

Virginia Medical Assistance Eligibility Manual

Chapter M18 Medical Services

Chapter M18 Changes

Date Converted to New Template: April 2026

Changed With	Effective Date	Subchapters Changed
TN #DMAS-26	1/1/23	Pages 6a, 7 and 8
TN #DMAS-22	1/1/22	Page 8 Page 7 is a runover page.
TN #DMAS-20	7/1/21	Page 7 Page 8 is a runover page.
TN #DMAS-12	04/01/2019	Page 3, 5
TN #DMAS -11	01/01/2019	Page 3
TN #DMAS-10	10/1/18	Pages 3-5
TN #DMAS-6	10/1/17	Table of Contents Pages 3-5 Page 6 is a runover page. Page 6a was added.
TN #100	5/1/15	Table of Contents Pages 1-9 Pages 10-17 were deleted. Appendix 1 was removed.
UP #9	4/1/13	Page 3
UP #7	7/1/12	Page 12
TN #96	10/01/11	Pages 3, 4, 16
TN #95	3/1/11	Page 9
TN #94	9/1/10	Page 12
TN #93	1/1/10	Pages 4, 5
TN #91	5/15/09	Page 2 Pages 5, 6 Page 8

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Subchapter M1810: *Cardinal Care* Medicaid Eligibility Card

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M1810 CHANGES

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SECTION M1810.100: CARDINAL CARE MEDICAID ELIGIBILITY CARD

Last Section Revision Date: April 2026

A. *Cardinal Care* Medicaid Card Issuance

A *Cardinal Care* Medicaid card is issued to an individual who has been found eligible for Medicaid and is enrolled with the Department of Medical Assistance Services (DMAS). The card is plastic with the enrollee's name, gender and birth date on the front, and a strip on the back that providers can "swipe" to *determine* the type of coverage and the begin date of coverage. The card is intended to be permanent. Presentation of the card to the Medicaid-enrolled (certified) provider of medical services authorizes the provider to bill Medicaid for the needed services, if such services are covered by the Medical Assistance Program and DMAS has pre-authorized the service, when pre-authorization is required.

EXCEPTION: The following recipients do not receive a *Cardinal Care* Medicaid card:

- individuals eligible for Medicare premium payment only,
- individuals enrolled in a closed period of coverage in the past with no ongoing coverage, and
- incarcerated individuals eligible for Medicaid payment of inpatient hospitalization *and as of 7/1/2026, 5121 Youth Re-entry Targeted Case Management (TCM) and Transitional Coordination* services only.

B. Use of the *Cardinal Care* Medicaid Card

1. General

Local social services departments must provide recipients with information concerning use of the *Cardinal Care* Medicaid card. This includes information that misuse of the card is fraud and can result in prosecution. Examples of misuse include:

- using the card following cancellation of eligibility,
- alteration of names, dates, or other information to secure medical care to which the individual is not entitled, and
- knowingly permitting another person to use an individual's card to secure medical care.

2. Foster Care Children in Institutional Facilities

The local department of social services (LDSS) should use the local department's address when enrolling a foster care child whose custody is held by the local

department of social services and who is placed in an institution. Upon receipt of the Medicaid card, it should be sent to the appropriate institution for use on the child's behalf. The local department has the responsibility of advising the child caring institution of the medical and dental services covered by Medicaid.

3. Nursing Facility Patients

Patients in nursing facilities receive *Cardinal Care* Medicaid cards. The nursing facility also receives a computer-generated list at the first of the month which lists all eligible Medicaid patients in that facility.

This report reflects only those Medicaid-eligible patients for whom the nursing facility has submitted an "admission packet."

DMAS staff enters the patient information into the system and assigns a patient control number to the facility for use in billing Medicaid for the patient's care.

When a patient dies or is discharged from the facility, the facility is responsible for notifying DMAS and the LDSS of the date of discharge or death. Long-term *Services and Supports* (LTSS) providers have been instructed to notify the LDSS of death or discharge via the Medicaid Long-term Care Communication Form (DMAS-225).

Subchapter M1820: Service Providers

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M1820 CHANGES

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SECTION M1820.100: SERVICE PROVIDERS

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A. Enrollment Requirement

Providers of medical services must be enrolled by DMAS to receive Medicaid payment for their services. Lists of enrolled providers are available to local departments of social services and to enrollees, and can also be accessed online at www.dmas.virginia.gov.

B. Out-of-State Providers

1. Covered Services

Medicaid will cover medical services rendered by out-of-state providers when the use of such providers is:

- the general custom of the eligible individual (e.g., a recipient living near the border of another state),
- needed by a non IV-E Foster Care child placed outside Virginia,
- necessitated when an eligible person is temporarily outside Virginia and has a medical emergency, or
- indicated because of referral to an out-of-state facility when preauthorized by DMAS.

2. Provider Enrollment

In instances where an out-of-state provider is not currently enrolled as a DMAS provider, DMAS will accept the provider's initial billing and will contact the provider to determine the provider's wish to become enrolled so that subsequent services can be paid through the computerized Medicaid claims processing system. [New Enrollment](#) webpage can be accessed to enroll the provider online.

Subchapter M1830: Managed Care

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SECTION M1830.100: MANAGED CARE

Last Section Revision Date: April 2026

A. General Information

DMAS provides Medicaid coverage to enrollees primarily through two delivery systems: fee-for-service (FFS) and managed care. FFS benefits are administered by DMAS through participating providers within the traditional Medicaid program rules. Most Virginia Medicaid enrollees including individuals with other forms of health insurance (TPL) are required to receive medical care through a managed care organization.

B. Cardinal Care

The *Cardinal Care* managed care program is administered through DMAS' contracted managed care organizations (MCOs). *On October 1, 2023, Virginia Medicaid combined the two managed care programs of Medallion 4.0 and Commonwealth Coordinated Care Plus (CCC Plus) into Cardinal Care Managed Care (CCMC). CCMC continues to offer members the same programs and services and does not reduce or change any existing coverage. CCMC are categorized in two benefit plans/populations:*

- *Acute (previously Medallion 4.0) and MLTSS (previously CCC Plus).*
 - *Provides services to qualified members in the areas of maternity care, including early prenatal care, case management, and postpartum care; care for infants and children (including foster care), including early intervention services, immunizations, screening, and preventive care; and wellness, behavioral health, community mental health services, behavioral therapy, family planning and chronic disease support for adults.*
- *MLTSS (Managed Long-term Services and Supports):*
 - *Designed to assist individuals with health or personal needs, activities of daily living, and instrumental activities of daily living over a period. LTSS can be provided at home, in the community, or in various types of facilities, including Nursing Facilities.*
 - *MLTSS is meant for members who cannot perform daily living tasks, private care can come to members' homes or communities to provide additional services.*

Some enrollees in the groups below are served through Fee for Service because they meet exclusionary criteria. The following is a **partial** list of enrollees excluded from managed care enrollment:

- Enrollees who meet a spenddown and are enrolled for a closed period of coverage
- Enrollees who are participating in Plan First

- Enrollees who have an eligibility period that is less than three months or who have an eligibility period that is only retroactive
- *Limited covered groups – Plan First, Qualified Medicare Beneficiaries (QMB) only, Special Low-income Medicare Beneficiaries (SLMB), and Qualified Individuals (QI)*
- *Enrollees in specialized settings – intermediate care facilities for individuals with intellectual disability (ICF-ID), Veterans’ nursing facilities, psychiatric residential treatment facilities (PRTF), the Virginia Home, and the Piedmont, Catawba and Hancock state facilities*
- *Enrollees in hospice care (CCC Plus who elect hospice will remain in CCC Plus.)*
- *Enrollees in other programs – Medicaid or FAMIS Medallion 4.0 managed care, and the Program for All-inclusive Care for the Elderly (PACE)*

All Cardinal Care health plans offer enhanced benefits to members including, but not limited to:

- Boys and Girls Club membership (6-18 olds)
- Cell phone
- Centering pregnancy program
- Free meal delivery after inpatient hospital stays
- GED for Foster Care
- Sports physical at no cost (under age 21)
- Swimming lessons for members six (6) years and younger
- Vision for adults

NOTE: Not all health plans will offer all of the same enhanced benefits

Enrollees excluded from mandatory managed care enrollment shall receive Medicaid services under the current fee-for-service system. When enrollees no longer meet the criteria for exclusion, they shall be required to enroll in the appropriate managed care program.

Enrollees and their families may contact the Managed Care *Cardinal Care* Helpline at 1-800-643-2273 for information and assistance.

C. Managed Care Helpline

Eligible individuals can enroll in an MCO or obtain additional information, as well as assistance with coverage issues, by calling the Managed Care *Cardinal Care* Helpline at 1-800-643-2273 (TTY/TDD 1-800-817-6608). The Helpline is available Monday through Friday from 8:30 a.m. until 6:00 p.m. Information is available online at www.virginiamanagedcare.com.

D. Family Access to Medical Insurance Security Plan (FAMIS) Managed Care

FAMIS benefits are *also* administered through *Cardinal Care* (DMAS contracted MCOs) or through FAMIS fee-for-service.

In all areas of the Commonwealth, FAMIS enrollees have the choice between 5 MCOs. When a child is first enrolled in FAMIS, *they are* able to access health care through the FAMIS fee-for-service program. Within 1 or 2 months after FAMIS enrollment, the child will be enrolled with a *Cardinal Care* MCO.

FAMIS benefits are slightly different than the benefits that children enrolled in Medicaid receive.

FAMIS enrollees may receive nurse practitioner services, nurse midwife services, and private duty nursing services. Skilled nursing services provided by a Local Education Association (LEA) include medical evaluations or assessments, state mandated health screenings, and other services that are determined to be necessary to assess, monitor, and provide nursing interventions to prevent or maintain health or a medical condition, under the scope of a licensed school nurse (RN or LPN working under the supervision of an RN).

Additionally, FAMIS enrollees are eligible for up to 180 days of Nursing Facility services in accordance with the base benchmark plan.

The following is a partial list of services (while covered under Medicaid) are **NOT** covered under FAMIS.

- Early and Period Screening Diagnosis and Treatment (EPSDT) services are not covered for FAMIS MCO members. Many of the services that are covered as EPSDT services by Medicaid are covered under FAMIS MCO's well child and immunization benefits. EPSDT services **are** covered for FAMIS FFS members because they receive the Medicaid benefit package.
- Psychiatric treatment in free standing facilities is not covered under FAMIS. However, psychiatric treatment is covered when provided in a psychiatric unit of an acute hospital.
- Routine transportation to and from medical appointments is not covered for FAMIS enrollees. Children enrolled in FAMIS FFS may receive non-emergency transportation services. Emergency transportation is covered for *all* FAMIS enrollees.
- Psychiatric Residential Treatment Facility (PRTF) and Therapeutic Group Home (TGH) Services are not covered for FAMIS enrollees. Youth in FAMIS are eligible to receive other mental health and substance use treatment services.

Eligible FAMIS individuals can enroll in an MCO or obtain additional information, as well as assistance with coverage issues, by calling Cover Virginia at 1-855-242-8282, Monday

through Friday from 8:00 a.m. until 7:00 p.m. and Saturdays from 9:00 a.m. – noon.
Information is also available online at [Home | CoverVA](#).

A summary of FAMIS covered services can be found online at: [Medicaid for Children and FAMIS | CoverVA](#)

E. Enrollment Corrections/Changes

DMAS pays a capitation rate for every month an individual is enrolled in managed care regardless of whether the individual receives *Cardinal Care* during the month. If an individual is incorrectly enrolled in a Medicaid managed care program, the eligibility worker must refer the case to DMAS at the following address for possible recovery of expenditures (see chapter M1700):

Recipient Audit Unit
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, VA 23219

Subchapter M1840: Utilization Review and Client Medical Management

Last Subchapter Revision Date: October 2017

M1840 CHANGES

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SECTION M1840.100: UTILIZATION REVIEW AND CLIENT MEDICAL MANAGEMENT

Last Section Revision Date: October 2017

A. Utilization Review

Federal regulations require the Department of Medical Assistance Services (DMAS) to regularly review recipients' use and need for the covered medical services they receive. Regulations require that Medicaid pay only for medically necessary covered medical services. Medicaid cannot pay for duplicate services since they are not necessary.

DMAS staff in the Program Integrity Division reviews provider claims and recipient utilization histories for medical necessity. If it is determined that services were not medically necessary, providers are obligated to reimburse DMAS for any Medicaid payment they have received.

B. Client Medical Management (CMM) Program

An enrollee's utilization of Medicaid cards for physicians' services and pharmaceutical services is monitored regularly by DMAS. Whenever the utilization of one or both of these services is unusually high, the services will be reviewed for medical necessity. If some services are considered not medically necessary, recipients who are not enrolled in a managed care program will be placed in the CMM Program and required to select a primary physician and/or pharmacy or both.

Individuals identified as high utilizers will receive a letter of notification with instructions about selecting primary providers and identifying those providers to DMAS. Individuals who do not respond to the letter within the specified time will have their primary physician and pharmacy designated by DMAS.

For recipients who have been placed in the CMM Program, Medicaid payment for physicians' services will be limited to those services rendered by the primary physician (including a physician providing services to the patients of the primary physician when the primary physician is not available), physicians seen on referral from the primary physician, and emergency medical services.

Prescriptions may be filled by a non-designated pharmacy only in emergency situations when the designated pharmacy is closed or cannot readily obtain the drug.

Subchapter M1850: Covered Services

Last Subchapter Revision Date: January 2023

M1850 CHANGES

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SECTION M1850.100: COVERED SERVICES

Last Section Revision Date: January 2023

A. General Information

Information on Medicaid covered services is provided to assist the eligibility worker in responding to general inquiries from applicants/recipients. Individuals who have problems with bills or services from providers of care should be referred as follows:

- Refer FFS Medicaid enrollees to the DMAS Recipient Helpline at 804-786-6145. Refer individuals who need assistance with transportation to the DMAS transportation broker at 1-866-386-8331.
- Refer individuals enrolled in managed care to the Managed Care Helpline at 1-800-643-2273 or directly to their MCO. Individuals in managed care who need assistance with transportation must contact their MCO directly.

B. Copayments

1. Medicaid Enrollees without Medicare

Medicaid covered services *no longer* have a “copayment,” which is the portion of the cost of the service for which the recipient is responsible.

2. Medicare Beneficiaries

Medicaid covers the Medicare copayment for individuals with Medicare and full-benefit Medicaid (dual eligibles) and Qualified Medicare Beneficiaries (QMB).

However, a provider is allowed to collect the Medicare copayment at the time of service. If the provider requires the individual to pay the Medicare copayment, the individual must be reimbursed or credited the difference between the Medicare and Medicaid copayments once the provider receives payment of the Medicaid claim.

3. Covered Services

The services listed below are covered:

- Behavioral health services, including clinic services, outpatient psychiatric services, mental health case management, psychosocial rehabilitation, mental health skill building, therapeutic day treatment for children and adolescents, intensive in-home services for children and adolescents, mental health partial hospitalization, mental health intensive outpatient, assertive community treatment, applied behavior analysis, multisystemic therapy, functional family therapy, mobile crisis response, community stabilization, 23-hour crisis stabilization, residential crisis stabilization unit services, therapeutic group homes and psychiatric residential treatment services

- Case management services
- Certified pediatric nurse and family nurse practitioner services
- Clinical psychologist services
- Community-based services for individuals with intellectual disabilities, including day health rehabilitation services and case management
- Dental services for children enrolled in Medicaid and FAMIS, pregnant women enrolled in Medicaid, FAMIS MOMS, and FAMIS Prenatal Coverage, and effective July 1, 2021, all other adults with **full** Medicaid benefits
- *Dialysis services*
- Early Periodic Screening, Diagnostic and Treatment (EPSDT) services
- Emergency hospital services
- Family planning services
- Federally Qualified Health Center clinic services
- Home and community-based care waiver services (see subchapter M1440)
- Home health services: nurse, aide, supplies, treatment, physical therapy, occupational therapy, and speech therapy services
- Hospice services
- Inpatient hospital services
- Intensive Behavioral Dietary Counseling, for individuals in MEDICAID WORKS
- Intermediate care facility services for the intellectually disabled (ICF-ID)
- Laboratory and x-ray services
- Medicare premiums: Hospital Insurance (Part A); Supplemental Medical Insurance (Part B) for the Categorically Needy (CN) and Medically Needy (MN)
- Nurse-midwife services
- Nursing facility care
- Other clinic services: services provided by rehabilitation agencies, ambulatory surgical centers, renal dialysis clinics, and local health departments
- Outpatient hospital services
- Personal assistance services, for individuals in Medicaid Works
- Physical therapy and related services

- Physician services
- Podiatrist services
- *Pregnancy related services*
- Prescribed drugs
- Prosthetic devices
- Rural Health Clinic services
- Skilled nursing facility services for individuals under age 21 years
- Substance abuse services
- Transplant services
- Transportation to receive medical services
- Vision services

Subchapter M1860: Services Received Outside Virginia

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SECTION M1860.100: SERVICES RECEIVED OUTSIDE VIRGINIA

Last Section Revision Date: May 2015

A. General

Medicaid must pay for covered medical services received by any eligible person who is temporarily absent from Virginia if the medical service provider agrees to accept Medicaid payment.

B. Out-of-State Institutional Placements

Virginia Medicaid will cover an enrollee who is placed in an LTC facility in another state only if the placement is preauthorized by the DMAS Long Term Care Section.

A child in IV-E Foster Care who is placed in an institution outside Virginia is eligible for Medicaid through the state in which he resides. A child in non-IV-E Foster Care is eligible for Virginia Medicaid when the child is in an institution outside Virginia, since the child is considered to be a resident of the locality which holds custody.