~~Providers who are affiliated with a designated CMM provider in the Medicaid system bill Medicaid in the usual manner with no special billing instructions. Claims process with a look-up to the CMM Affiliation Groups in the system.~~

~~Referral Providers~~

~~To receive payment for their services, referral providers authorized by the client's PCP to provide treatment to that client must place the Provider Identification Number of the PCP in Locator 17a (1D qualifier followed by the API number) or 17b (National Provider Identifier number of referring physician – 17B requirement effective 5/23/08) of the CMS-1500 (0805) and attach the Practitioner Referral Form.~~

~~Physicians Billing Emergency Room Services~~

~~When billing for emergency room services on the CMS-1500, the attending physician bills evaluation and management services with CPT codes 99281-99285 and enters "Y" in Block 24-C. When the PCP has referred the client to the emergency room, place the PCP's NPI number in Block 17b on the CMS-1500 and attach the Practitioner Referral form.~~

~~Facilities Billing Emergency Room Services with a Referral~~

~~When billing for emergency room services on the on the UB-04 CMS 14-50, place the PCP's provider number in space 78, and attach the Practitioner Referral Form.~~

~~Non-designated Pharmacy Providers~~

~~When billing on the Pharmacy Claim Form or as a Point-Of-Sale (POS) provider, enter code "03" in the "Level of Service" field to indicate emergency.~~

~~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 (RMU) of the Department of Medical Assistance Services. Referred members will be reviewed by DMAS staff to determine if the utilization meets regulatory criteria for restriction to a primary physician or pharmacy in the Client Medical Management (CMM) Program. 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 members on 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. Voice mail receives after-hours referrals. Written referrals should be mailed to:~~

~~Lead Analyst, Recipient Monitoring Unit~~

~~Division of Program Integrity
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 member and a brief statement about the nature of the utilization problems. 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.~~

~~PROVIDER RESTRICTION~~

~~Restricted providers are identified and managed by the DMAS Provider Review Unit. States may restrict providers from participation in the Medicaid Program when the provider has provided items or services at a frequency or amount not medically necessary or has provided items or services of a quality that does not meet professionally recognized standards of health care. State regulations allow DMAS to restrict providers' participation as designated providers, referral providers, or covering providers for CMM restricted members when a provider has billed services at a frequency or level exceeding that which is medically necessary or when a provider's license to practice has been revoked or suspended in Virginia by the appropriate licensing board.~~

~~Provider restriction is for 24 months. Providers may appeal any proposed restriction in accordance with the Code of Virginia, Section 2.2-4000 et seq., as discussed in the chapter containing utilization review and control information in this manual. Restriction is not implemented pending the result of a timely appeal request.~~

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
 CLIENT MEDICAL MANAGEMENT PROGRAM
PRACTITIONER REFERRAL FORM

Recipient's Name: _____ DMAS#: _____

Referred to: _____ Date: _____

Purpose of Referral (check one):

____ Physician covering in absence of primary health care provider for (specify period of absence for up to 90 days) _____

____ See one time only for _____

____ See as needed for on-going treatment of _____

(Referral for on-going treatment must be renewed at 90 day intervals.)

This recipient is restricted to me as his/her primary health care provider. Please refer to the billing chapter in your Medicaid Provider Manual for billing information. **This form must be part of your medical record. For reimbursement, a copy must be attached to every claim submitted on behalf of this recipient.**

If you wish to refer this patient to another source who will be billing Medicaid, you must obtain another referral form for that physician from me.

These referral provisions do not apply while the recipient is an inpatient in a hospital.

Signature of Primary Health Care Provider

Name of Primary Health Care Provider

Provider ID#: _____

Address: _____

Telephone #: () _____

(Instructions on Back)

DMAS-70 4/89

REFERRAL PHYSICIAN'S COPY

~~DEPARTMENT OF MEDICAL ASSISTANCE SERVICES CLIENT MEDICAL MANAGEMENT PROGRAM~~

~~RECIPIENT/PRIMARY PROVIDER AGREEMENT PHYSICIAN~~

~~DATE: _____~~

~~RECIPIENT NAME: _____ DMAS#: _____~~

~~I. My choice for primary physician is given below. I understand that Medicaid will pay for covered outpatient physician services provided by my primary physician. Other physicians will be paid only when my primary physician makes a medical referral or is unable to provide services in a medical emergency requiring immediate treatment.~~

~~RECIPIENT SIGNATURE: _____~~

~~DATE: _____~~

~~TELEPHONE NUMBER: (____) _____~~

~~II. PRINT NAME AND ADDRESS OF PHYSICIAN: _____~~

~~I agree to undertake primary health care and make appropriate referrals to specialists for the recipient named above.~~

~~PHYSICIAN'S SIGNATURE: _____~~

~~DATE: _____~~

~~PHYSICIAN'S DMAS ID#: _____ TELEPHONE NUMBER: _____~~

~~(____) _____~~

~~(Use Virginia Medicaid Provider Billing Number)~~

~~MAIL/FAX BY _____ TO: _____~~

~~RECIPIENT MONITORING UNIT
DEPARTMENT OF MEDICAL ASSISTANCE SERVICES RICHMOND, VIRGINIA 23219
600 EAST BROAD STREET, SUITE 1300~~

INSTRUCTIONS

- ~~1. You must sign the form in Section I. If the form is for a child, the parent or guardian must sign.~~
- ~~2. The physician you select must be enrolled as an individual physician with Medicaid and bill on the HCFA 1500 invoice or other acceptable media using his/her own Medicaid provider number. The physician can tell you if these requirements are met.~~
- ~~3. If the physician agrees to be your primary physician, ask him/her to sign and date the form and write in the Medicaid provider number.~~
- ~~4. Be sure the physician's name and the office address are PRINTED clearly in Section II.~~
- ~~5. When Sections I and II are completed, return the form to our office in the enclosed postage paid envelope. The form may also be FAXED to (804) 371-8891.~~
- ~~6. Any questions can be directed to the Recipient Monitoring Unit in Richmond, (804) 786-6548 or toll free 1-888-323-0589.~~

~~(03/03)~~

~~DEPARTMENT OF MEDICAL ASSISTANCE SERVICES CLIENT MEDICAL MANAGEMENT PROGRAM~~

~~RECIPIENT/PRIMARY PROVIDER AGREEMENT PHARMACY~~

~~DATE: _____~~

~~RECIPIENT NAME: _____ DMAS#: _____~~

~~I. My choice for designated pharmacy is given below. I understand that Medicaid will pay for covered outpatient pharmacy services from my designated pharmacy. Other pharmacies will be paid only when my designated pharmacy does not stock or cannot supply medications in a medical emergency requiring immediate treatment.~~

~~RECIPIENT SIGNATURE: _____ DATE: _____~~

~~TELEPHONE NUMBER: (____) _____~~

~~II. PRINT NAME AND ADDRESS OF PHARMACY:~~

~~_____~~

~~I agree to monitor the drug utilization and provide all outpatient pharmaceutical needs for the recipient named above.~~

~~PHARMACY REPRESENTATIVE'S SIGNATURE:~~

~~DATE:~~

~~PHARMACY'S DMAS ID#: TELEPHONE NUMBER:~~

~~(Use Virginia Medicaid Provider Billing Number)~~

~~MAIL/FAX BY TO: RECIPIENT MONITORING UNIT~~

~~DEPARTMENT OF MEDICAL ASSISTANCE SERVICES RICHMOND, VIRGINIA 23219
600 EAST BROAD STREET, SUITE 1300~~

INSTRUCTIONS

- ~~1. You must sign the form in Section I. If the form is for a child, the parent or guardian must sign.~~
- ~~2. The community pharmacy you select must be a Medicaid provider that bills on the Pharmacy Claim Form or other acceptable media. The pharmacist can tell you if the pharmacy meets these requirements.~~
- ~~3. If the pharmacist agrees to be your designated provider, ask him/her to sign and date the form and write in the pharmacy's National Provider Identifier.~~
- ~~4. Be sure the name and address of the pharmacy is PRINTED clearly in Section II.~~
- ~~5. When Section I and II are completed, return the form to our office in the enclosed postage paid envelope. The form may also be FAXED to (804) 371-8891.~~
- ~~6. Any questions can be directed to the Recipient Monitoring Unit in Richmond. Call toll-free to the CMM Helpline (1-888-323-0589) or call (804) 786-6548 in the Richmond Metro area.~~

SECTION I: General Information

~~Provider Name: Provider Number:~~

~~_____~~

Business Name: ~~IRS ID number~~

Street Address*:**

Contact Person:

Telephone Numbers:

Contact Phone:

24-hour Access: (Required)

Email:

Office Hours: FAX:

~~(**The address *must* be a physical street address.)~~

SECTION II: ~~Service Locations~~

~~Please list all Medicaid provider identification numbers issued to you.~~

~~**Medicaid Number Medicaid Number**~~

SECTION III: ~~Affiliations~~

~~Please list the names and Medicaid numbers of those associated physicians or nurse practitioners at the location listed in Section I who are to be affiliated for business and billing purposes. Use the back of this form if more space is needed.~~

~~**Name Medicaid Number**~~

DO NOT WRITE BELOW THIS SPACE

RETURN FORM TO:

**Recipient Monitoring Unit
Department of Medical Assistance Services
Richmond, Virginia 23219
600 E. Broad Street, Suite 1300**

**Affiliation group to include provider
numbers listed in Sections II and III.**

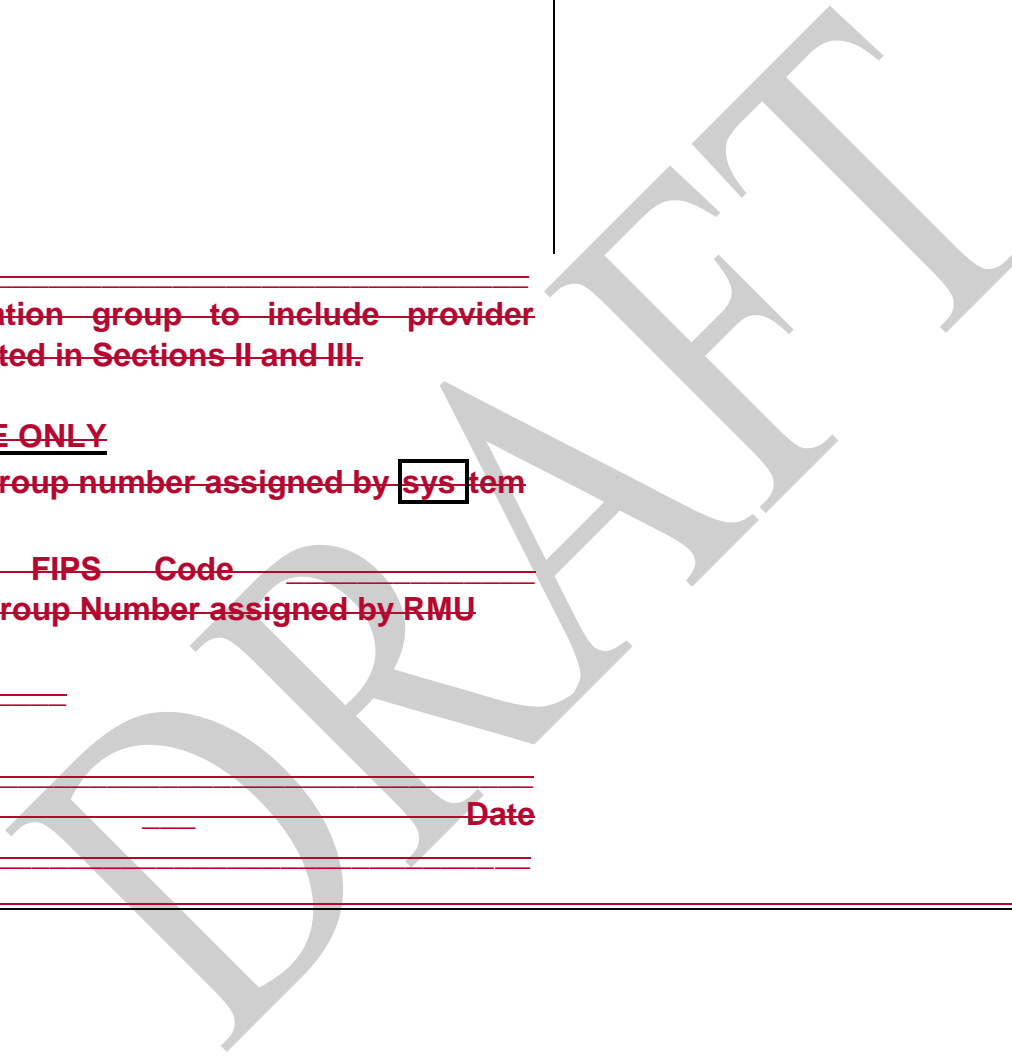
OFFICE USE ONLY

Affiliation Group number assigned by system

FIPS Code _____
Affiliation Group Number assigned by RMU

RMU
Signature _____

Date



CONFIDENTIAL