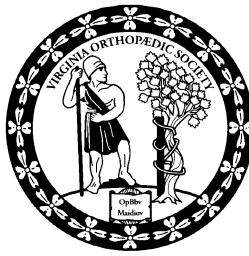




2019 Advocacy Summit Proposal Appendix



Virginia Orthopaedic Society
Founded 1933

Submitted by: Dr. Jeff Schulman, VOS President and Lauren Schmitt

On Behalf of: Virginia Orthopaedic Society

Proposed Issue: Study of Potential Patient-Reported Outcomes Registry for the State Employee Health Plan

Issue Background: Data collection is an integral part of our health care system and can result in better outcomes for our patients. However, our health care system often fails to collect the right kind of information. It sometimes even collects too much unusable information. As a result, we are seeing a push toward Patient-Reported Outcome measures- which are a much more efficient and effective data collection tool because they measure quality based on direct feedback from patients. Through PROs, patients give a more accurate reporting of their symptoms. For example, a patient will complete a simple questionnaire that includes questions relevant to daily functions, such as: “Did your hip replacement enhance mobility?” and “are you in less pain following the knee surgery?” That way, the physician has a clear sense of how the patient is responding. This information is then reported to a clinical data registry that records information about the health status of a population of patients and the health care they receive over varying periods of time.

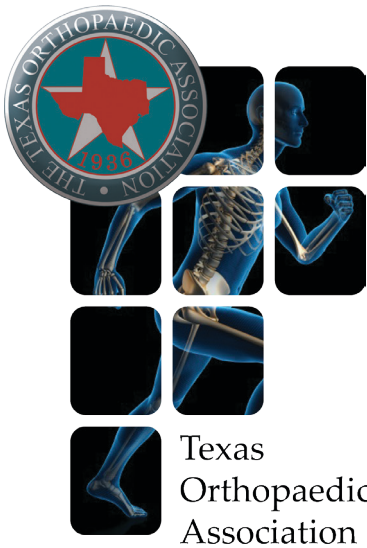
The collection of structured PROs, through registries enables physicians to establish national or regional benchmarks, detect trends and identify best practices from the comparative experiences of others. The American Joint Replacement Registry is an example of a registry that helps patients achieve the best outcomes from surgeries by helping surgeons understand which treatments are most effective.

Another example, the Michigan Arthroplasty Registry Collaborative Quality Initiative (MARQI) has shown the impact of PROs. The initiative led to the reduction of blood transfusions after arthroplasty procedures from an all-joint average of 15 percent to 1.6 percent in about four years. MARQI has shown that collaborative registry work can be used effectively to improve the quality of patient care and set a new benchmark for high-quality care.

VOS believes that Virginia patients could greatly benefit from using a PRO registry. We believe it would be useful to initiate a pilot study on a specific group. We are proposing that the Virginia Department of Human Resource Management study this issue and determine whether PROs can bring value to the Commonwealth’s employee health plan.

In 2017, Texas did something similar and passed a bill requiring two of their state employee health plans to study PROs and determine whether they could improve outcomes for musculoskeletal care. We would like to see Virginia do the same in 2020.

Desired Outcome/Recommendation: That the Medical Society of Virginia will support VOS legislation in 2020 that would direct the Department of Human Resources Management to conduct a study and determine whether a Patient-Reported Outcomes Registry for the state employee health plan would be of value to the Commonwealth.



The Future of Measuring Health Care Quality: *Migrating from Process Measures and Administrative Data to Patient Reported Outcomes*



AAOS

AMERICAN ACADEMY OF
ORTHOPAEDIC SURGEONS

“The AAOS (American Academy of Orthopaedic Surgeons) believes that systems for measuring and reporting quality in health care should continue to evolve and expand. The current generation of quality measures, which primarily rely on process measures and administrative data, have not yet been proven to accurately correlate with improved functional outcomes, which are the primary outcomes of interest to patients who undergo orthopaedic procedures.”

- *The AAOS's 2012 Position Statement on Public Reporting of Provider Performance.*

Commercial and government health insurance payers have introduced a number of initiatives to measure providers' quality and costs. To date, most of the measurements have only focused on the costs of the services provided and hard quality endpoints, such as survival rates or complications.

Patient reported outcome measures (PROMs) represent one of the most promising tools to determine whether a musculoskeletal services will provide value to a patient to relieve their pain and enhance their mobility. An increasing number of orthopaedic surgeons are combining preoperative PROMs with shared decision-making tools to help patients determine if a surgery will provide clinically meaningful change. For a subset of patients seeking a total knee replacement, their pre-operative Knee injury and Osteoarthritis Outcome Score (KOOS) indicates that the surgery may not lead to clinically meaningful change to relieve their pain and lack of function.

In most of the existing PROMs, a patient fills out a simple questionnaire via an electronic tablet in the physician's waiting room or online at home. It is filled out at several different intervals: from when the patient

Texas Leads the Nation

Texas became the first state legislature in the nation to recognize PROMs through legislation when it passed SB 55 in 2017. The bill, which was sponsored by Senator Judith Zaffirini and Representative JD Sheffield, DO, directs the state's employee health plans to analyze PROMs and determine whether they could be utilized to enhance musculoskeletal care delivered to state employees.

first reports to a physician and during subsequent visits. The patient fills out simple questions that measure their pain and function. Ultimately, the data assess surgical outcomes and determine whether various treatments - such as surgery, pain injection, or physical therapy - were effective in treating patient pain and lack of mobility. In addition, the data can be used to determine how various treatments respond to various patient populations, including gender, age, and other factors.

Texas Orthopaedic Association
401 West 15th Street, Suite 820
Austin, Texas 78701

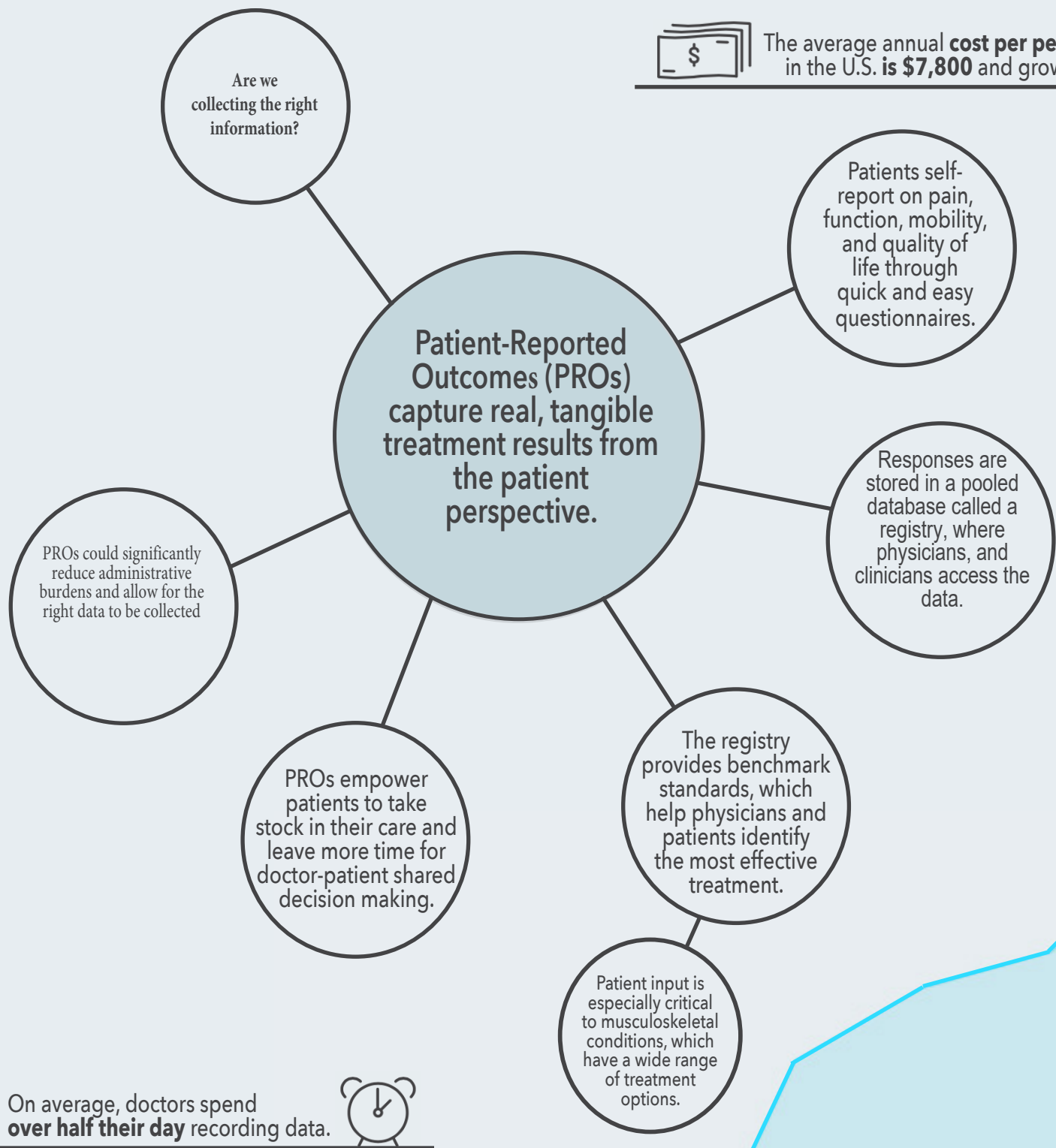
www.toa.org

PATIENT-REPORTED OUTCOME:

How We Can Improve Quality of Care, Alleviate Administrative Burden, and Lower Health Care Costs

Over **126 million** Americans experience musculoskeletal conditions.

The average annual **cost per person** in the U.S. is **\$7,800** and growing.



On average, doctors spend **over half their day** recording data.

Between 1975-2010, the number of physicians in the U.S. grew 150% -- keeping with population growth -- while the number of **administrators grew by 3,200%.**



Resources

- <http://www.annfammed.org/content/15/5/419.long>
- <http://www.boneandjointburden.org>
- <https://www.aaos.org/Govern/Federal/CapHill/Numbers.pdf>
- <https://www.athenahealth.com/insight/expert-forum-rise-and-rise-healthcare-administrator>



VIRGINIA CHAPTER

Submitted by: Dr. Sandy Chung, VA AAP President and Aimee Perron Seibert

On Behalf of: American Academy of Pediatrics– VA Chapter, VA College of Emergency Physicians, VA Academy of Family Physicians, Virginia Psychiatric Society, Virginia Society of Eye Physicians and Surgeons, VA Society of Anesthesiology, VA Orthopaedic Society, Virginia Chapter of the American College of Radiology, Virginia Society of Plastic Surgeons and Virginia College of Obstetrics and Gynecology

Proposed Issue: Annual Inflation Increase for Physician Medicaid Reimbursement

Issue Background: The 2018 legislative session was marked by the historic passage of Medicaid expansion, allowing up to 400,000 Virginians who were uninsured the opportunity to apply for, and receive, Medicaid coverage. MSV and the specialty societies advocated for the expansion, but also urged the legislature to ensure that those new recipients would have access to physicians, most easily achieved by increasing the rates to offset the administrative costs and burdens of participating in the program. That was not included in the final expansion. The last raise for all physicians in the Medicaid program was 2% in July 2008. This past legislative session, MSV advocated for bringing up all physician payments to 75% of Medicare but instead, the legislature passed an increase up to 70% of Medicare, affecting only adult primary care and emergency physicians who were below the 70% mark. (see the chart below)

Physician Rates as Medicare Equivalent (Per DMAS, 2019)

Obstetrics/Gynecology	87.6%
Surgery	85.1%
Psych/Mental Health	84.8%
Radiology	84.5%
Pathology and Laboratory	84.4%
Medicine	84%
Pediatrics	74.9%
Anesthesia	73% * (amended by DMAS and disputed by the VSA)
Emergency Room	69.8%→70% as of July 1, 2019
Adult Preventative and Primary Care	66.8%→70% as of July 1, 2019

Any gains in payments are almost immediately erased as Medicaid payments continue to slide backward due to inflation. In addition, Medicaid managed care companies can pass on their reductions to providers, resulting in deeper cuts to physicians. Many physician practices are small businesses. There is significant overhead to the cost of a medical business, and medical costs have risen at a faster rate than general inflation.

The only recourse a private practice physician has to avoid taking an unsustainable business loss is to either limit or refuse all new Medicaid patients. For example, when pediatricians' offices cannot maintain financial viability by accepting Medicaid enrollees that pay \$36 for an acute visit compared to average business overhead costs of \$48 per visit, pediatricians will have to close their doors to Medicaid enrollees. Emergency physicians and any other specialists who provide EMTALA-related care are at a distinct disadvantage because they are bound by law to treat ALL patients, including Medicaid patients, under the federal EMTALA law.

Every year, the Virginia Hospital and Healthcare Association and the nursing homes request (and usually receive) an inflation rate adjustment that the General Assembly allocates out of the general fund and is part of the Medicaid forecast that happens by November 1 of each year. We would be asking to be treated in the same manner on a yearly basis.

Recommendation: That the Medical Society of Virginia will lead a push for an annual Medicaid inflation increase for all physicians, supported by all the interested physician specialty groups: the Virginia Chapter of the American Academy of Pediatrics, the VA College of Emergency Physicians, the VA Academy of Family Physicians, the Virginia Psychiatric Society, the Virginia Society of Eye Physicians and Surgeons, the VA Society of Anesthesiology, the VA Orthopaedic Society, Virginia Chapter of the American College of Radiology, Virginia Society of Plastic Surgeons, and the Virginia College of Obstetrics and Gynecology to develop a strategic legislative plan to be included in the Governor's 2020 biennial budget.

When visits become ‘on the record’

With recording technology becoming ubiquitous, more patients are recording their encounters with physicians, sometimes without their knowledge.

By Mollie Durkin

Ali Seifi, MD, FACP, hadn't considered the implications of patients or caregivers recording visits until he saw it happening without his permission.

A few years ago, during a meeting with a very ill patient's family members, he noticed that they were recording the conversation with a smartphone. “Honestly, at the beginning, I was feeling a little bit uncomfortable,” said Dr. Seifi, associate professor of neurosurgery and neuro critical care and director of the neuro intensive care unit at the University of Texas Health Science Center at San Antonio. “I wasn't even sure if I could ask them to stop the recording, or is it something that's going to be against me?”

He then reached out to lawyers and colleagues about the legal and ethical rights of doctors, patients, and families and published a viewpoint on the issue in *JAMA* in March 2015. It turned out that, in Texas, it was legal for the family to record a conversation without his consent, even though it was off-putting. “Then, when I looked from a different angle, I found it's actually very helpful for the patient,” Dr. Seifi said.

The issue of recording visits has come up in the past, but cell phones make it easier than ever for patients to hit that red button. “Practically everybody has an audio- and video-recording device in their pocket now,” said Tom Bledsoe, MD, FACP, chair of ACP's Ethics, Professionalism and Human Rights Committee and clinical associate professor of medicine at the Alpert Medical School of Brown University in Providence, R.I.

Because of the ubiquity of recording devices today, physicians should be prepared to respond to patients and families who want to record visits (either in secret or with permission), experts said. They offered advice and outlined the benefits and drawbacks of being on the record.

Legality and prevalence

In 39 states and Washington, D.C., it's perfectly legal for someone to audio record another party without his or her permission, as long as one party consents (and this can be the person who is recording), according to a *JAMA* viewpoint published in August 2017. The 11 states that have statutes requiring consent from all parties are California,

Florida, Illinois, Maryland, Massachusetts, Michigan, Montana, New Hampshire, Oregon, Pennsylvania, and Washington.

It's difficult to pin down exactly how many patients may be taking advantage of their opportunity to record. One survey of about 130 U.K. patients found that 15% had secretly recorded visits, and 11% knew of someone who had done so, according to results published in 2015 by *BMJ Open*.

Even more patients would consider recording: 35% said they would do so secretly, and 34% would ask permission first. “My feeling is that that estimate's probably about right, and probably rising,” said lead author Glyn Elwyn, MD, PhD, MSc, professor at the Dartmouth Institute for Health Policy and Clinical Practice in Lebanon, N.H.

People may want to record for many reasons, such as when there are challenges to language, memory, or recall, or when caregivers want to capture all the details of a patient's complicated regimen, he said. A smaller group of people may be on the litigious side and want to have everything on record in case something goes wrong, Dr. Elwyn added. “But I don't think that's the majority whatsoever,” he said. “I think most people want to have a recording for recall issues.”

Dr. Seifi said that he now gets requests to record every week, mostly from family members of unconscious ICU patients who want to share updates with others near and far. In outpatient practice, however, the phenomenon seems to be uncommon, experts said. For Dr. Bledsoe, it's uncommon to the point of being rare. “It definitely makes doctors nervous. Because it's not common, many doctors will immediately worry about risk management issues, especially if recorded surreptitiously, wondering, ‘Is there a problem in my relationship with this patient?’” he said.

Ana María López, MD, MPH, FACP, ACP's President-elect, said that patients in her oncology practice will occasionally ask to record visits, although it's not standard practice. She routinely agrees without feeling uncomfortable, “simply because it is complex, and people want to share the information with their loved ones.”

Addressing the situation

When it comes to recording visits, clinicians often voice concerns about altering the patient-physician relationship or incurring malpractice lawsuits, whereas patients typically react positively to the idea, said ACP Member Timothy P. Lahey, MD, an associate professor at the Dartmouth Institute for Health Policy and Clinical Practice who has written about the issue. “These disparate reactions to the concept are probably the thing that drives me most strongly to think it's a good idea to establish some ground rules,” he said. “Our patients are requesting it. Doctors are worried. Negotiation seems like the right next step.”

However, if a patient asks to record, experts said that it's OK for a physician to decline. "There should be a shared decision in which the goals and values of both the patient and the physician are taken into account," said Dr. Bledsoe. "A unilateral decision, either by the patient to record surreptitiously or the physician to refuse the request, may have negative consequences."

Dr. Lahey agreed, especially when the situation arises in states where it's illegal to record someone without consent. "It's probably inadvisable for [doctors] to say no, but I think it's their right as a person that's being recorded," he said.

Dr. López recommended that physicians who do not want to be recorded have an honest conversation with the patient to clarify the reasons why and come up with alternative ways to address them. For instance, writing down recommendations can help patients remember them, and bringing in loved ones or calling them on the phone during the visit may be another way to share information, she suggested.

Although Dr. Lahey said he's never declined a patient's request to record (which only happens about once a year in his practice), he gets the sense that his young patient population may be doing so in secret. "They all have their phones out on the desk, so my guess is sometimes those things are on, and that's fine," he said, even though he practices in New Hampshire, where the law requires consent to record.

Since covertly recording visits seems to be an unavoidable issue, clinicians need to prepare by starting an open conversation about managing the situation, said Dr. Lahey. "That would help lessen some of the fear," he said.

A [recent ACP ethics case study](#) modeled that scenario by presenting a hypothetical example of a patient who, after a visit with his doctor, pulls out his phone and presses a red button at the bottom of the screen, prompting his doctor to suspect he was covertly recording. Case study author Jon C. Tilburt, MD, FACP, recommended asking the patient in a face-to-face follow-up visit if he was recording and initiating a frank conversation about it. "Sometimes we infer what the patient's motivations are when we catch something that looks surreptitious, but my general sense is that we're too spooked sometimes when we ought not to be," he said.

Other potential responses to encountering a secret recording include saying nothing but being very guarded or even suspicious of the patient in the future, brushing it off without regret, or firing the patient, Dr. Bledsoe said. If that last option sounds drastic, consider this: Colleagues gasped in horror when he recently presented the scenario to them. "There was really a dramatic, toxic reaction to it," Dr. Bledsoe said.

However, their attitudes shifted when he twisted the case around to reflect a positive, long-term clinical relationship and a patient who asks for permission to record at the beginning of a visit for clear reasons. "Most of them said, 'Well yeah, I've had people do that,'" said Dr. Bledsoe.

In general, patients should ask permission to record, and it would probably behoove doctors to set some ground rules, such as no videotaping during sensitive parts of the physical examination, such as a pelvic exam, Dr. Lahey recommended. But physicians shouldn't worry too much about being recorded without consent, he said. "If you are behaving in a way that makes it so you have nothing to hide, then you might feel a little put off by the fact that you're being secretly recorded," Dr. Lahey said. "But in the end, is it really that big of a deal?"

Clinics may consider establishing office policies that address audio and video recordings. Because of the prevalence of social media, patients may not even realize they should ask before recording, said Dr. López, who is a professor of medicine at the University of Utah School of Medicine in Salt Lake City. "It's like the culture seeping in, so I think being able to ... proactively let people know how the practice is choosing to address this might be helpful in this time period," she said.

Individual practices may find it helpful to involve a patient and family advisory council in discussions about the root problem—that patients or their families have trouble remembering clinical recommendations, for instance—when coming up with a viable solution, Dr. Bledsoe suggested. "One of the possible approaches might be to record the visits or offer to record the visits," he said. The Barrow Neurological Institute in Phoenix, for example, routinely offers patients video recordings of their visits, according to the 2017 *JAMA* viewpoint.

Pros and cons

Experts agreed that one of the biggest benefits of recording visits is improving patients' recall and understanding of their medical conditions.

Back in a 2012 blog post, [internist Eric Bricker, MD, recommended that patients audio record their doctor visits](#). As chief medical officer of Compass Professional Health Services in Dallas, he had noticed that when patients called the health care technology and consulting company for help navigating the health care system, they often didn't know, for instance, which specific scan they needed—or even their doctor's full name. "I think recording doctor visits behooves all parties involved because it helps ensure the patient has an accurate understanding and record of the care being prescribed," Dr. Bricker said.

Furthermore, recordings allow patients to accurately share information with caregivers and family members, no matter how far away they live, Dr. Bledsoe said. Dr. Seifi agreed, adding that "It's like they are sitting in that meeting and they know exactly what I said." He noted that he even encourages his own parents to record their doctors' visits. "Interestingly, before they recorded, they didn't remember anything after the session, but now because they can replay the record, they have better care," Dr. Seifi said.

An on-the-record visit could also lead to better behavior on the doctor's part, Dr. Bledsoe said. "Some doctors are abrupt or brusque or even rude, and if the tape is on, their behavior may actually be improved," he said, adding that if something goes wrong, a recording can serve as documentation of the recommendations given.

As far as the downsides, there is no guarantee that patients will actually go back and listen to their recorded visits and reap the aforementioned benefits, said Dr. Tilburt, professor of medicine and biomedical ethics at Mayo Clinic in Rochester, Minn. However, a scoping review, published in June 2014 by *Patient Education & Counseling*, found that across 33 studies, an average of 72% of patients listened to their recorded clinic visits, and about two-thirds shared them with others.

Another drawback is the potential for questions to arise during playback, added Dr. López. "One of the things I say to folks is that 'We're here together, and I'm able to answer your questions, but when you're going to listen to it again, other questions may come up for you, and I'm not right there to help clarify,'" she said.

In addition, patients might not realize that the recommendations given at the end of the visit are the most meaningful and may neglect to listen through to the end of the recording, Dr. Bledsoe said. "My history-taking methods, my physical exam, and my planning are being built through the course of the visit, and what I say earlier in the visit may not be where I end up," he said. "My assessment and my plans for the patient at the end of the visit is really what I want to share."

Patient privacy is also always a concern, and there is a chance that people with bad intentions could obtain sensitive recordings and share them publicly, noted Dr. Seifi. "So the patient should be careful to keep their own information private," he said. "That's their downside, and that's their responsibility."

Recording visits is only going to become more common as time goes on, and people will more than likely become increasingly relaxed about it in the future, according to Dr. Elwyn. "My advice would be assume somebody is recording you ... [and] always behave as if you're on record," he said.

<https://acpinternist.org/archives/2018/04/when-visits-become-on-the-record.htm>

Patients press the ‘record’ button, making doctors squirm

By **Christie Aschwanden**

May 11, 2015

My dad had a health scare recently, and at a doctor’s appointment to receive some important test results, my mom wanted to record audio of the visit on her smartphone. “If he had gotten some terrible diagnosis, I wanted to be able to share that discussion with you and your sister,” Mom told me later.

But when she asked if it was okay to record, the doctor replied, “No. I don’t want you to do that.”

Mom was shocked, and she felt the relationship instantly change. “The doctor kept looking at my phone the whole time, like she was worried.” My parents felt concerned, too. “To me, it’s a line in the sand — is this doctor willing to work with me or not?” Mom said. “Why should I put my trust in them if they’re not going to trust me?” She wasn’t recording to be litigious but to understand and review what was said.

The question of when or whether patients should record physician visits has become a highly contentious issue in medicine.

“Doctors are very angry about this,” says Glyn Elwyn, a physician and scientist at the Dartmouth Center for Health Care Delivery Science who has written about the issue for the journal [BMJ](#). “Their first reaction — and it’s ill-considered — is to be defensive or worried that it could be used against them in some way.”

Ali Seifi, a neuro-critical care physician at the University of Texas Health Science Center in San Antonio, wrote about secret patient recordings in the Journal of the American Medical Association. After his piece appeared, Seifi heard from doctors who said that they become more risk-averse and less frank when they see that a patient is taping a conversation. “Physicians take it as ‘This patient might file a lawsuit later,’ so they try not to be open to any complaints,” Seifi says.

Recording raises issues of trust for doctors as well as patients, especially if it's [done surreptitiously](#). Seifi's interest in this issue began when he noticed a patient secretly recording their conversation. The message was clear, he says: "The patient doesn't trust me."

Perhaps that's true. On the other hand, Elwyn says, his research has shown that doctors who agree to go on the record with advice can boost their patients' trust and strengthen their relationship. It takes confidence to grant permission, though. Even experienced, competent doctors may worry about subjecting their advice to extra scrutiny.

"Humans are fallible, and it's very difficult for doctors to stay on top of everything," Elwyn says. A doctor who misses the latest evidence or neglects to disclose a particular risk or side effect may be called out later by a dissatisfied patient. When patients record, doctors may feel an added pressure to stay up-to-date and to give extra care and attention to what they're saying. "That's not argument for not doing it — it just means that doctors have to be on their game," Elwyn says.

Despite doctors' hesitation, Elwyn says his experience has found that recording has important benefits for patients. Retaining all the information conveyed during a visit can be difficult — especially if the patient's medical condition is complex — and patients and their families value an audible record, Elwyn says, because it allows them to share and reflect on what has been said.

Given these benefits, it's not surprising that some patients are covertly recording, as Elwyn describes in a study published earlier this month in the journal [PLOS One](#).

My parents are sharp of mind, but sometimes they come away from a visit with different interpretations of what the doctor said, and reviewing the conversation would help them clarify what went on. Sometimes the patient relies on others for day-to-day help, and these caregivers may want to review a doctor visit, too.

Seifi generally grants his patients and their families permission to record, but he says that intent is important. "Are they doing it to help the family or to give them material for a lawsuit?"

Patients in most places have a right to record even without a doctor's consent. Only 12 states — Maryland is among them, but Virginia is not (nor

is the District) — [require permission from all parties for audio recordings](#), including conversations with a doctor.

Doctors worry about a recording that gets shared with a wider audience or goes viral on the Internet. “It’s a legitimate concern: What happens to the recording after the visit?” Elwyn says. “This is virgin territory.”

The Health Insurance Portability and Accountability Act grants privacy protection to patient records, but Seifi says that once a recording is made, it may be hard to ensure that it remains private. Many of his patients are hospitalized with serious brain injuries. If the sibling of a patient in a coma posts a recording of the doctor’s discussion with the family on social media, the patient’s privacy may be violated or the doctor’s comments might be misrepresented.

“What’s lacking here is a policy that says we encourage you to record, but please take good care of this record — we don’t want it to appear on the Internet or social media,” Elwyn says. Such policies may be coming, but for now there are few rules in place.

For my parents, the issue remains a matter of trust. Although they’re planning to return to the do-not-record doctor for another set of test results, they have decided to take their business elsewhere over the long term.

https://www.washingtonpost.com/national/health-science/patients-press-the-record-button-making-doctors-squirm/2015/05/11/7c200306-f33a-11e4-b2f3-af5479e6bbdd_story.html?utm_term=.13e9c6c41337

Advancing Worker Heat Protection in the State of Virginia

- (1) Whereas: Excessive heat exposure poses a direct threat to workers and the economy. Climate change increases this danger, as 18 of the 19 hottest years on record have occurred since 2001. In Virginia, multiple cities including Richmond, Charlottesville, and Roanoke have had progressive increases in number of days above 95 degrees over the past forty years according to National Oceanic and Atmospheric Administration data.
- (2) Whereas: The Fourth National Climate Assessment identifies outdoor workers, who often labor in extreme heat without protections, as a population that “experience(s) increased climate risks due to a combination of exposure and sensitivity”(1).
- (3) Whereas: People working in excessive heat suffer diminished mental acuity and physical ability, which increases the risk of accidents. Heat-related injuries and illnesses increase workers compensation costs and medical expenses.
- (4) Whereas: Heat is the leading weather-related killer in the United States. Bureau of Labor Statistics show that for the year of 2015 The Commonwealth of Virginia reported 100 nonfatal injuries and illnesses and 3 fatalities caused by heat exposure.

From Jan 2017 through Oct 2018 there were 5570 emergency department/urgent care heat related visits in Virginia with the peaks being July 2017 with 971 cases and August 2018 with 689.
- (5) Whereas: Recognizing the vulnerability of service members to extreme heat, multiple branches of the United States Armed Forces – including the Army (2), Navy (3), Marine Corps (3) and Air Force (2) – have issued heat illness/injury prevention standards.
- (6) Whereas: There is currently no national or Virginia occupational heat exposure standard. Several states-California (4), Washington (5), and Minnesota (6) – have issued heat illness/injury prevention standards.
- (7) Whereas: Current Medical Society of Virginia policy supports protecting human health in a changing climate.

RESOLVED, that the Medical Society of Virginia advocates for the Virginia Legislature to pass legislation **and will support related efforts that advance** worker heat protections.

1. <https://nca2018.globalchange.gov/chapter/14/>
2. https://armypubs.army.mil/epubs/DR_pubs/DR_a/pdf/web/tbmed507.pdf
3. Navy Tech Manual 6260_6A 2007 Prev Heat In Js.pdf
4. <https://www.dir.ca.gov/title8/3395.html>
5. <https://www.lni.wa.gov/Safety/Topics/AtoZ/HeatStress/rules.asp>
6. <https://www.dli.mn.gov/business/workplace-safety-and-health/mnosha-compliance-heat-stress>

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CHAPTER IV
COVERED SERVICES AND LIMITATIONS

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INTRODUCTION

The Virginia Medicaid Program is dependent upon the participation and cooperation of Virginia physicians who provide health care.

The physician is responsible for certifying that the service is medically necessary and that the treatment prescribed is in accordance with community standards of medical practice.

MEDALLION 3.0

As described in Chapter I of this Manual, many Medicaid members receive primary and acute care through Medicaid contracted managed care organizations (MCO), also known as the Medallion 3.0 Program. MCOs may have different service authorization criteria and reimbursement guidelines; however the MCO benefit limitations may not be less than fee-for-service benefit limitations. Providers must participate with the enrollee's MCO (or negotiate as an MCO out-of-network provider) in order to be reimbursed for MCO contracted services. Providers must contact the member's MCO directly for information regarding contractual, coverage, and reimbursement for services provided through the MCO. Reference Chapter I of this Manual for details regarding certain individuals who are excluded from participation in Medallion 3.0. Additionally, Chapter I provides information regarding services that are carved out of the MCO Contract. MCO contact information is available on the DMAS website at: <http://www.dmas.virginia.gov/mc-home.htm>.

COPIES OF MANUALS

DMAS publishes electronic and printable copies of its Provider Manuals and Medicaid Memoranda on the DMAS Web Portal at <https://www.virginiamedicaid.dmas.virginia.gov/wps/portal>. This link opens up a page that contains all of the various communications to providers, including Provider Manuals and Medicaid Memoranda. The Internet is the most efficient means to receive and review current provider information. If you do not have access to the Internet or would like a paper copy of a manual, you can order it by contacting Commonwealth-Martin at 1-804-780-0076. A fee will be charged for the printing and mailing of the manuals and manual updates that are requested.

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SERVICE AUTHORIZATION

Effective April 1, 2012, certain services currently reviewed by DMAS' Medical Support Unit (MSU) will be reviewed by Keystone Peer Review Organization (KePRO), DMAS' service authorization contractor. Refer to Physician/Practitioner Manual, Appendix D for details regarding service authorization instructions, timely submittal, retroactive reviews, criteria, procedure codes and other pertinent information.

PHYSICIAN'S ROLE IN RENDERING SERVICES

Physician services are those services provided within the scope of professional license. These services must be rendered by or under the supervision of an individual licensed under State law and, including care delivered by physician assistants, are to be billed by the physician who renders the service. In those instances where coverage is provided by a physician other than the patient's regular physician, the actual provider of services must be a participating Medicaid provider in order to bill for services performed even though he or she may not be the patient's regular physician (e.g., "covering physicians" must bill for the services they personally render). Additionally, physicians are required to maintain records detailing the nature and scope of the health care provided to Medicaid members. Entries in patient records must be signed by the physician rendering the service (name and title) and dated (month, day, year) on the date of service delivery. Dates may not be typed onto medical records in advance of the signature. Care rendered under the supervision of the participating provider must be countersigned by that provider.

Out-of-State Physicians

Effective April 1, 2012, out of state providers (non-participating, enrolled) are held to the same service authorization processing rules as in state (participating, enrolled) providers and must be enrolled with Virginia Medicaid prior to submitting a request for out of state services to DMAS Service Authorization contractor, KePRO. If the provider is not enrolled with Virginia Medicaid, the provider is encouraged to submit the request to KePRO, as timeliness of the request will be considered in the review process starting July 1, 2012. KePRO will pend the request back to the provider for 12 business days to allow the provider to become successfully enrolled. Providers will not be penalized if DMAS does not process the enrollment request within 12 business days.

If KePRO receives confirmation of the provider's enrollment with Virginia Medicaid within 12 business days, the request will then continue through the review process and a final determination will be made on the service request. If the request was pended for no provider enrollment and KePRO does not receive confirmation of the provider's enrollment within the 12 business days, KePRO will reject the request back to the provider, as the service authorization cannot be entered into MMIS without the providers National Provider Identification (NPI). Once the provider is successfully enrolled, the provider must resubmit the entire request. Timeliness from the prior submission will not be considered with the re-submission.

Any provider not enrolled with Virginia Medicaid may do so by going to <https://www.viriniamedicaid.dmas.virginia.gov/wps/myportal/ProviderEnrollment>. At the toolbar at

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the top of the page, click on “*Provider Services*” and then “*Provider Enrollment*” in the drop down box. It may take up to 10 business days to become a Virginia participating provider.

(Note: If specific physician services required by the member are available in Virginia within a reasonable distance from the member's home, the member should not be referred to an out-of-state physician.)

Physician's Role in the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program

The EPSDT program provides preventive health care to individuals (from birth up to age 21) eligible for medical assistance. The purpose of the EPSDT program is prevention of health problems through early detection, diagnosis, and treatment. The goal of the EPSDT program is to promote a medical home so members can receive both sick and well-child care from the same provider. EPSDT screenings are Medicaid's well child visits and should occur according to the DMAS periodicity schedule included as Appendix 1 under “Exhibits” of the EPSDT Supplement.

Any physician enrolled as a provider in the Medicaid Program to provide physician or clinic services can provide EPSDT screening services. See Supplement B to this manual for details on EPSDT coverage and billing.

The EPSDT screening is a comprehensive health screening/well-child examination. The comprehensive health screening/well child visit content should be in line with the most current recommendations of the “**American Academy of Pediatrics (AAP), Guidelines for Health Supervision**”. Another resource for preventive health guidelines is the AAP compatible “**Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents**”. **All components of EPSDT screenings, including specimen collection, must be provided during the same screening visit.**

EPSDT Screening Services

Required EPSDT screening components include:

- A comprehensive health and developmental history (including assessment of both physical and mental health development);
- A comprehensive unclothed physical exam;
- Vision screening by a standardized testing method according to the DMAS periodicity schedule;
- Hearing screening by a standardized testing method according to the DMAS periodicity schedule;
- Developmental screening with a standard screening tool according to the American Academy of Pediatrics guidelines;
- Age appropriate immunizations as needed according to the Advisory Committee on Immunization Practices (ACIP) guidelines;

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- Laboratory tests (including lead blood testing at 12 and 24 months or for a new patient with unknown history up to 72 months or as appropriate for age and risk factors);
- Health Education/Anticipatory Guidance/problem-focused guidance and counseling.

The chart below indicates when a child should receive an EPSDT screening:

INFANCY	EARLY CHILDHOOD	LATE CHILDHOOD	ADOLESCENCE
1 month	15 months	5 years	12 years
2 months	18 months	6 years	14 years
4 months	2 years	8 years	16 years
6 months	3 years	10 years	18 years
9 months	4 years		20 years
12 months			

Billing for Hearing, Vision, and Developmental Screenings During the EPSDT Well Child or Problem Focused Visit

Objective hearing screening (CPT code 92551), vision screening (CPT code 99173), and developmental assessment (CPT code 96110) procedures performed using a standardized screening method on the same date of service as a Preventive Medicine E&M will be reimbursed separately when Modifier 25 is used along with the appropriate E&M code for that visit.

Other Necessary Health Care, Diagnostic Services and Treatment Services – Specialized Services

As with all Medicaid services, any limitation that the state imposes on EPSDT services must be reasonable and the benefit provided must be sufficient to achieve its purpose. In addition, the state must provide other necessary health care, diagnostic services, treatment and other measures listed in the Federal Medicaid statute, to correct and ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not they are covered in the state Medicaid plan. The non-state plan services are called Specialized Services. Please refer to the EPSDT Supplement and other EPSDT manuals to find more information about the EPSDT Specialized Services.

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Physician's Role in Home Health Services

Home health services provide periodic nursing care and therapy under the direction of a physician. Such services are provided by participating home health agencies and can be used effectively by the physician for post-hospital care and periodic nursing care. The Medicaid Program will reimburse home health agencies for necessary services prescribed by the physician. The practitioner performing the face-to-face encounter must document the clinical findings in the individual's medical record and communicate the clinical findings of the encounter to the ordering physician. For the home health services that exceed five (5) visits and require service authorization, home health providers will be asked, during the service authorization process, to "attest" that the face-to-face encounter requirement was met.

The face-to-face encounter may occur through telehealth, which is defined as the real-time or near real-time two-way transfer of medical data and information using an interactive audio/video connection for the purposes of medical diagnosis and treatment (DMAS Medicaid Memo dated May 20, 2014). Telehealth shall not include by telephone or email. See the Home Health Manual for additional information.

PHYSICIAN'S ROLE IN THE PRESCRIPTION DRUG PROGRAM

Prescription drugs are covered under the Virginia Medicaid Program. The physician's normal procedure for prescribing drugs should be followed. However, the prescriber's National Provider Identifier (NPI) number must be included on all prescriptions for Medicaid members including those serviced by Health Maintenance Organizations (HMOs).

The prescribing of drugs should be in accordance with community standards of medical and pharmacy practices and consistent with economy. Virginia Medicaid requires the use of generic drugs where possible. Physicians may specify a brand name only when it is medically necessary. In acute illnesses, prescribed drugs should be limited to the quantity needed for the course of treatment for the illness. Maintenance drugs for chronic illnesses should be prescribed in quantities according to treatment needs.

Coverage and Limitations

Prescription services are provided to Medicaid members. Please see the Pharmacy Manual under Chapter IV. Providers are too referred to the Preferred Drug List (PDL) for verification of covered drugs, and Physician requirements.

PROGRAM COVERAGE

Introduction

The Medicaid Program is designed to assist eligible Medicaid members in obtaining medical care within the guidelines specified in this manual and the State Plan. Allowable Medicaid reimbursement is based upon medical necessity. Medicaid defines "medically necessary services" as those services

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that are covered under the State Plan and are reasonable and necessary for the diagnosis or treatment of an illness or injury, or to improve the functioning of a malformed body member. Coverage may be denied if the requested service is not medically necessary according to the preceding criteria or is generally regarded by the medical profession as experimental or unacceptable.

Scope

"Physician Services" are defined as services provided within the scope of a physician's professional license as defined by Virginia law. These services must be rendered by or under the supervision of an individual licensed under State law to practice as a doctor of medicine (M.D.), or doctor of osteopathy (D.O.), and are to be billed by the physician rendering the service.

In billing for covered services, the Department of Medical Assistance Services requires the use of codes and definitions published in the Physicians' Current Procedural Terminology, Fourth Edition (CPT), which has been incorporated into the federal Health Care Financing Administration Common Procedure Coding System, or HCPCS (for clarity, this combined coding system is identified as "CPT/HCPCS"). The physician is to select from the CPT/HCPCS book the procedure code which most appropriately describes the service rendered and documented. Definitions and descriptions of levels of service contained in the introduction to the CPT/HCPCS are to be used when determining the level of service to be billed. These same definitions and descriptions will be used to evaluate documentation during Program audits of medical records. (See also the section on documentation). Copies of the Physicians' Current Procedural Terminology, Fourth Edition (CPT) may be obtained from:

Order Department: OP054192
American Medical Association
P.O. Box 10950
Chicago, Illinois 60610

Payments for physician services are made only when medically necessary for the diagnosis and treatment of an illness, injury, restoration of a body function, family planning, or maternity care. Patient records must document fully the extent of all services which are rendered and billed to the Program. These records must be made available for inspection by an authorized Program representative and/or federal personnel when requested. Failure to do so may result in termination of the provider participation agreement.

Benefit and Coverage Limitations

The following services are covered under the Virginia Medicaid Program only when provided in accordance with the limitations and requirements specified.

Anesthesia

A qualified provider may submit charges for anesthesia administration only under the following conditions:

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- The cost of the anesthesia services is not included as an expense item in the hospital reimbursable cost report and the hospital makes no charge for the service; and,
- The anesthesia is personally administered by a physician who remains in constant attendance during the surgery; or,
- The anesthesia is administered by a Certified Registered Nurse Anesthetist in accordance with the supervision and practice requirements as established by the Board of Nursing.
- In a hospital setting, the services are provided in accordance with the Department of Health's hospital licensure requirements.

Anesthesiology' services are paid for by units of time - one unit for each 15 minutes or fraction thereof for the surgical procedure performed. When billing for anesthesiology, use the CPT/HCPCS anesthesia code for the procedure performed and insert the time units in Locator 24G of the CMS-1500 (08-05) (08-05) claim form. The base unit (preoperative consultation with the patient) is included in the reimbursement and should not be included in the units of time for the procedure. Example: An anesthesiological procedure required one hour and 45 minutes. Locator 24G would properly show seven (7) units. (NOTE: regarding the administration of epidural blocks, only those units of time during which the anesthesiology provider directly attended the patient will be paid.)

Chemotherapy

The combination of several procedure codes is required in order to bill for the administration of chemotherapy treatments:

- The appropriate CPT/HCPCS chemotherapy administration procedure codes, 96401-96549
- The appropriate HCPCS codes for chemotherapy drugs, J9000-J9999
- The appropriate office visit (if applicable), procedure codes 99201-99215 (See the CPT/HCPCS book for additional listing.)

The chemotherapy injection or infusion procedure codes are independent of the office visit. These codes describe chemotherapy administration by a qualified assistant under the supervision of a physician or by the physician and include the necessary administration supplies and mixing agent. The chemotherapy drug procedure codes describe the drug administered and do not include the chemotherapy administration or the office visit, if applicable.

Physicians administering chemotherapy in their offices may bill for the appropriate chemotherapy administration (procedure codes 96401-96549), the appropriate procedure code for chemotherapy drugs (J9000-J9999), and the appropriate office visit (procedure codes 99201-99215), if applicable.

Concurrent Care

Payment for concurrent care will only be considered when more than one physician is actively engaged in the patient's treatment. Each physician must sufficiently explain the condition or conditions for

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which treatment was rendered through the use of an attachment to the Health Insurance Claim Form, the CMS-1500 (08-05) (08-05) billing invoice

Consultations

A service rendered by a physician whose opinion or advice is requested by another physician for the further evaluation or treatment or both of the patient is considered a consultation. If such a service is provided and Medicaid is billed for this type of service more than once within a six-month period, justification must be furnished as an attachment to the CMS-1500 (08-05) (08-05) claim form, and individual consideration requested. Enter "ATTACHMENT" in Locator 10D and enter procedure modifier "22" ("Unusual Service") in Locator 24D of the CMS-1500 (08-05) claim form. Consultation services should be billed using the appropriate CPT/HCPCS code. If the consulting physician assumes the care of the patient, any subsequent services rendered will cease to be a consultation and should be billed according to the appropriate CPT/HCPCS treatment/visit codes.

Referrals

A referral is the transfer of the total or specific care of a patient from one physician to another and does not constitute a consultation. Initial evaluation and subsequent services for a referral patient are to be billed according to CPT/HCPCS treatment/visit codes.

Dental Services

Any eligible member under 21 years of age can receive medically necessary dental care, such as preventive care, fillings, extractions, crowns, and prosthetics from participating dentists. The member can be referred directly by the physician to any dental provider participating in the Doral Dental USA Program.

Smiles For Children, for Medicaid, FAMIS, and FAMIS Plus children covers all children under age 21 and over will receive the same limited oral surgery benefits that are currently provided under the Medicaid program. The ***Smiles For Children***, office Reference Manual outlines procedures that dental providers should follow for services rendered. This manual and other important information can be accessed on Doral's website at www.doralusa.com.

End-Stage Renal Disease

Medicaid has secondary coverage to Medicare for end-stage renal disease (ESRD) treatment. Kidney transplantation when preauthorized by Medicaid and supervision of chronic hemodialysis are covered by Medicaid only when the patient is not eligible for Medicare benefits. (Medicaid will withhold payment until a determination is made concerning the patient's Medicare eligibility.)

Professional staff in the Medicare-certified ESRD facility will have responsibility for management of the treatment program and will determine the appropriate type of services needed at any time, e.g., patient hospitalization.

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Dialysis centers enrolled in the Virginia Medicaid Program are responsible for submitting charges for outpatient and home dialysis services. The provider must advise the Program as to whether or not the facility charges include the physician component.

Eye Care

Ophthalmologists and other physicians skilled in treatment of diseases of the eye and its appendages may provide eye care and treatment. Eyeglasses for members under age 21 are covered by Virginia Medicaid; however, no more than one pair will be allowed by Virginia Medicaid within a 24-month period without a statement of medical need submitted as an attachment to the CMS-1500 (08-05) form, and the word “attachment” written in block 10d. The refraction that is not covered by Medicare may be billed to Medicaid. To bill Medicaid for the refraction, use CPT/HCPCS procedure code 92015 (determination of refractive state) on the CMS-1500 (08-05) form. Locator 11D will need to be indicated as a ‘Yes’.

Contact lenses are not covered by Virginia Medicaid except as may be service authorized by DMAS’ Service Authorization contractor. Authorization will be based on medical necessity and that eyeglasses cannot accomplish the optometric treatment.

Family Planning Services (Plan First)

Plan First is the Medicaid fee-for-service family planning services program. The purpose of this program is to improve birth outcomes and reduce unintended pregnancies. Men and women who meet the income level and meet citizenship and identity requirements may be eligible for Plan First. Individuals, who are eligible for full Medicaid benefits coverage, are not eligible to participate in the program. Refer to the Plan First provider manual available at <http://dmasva.dmas.virginia.gov> for specific information about the Plan First program.

Services to Promote Fertility

The Virginia Medicaid Program does not cover services to promote fertility. Medicaid will not pay for the medical procedure if its only goal is to make someone able to get pregnant or to get someone pregnant. If there is a disease of the reproductive system that requires treatment to maintain overall health, it will be covered. Providers must submit sufficient documentation to substantiate the medical necessity of the procedure. To receive special consideration, providers must request individual consideration on the CMS-1500 (08-05) by attaching documentation to the claim form.

The following procedures are not covered by Virginia Medicaid for the purpose of promoting fertility:

- 54900 Epididymovasostomy, anastomosis of epididymis to vas deferens, unilateral
- 54901 Bilateral
- 55400 Vasovasostomy, vasovasorrhaphy
- 58321 Artificial insemination; intra-cervical
- 58322 Artificial insemination; intra-uterine
- 58323 Sperm washing for artificial insemination

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- 58345 Transcervical introduction of fallopian tube catheter for diagnosis and/or re-establishing patency (any method) with or without hysterosalpingography
- 58672 Laparoscopy, surgical with fimbrioplasty
- 58750 Tubotubal anastomosis
- 58752 Tubouterine implantation
- 58760 Fimbrioplasty
- 58770 Salpingostomy (salpingoneostomy)
- 58970 Follicle puncture for oocyte retrieval, any method
- 58974 Embryo transfer, intra-uterine
- 58976 Gamete, zygote or embryo intra-fallopian transfer, any method
- 89322 Semen analysis; volume, count, motility, and differential using strict morphologic criteria
- 89331 Sperm evaluation, for retrograde ejaculation, urine

Free Services

Services provided at no charge to the general public cannot be billed to Medicaid.

Hospital Visits

Payment to physicians for inpatient hospital services is limited to the number of days covered by Medicaid for the medically necessary hospital stay.

Payment to physicians for inpatient hospital visits conducted in acute general hospitals will not be limited by DMAS. DMAS will be reimbursing hospitals based on AP-DRG's payment methodology for the total hospitalization rather than a daily per-diem rate. Physician services provided for psychiatric care, either to members hospitalized in a free-standing psychiatric hospital or as part of a psychiatric unit of a general acute care hospital, the limitation of their services is related to the number of covered days authorized by Medicaid or the DMAS Service Authorization contractor. Psychiatric services remain limited to 21 days for members age 21 or older. The limitation of 21 days within a 60-day period still remains in effect for members 21 years of age with same or similar diagnosis. This restriction applies whether the 21 days is within one or more hospitals within the 60-day period.

Radical or Modified Radical Mastectomy

Coverage for a radical or modified radical mastectomy for treatment of disease or trauma of the breast shall be provided for a minimum of 48 hours. Coverage for a total or partial mastectomy with a lymph node dissection for treatment of disease or trauma of the breast shall be provided for a minimum of 24 hours. Additional days beyond the specified minimums for radical, modified, total, or partial mastectomies may be covered if medically justified and authorized. Nothing in this manual shall be construed as requiring the provision of inpatient coverage where the attending physician in consultation with the patient determines that a shorter period of hospital stay is appropriate.

Unauthorized inpatient services will not be covered or reimbursed by Medicaid.

Regardless of service authorization, if the invoice reflects organ transplant, a sterilization, hysterectomy, or abortion procedure, the claim will pend for Medicaid manual review. If the required Medicaid form is not attached, the claim will be reduced or denied according to Medicaid policy.

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Maternity Care

Antepartum care, delivery, and postpartum care should be billed as an all-inclusive, single unit ("global billing"), except when the antepartum care and the delivery are provided by different physicians or the member is enrolled as a non-resident alien (NRA). Antepartum care is not covered for these NRA clients. Additionally, if the member changes benefit plans [i.e., fee-for-service or DMAS contracted managed care organization (MCO)] during antepartum care, i.e., prior to delivery, the provider should bill services according to the most appropriate CPT code definition according to the member's benefit plan of coverage.

As defined by CPT, Antepartum care includes the initial and subsequent history, physical examinations, recording of weight, blood pressures, fetal heart tones, routine chemical urinalysis, and monthly visits up to 28 weeks gestation, biweekly visits to 36 weeks gestation, and weekly visits until delivery. Per CPT guidelines, Delivery services include admission to the hospital, the admission H&P, management of uncomplicated labor, vaginal delivery (with or without episiotomy, with or without forceps), or cesarean delivery. Per CPT guidelines, postpartum care includes hospital and office visits following delivery.

If a physician provides all or part of the antepartum care, and/or postpartum care but does not perform the delivery, that physician would bill the antepartum and postpartum codes according to CPT guidelines.

Charges for total maternity care are to be submitted only after the final postpartum visit. The Program recognizes that this will result in billing after the suggested 30-day timely-filing period identified in Chapter V of this manual. When billing for total maternity care, the date of delivery is to be used as the billing date (both "from" and "through" dates), using a one (1) in Locator 24G, "Days or Units," of the CMS-1500 (08-05) claim form. In the event the member has changed benefit plans [i.e., fee-for-service or DMAS contracted managed care organization (MCO)] prior to the final postpartum visit, and the physician who did the delivery and provided the inpatient postpartum care is also providing the office postpartum visit, the coverage at the time of delivery will determine which plan (fee-for-service or MCO) is to be billed the global delivery/postpartum charge.

Long Acting Reversible Contraceptives (LARC)

Effective for dates of service on or after January 1, 2017, DMAS will reimburse for LARCs provided after delivery in inpatient hospitals. Prior Authorization is not required. Providers billing for the insertion of the device must bill on the CMS 1500 claim form using either 11981 (implant insertion or 58300 (IUD insertion) depending on the device used. The provider must use place of service Inpatient Hospital (21). Providers will also be allowed to bill for and receive separate reimbursement for the applicable CPT code for the delivery.

Inpatient Hospital and Early Discharge Follow-Up Visit Policy

The 1996 General Assembly passed two bills that discuss allowable insurance provisions for the length of inpatient hospital stays for maternity cases (House Bill 87 and Senate Bill 148). These bills require the Medicaid program to provide for inpatient lengths of stay in accordance with the Guidelines for

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Perinatal Care as developed by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists. The language also requires payment for follow-up as recommended by the attending physician in accordance with the guidelines.

Medicaid covers maternity inpatient hospital charges as follows. Medicaid covers the day of delivery plus an additional two days for a normal, uncomplicated vaginal delivery without requiring documentation of medical necessity. Medicaid covers the day of delivery plus an additional four days without requiring documentation of medical necessity for cesarean births. Claims for any additional days must be medically justified.

If the mother and newborn are discharged earlier than 48 hours after the day of delivery, Medicaid will cover an early discharge follow-up visit as recommended by the physician, in accordance with the guidelines. The mother and newborn must both meet the criteria for early discharge to be eligible for the early discharge follow-up visit. This early discharge visit does not affect or apply to any usual postpartum or sick/well baby care; it applies only to an early discharge. The criteria for an early discharge are in the most current edition of the Guidelines for Perinatal Care.

Psychiatric Services Under EPSDT

Medicaid provides an all-inclusive rate to freestanding inpatient psychiatric hospitals for all services rendered to Medicaid children (up to age 21) under EPSDT. The professional component for the psychiatric care may be billed separately by the professional who is enrolled in Medicaid. Medicaid provides a per diem rate for inpatient residential programs. The professional component for the psychiatric care and pharmacy and laboratory services are billed separately by the enrolled provider. Please refer to the Psychiatric Services Manual for additional criteria and documentation requirements.

Psychiatric Services

For information regarding inpatient psychiatric services (including inpatient psychiatric services and freestanding inpatient psychiatric services) and outpatient psychiatric services, refer to the Psychiatric Services Manual.

Payment for psychiatric services is available within Program limitations as set forth within the Psychiatric Services Manual.

Services of Interns and Residents-In-Training

The medical services provided by an intern or resident-in-training under an “approved teaching program” of a hospital are covered. An “approved teaching program” means a program approved by the Council on Medical Education of the American Medical Association.

The services performed by interns and residents are reimbursable to the facility on a reasonable cost basis even though the intern or resident is a licensed physician. These services are not reimbursable on a fee-for-service basis as physicians’ services.

House Calls

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Payment for house calls is limited to patients who are bedridden and for whom a trip to a physician's office would be detrimental to both safety and health. CPT/HCPCS code 99056 is to be used for billing mileage

Injections

Reimbursement for the administration of a therapeutic injection is included in the office visit when a medical service is rendered. When a therapeutic injection is the only service performed, an appropriate minimal office visit (e.g., CPT/HCPCS code 99211) may be listed in addition to the injection.

To bill for the administered drug either:

- Use the appropriate HCPCS "J" code in Locator 24D and the usual and customary charge for the injectable in Locator 24F of the CMS-1500 (08-05) (08-05) claim form; or
- Use the appropriate CPT/HCPCS code for a therapeutic injection (90772-90779) with an attachment to the CMS-1500 (08-05) (08-05) listing the substance, quantity, and actual invoice for the cost of the drug.

Laboratory and Radiology Procedures

Payment for laboratory and radiology services will be made directly to the provider actually performing the service (i.e., physician, independent laboratory, or other participating facility). The ordering physician may bill for the handling of specimens sent to the laboratory when billed as a single unit using CPT/HCPCS procedure code 99000. Only one specimen-handling fee is allowed per office visit.

Laboratory procedures performed by outside sources at no charge to the practitioner are not to be billed to Medicaid, and only a handling fee will be paid.

Providers MUST put the Clinical Laboratory Improvement Amendment (CLIA) number of the physician office laboratory (POL) performing the service in Block 19 (Reserved for Local Use) of the CMS -1500 (08-05) claim form, as mandated by the Health Care Financing Administration.

Should the situation arise when multiple physician office laboratories are used for services for the same member, file a separate claim form listing the services that each laboratory performed and their applicable CLIA certificate number.

For example, if Physician Office Laboratory A performs CPT code 88150, and Physician Office Laboratory B performs CPT code 81000, and medical services are also performed on the same member, submit a separate claim for CPT 88150 since the CLIA number will be different than for the physician office laboratory performing CPT 81000. The medical services can be billed on either claim since the CLIA number is not applicable for medical services.

A claim will be denied if one or all of the following conditions exist:

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- There is no CLIA number on the claim, and the billing is for a laboratory service.
- The CLIA number that is on the claim is invalid.
- The CLIA number is valid, but the provider is billing Medicaid for a service that is outside of the scope of the laboratory's CLIA certificate (e.g., the lab holds a Certificate of Waiver, and the provider is billing for a Physician Performed Microscopy Procedure).
- The services that are being billed were rendered outside of the effective dates of the CLIA certificate.

Providers who currently submit claims electronically should contact their service centers to have their software updated. The CLIA number must be put in the FA0 Record, Claim Service Line Record, in field number 34.0 (CLIA ID NO).

- Medicaid requires that the services, as defined in the CPT Manual, be billed using the appropriate panel code and not the code for the individual components.

For codes 80046-80076, if all of the components are completed, the provider must bill using the panel code that best defines the panel.

- Whenever four or more components of a hemogram are performed, the appropriate hemogram CPT/HCPCS code must be used (85025-85027). The appropriate CPT/HCPCS codes are to be used when specimens are tested using automated or manual equipment.
- If fewer than four components of a hemogram are performed, bill for them using the appropriate individual CPT/HCPCS codes.

Telemedicine Services

Telemedicine is the real-time or near real time two-way transfer of medical data and information using an interactive audio/video connection for the purposes of medical diagnosis and treatment. The Medicaid member is located with a provider at the "originating" site, while the "remote" provider renders services via the audio/video connection.

All providers utilizing telemedicine and billing for services must be enrolled with DMAS. All coverage requirements described in the DMAS provider manuals apply when the service is delivered via telemedicine. The use of telemedicine must be noted in the service documentation of the patient record.

Equipment utilized for telemedicine must be of sufficient audio quality and visual clarity as to be functionally equivalent to a face-to-face encounter for professional medical services. Staff must be proficient in the operation and use of the telemedicine equipment. Telephone calls, e-mail, facsimile transmissions and similar electronic measure are not considered part of the telemedicine coverage and are not to be billed to DMAS.

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Telemedicine encounters must be conducted in a confidential manner, and any information sharing must be consistent with applicable federal and state laws and regulations and DMAS policy. Health Information Portability and Accountability Act of 1996 (HIPAA) confidentiality requirements are applicable to telemedicine encounters.

A description of services that may be delivered via telemedicine is included in Chapter V. The services include: evaluation and management, psychiatric care, specialty medical procedures, speech therapy, and radiology services and procedures. The remote provider groups recognized by DMAS for these services are also listed.

Chapter V also includes the provider groups recognized by DMAS whose offices or other locations serve as the originating site for the telemedicine encounter. The originating site provider, who is enrolled with DMAS and affiliated with the office or other location where the Medicaid member is located for the telemedicine encounter, is to bill the procedure code Q3014 (telemedicine facility fee) with the GT or GQ modifier entered on the claim. The originating site provider or designee must attend the encounter with the member, unless the encounter documentation in the patient record notes the reason staff was not present. Reasons may include instances where the member is reporting injuries due to physical abuse or psychiatric care where the member may feel uncomfortable with an additional person involved in the telemedicine encounter.

Physicians located outside of Virginia but within the continental United States must enroll with DMAS contractors Conduent or Magellan, depending on the services the physicians intend to bill, to utilize telemedicine in the delivery of services to Medicaid and FAMIS enrollees. More information about enrollment is in Chapter II.

A description of DMAS telemedicine coverage was issued in a “Medicaid Memo” in 2014 and available at:

<https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/MedicaidMemostoProviders>.

Non-Covered Services

The following laboratory and radiology services are specifically EXCLUDED from coverage and payment:

- Tests performed on a routine basis but not medically indicated by the patient's symptoms.
- Laboratory test professional component (CPT/HCPCS procedure modifier "26") for procedures performed in the physician's office, outpatient hospital, or in the independent laboratory. Payment for supervision and interpretation is included in the full procedure payment.

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- Sensitivity studies when a culture shows no growth or urine cultures with contaminant growth (10^3 or less). Payment will only be made for the culture.
- Radiology procedure professional component (CPT/HCPCS procedure modifier “26”) is used only when billing for interpretation and reporting of x-ray. The technical component (HCPCS/CPT procedure modifier “TC”) is used when billing for the use of the radiology equipment.

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COVERED SERVICES FOR MEDICAID EXPANSION

Individuals covered by Medicaid Expansion may receive the following additional covered services:

- Annual adult wellness exams
- Individual and group smoking cessation counseling. These services are covered for pregnant women and other members when billed with the ICD-10 diagnosis code F17.200 (Nicotine dependence, unspecified, uncomplicated) or Z87.891 (history of tobacco use).
- Nutritional counseling for individuals with obesity or chronic medical diseases. These services are covered for pregnant women, members with Diabetes Type 1 or Type 2, and members with a disorder of lipoprotein metabolism and other lipodemias.
- Advisory Committee on Immunizations Practices recommended adult vaccines (members \geq 21 years of age):
 - Coverage of the Shingles vaccine for members 50-65 years of age
 - Coverage of the HPV vaccine for members \leq 26 years of age
 - Coverage of the Hemophilus influenza type B vaccine available for members with asplenia (either congenital or acquired), sickle cell disorders and stem cell transplants
 - Coverage of the Meningococcal vaccine available for members with asplenia (either congenital or acquired), HIV infection, Persistent complement component deficiency (predisposes to lupus) and Eculizumab use
 - Coverage of the Hepatitis A or Hepatitis B vaccine is available for members on Dialysis, with chronic liver disease, acute kidney failure or chronic kidney disease

Procedures Covered for a Pathologist or Laboratory Outside the Physician's Office

Payment for the following tests will be made only to a pathologist, a hospital laboratory, or a participating laboratory. Specimens for the tests listed below may also be sent to the State Laboratory:

86171	Complement fixation tests, each antigen
87116	Culture, tubercle, or other acid-fast bacilli (e.g., TB, AFB, mycobacteria); any source, isolation only
87118	Culture, mycobacteria; definitive identification of each organism
87250	Virus identification; inoculation of embryonated eggs or small animal, includes observation and dissection

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Pap Smears

Screening Pap smears shall be covered annually for females consistent with the guidelines published by the American Cancer Society. Medicaid guidelines do not allow preventive care visits for anyone age 21 or over. The use of any preventive evaluation and management (E&M) CPT code for this age group will be denied as a non-covered service.

Therefore, if you want to submit a claim for a visit and the reason for the visit was to receive a yearly pap smear you may use the following guidelines for billing Medicaid.

- Use the E&M code that will reflect the level of care given during the visit plus the administration of the pap smear.
- Documentation to support the level of care provided must appear in the patient's medical records.
- Use either a preventive ICD diagnosis code or a diagnosis code for any presenting problem found in the process of examination.
- Additional guidelines may be found in the current CPT manual "Evaluation and Management (E/M) Services Guidelines.

Screening Mammography

Screening mammograms for the female member population shall be covered consistent with the guidelines published by the American Cancer Society.

Claims for mammography services for women determined to be at high risk according to accepted medical practices that are performed at the screening frequency for high risk must be coded for unusual service (Code 22) and must include an attachment providing a brief explanation of the high-risk condition.

Screening PSA

Screening PSA (prostate specific antigen) and the related DRE (digital rectal examination) for males shall be covered, consistent with the guidelines published by the American Cancer Society.

Gynecological and Obstetric Services

Medicaid members are given the same freedom of choice for these services that is currently available to the general public under private insurance and health maintenance organizations (HMOs). The Department of Medical Assistance Services implemented this change as a result of the recommendations made by a study commissioned by the Virginia General Assembly in House Joint Resolution 598.

Audiology Services

Medicaid reimburses audiologists for medically necessary services provided for diagnostic purposes to adults as long as they are physician-referred.

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Physicians and audiologists must indicate the NPI of the referring primary care physician in Block 17A (I.D. Number of Referring Physician) on the CMS-1500 (08-05) (08-05) claim form.

Intravenous Services

Effective for dates of service on and after July 1, 1998, Medicaid implemented the service day rate methodology for the reimbursement of home I.V. therapy services.

DMAS convened a Task Force to research the most efficient method of ordering and reimbursing for the equipment and supplies related to the delivery of intravenous (I.V.) therapy in the home. This I.V. Therapy Task Force was comprised of durable medical equipment (DME) providers actively involved in delivering home I.V. therapy, pharmacists who provide I.V. therapy services, and Medicaid staff. The Task Force developed the policy, which is effective for claims with dates of service on and after July 1, 1998.

See “Exhibits” at the end of the chapter for a sample of the DMAS-354, Therapy Implementation Form.

Home Infusion Therapy is the intravenous administration of fluids, drugs, chemical agents, or nutritional substances to members in the home setting. Medicaid will reimburse for the services, supplies, and drugs only when they are determined to be:

- Medically necessary to treat a member’s medical condition;
- In accordance with accepted medical practice; and
- Not for the convenience of the member or the member’s caregiver.

The member must:

- Reside in either a private home or a domiciliary care facility, such as an adult care residence. Members in hospitals, nursing facilities, rehabilitation centers, and other institutional settings are not eligible for this service;
- Be under the care of a physician who prescribes the home infusion therapy and monitors the progress of the therapy;
- Have body sites available for I.V. catheter or needle placement or have central venous access; and
- Be capable of self-administering or have a caregiver who can be adequately trained, is capable, and is willing to administer/monitor home infusion therapy safely and efficiently following the appropriate teaching and adequate monitoring. In those cases where the member is incapable of administering or monitoring the prescribed therapy, and there is no adequate or trained caregiver, it may be appropriate for a home health agency to administer the therapy.

Provider Eligibility

Providers must have a valid NPI to participate in the home I.V. therapy program. Providers eligible to participate in this program are:

- I.V. therapy providers;
- Home health agencies;

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- Pharmacies; and
- DME providers.
- A provider must be enrolled as a Medicaid provider and must:
- Meet any state licensing and certification requirements;
- Render infusion therapy covered services;
- Use Medicaid-established billing guidelines; and
- Accept Medicaid reimbursement as payment in full.

Therapy Coverage

Medicaid has assigned a service day & reimbursement rate code for each of the following:

- Hydration therapy;
- Chemotherapy;
- Pain management;
- Drug therapy; and
- Total parenteral nutrition (TPN).

Service Day Rate Definition

This payment methodology provides a fixed amount for each day of infusion therapy. The service day rate (per diem) reimburses for all services delivered in a single day. This payment methodology will be mandatory for the reimbursement of all I.V. therapy services, unless the member is enrolled in one of the waived services outlined under Special Considerations. Service day rates are based on an average day of service, and there will be no additional reimbursement for special or extraordinary services. The service day rate payment will be in two service categories: durable medical equipment (DME) and pharmacy. Items in the DME service day rate include all supplies required to administer I.V. therapy, including but not limited to, the:

- I.V. pump/pole rental/control devices;
- Tubings, adapters, caps, needles, filters, cannulas, extension sets, and alcohol swabs; and
- I.V. start kits and central venous catheter dressing kits.

Items in the pharmacy service day rate include the:

- Diluent for the therapeutic agent;
- Mixing and compounding;
- Flush kits and solutions (heparin and saline); and
- Cassettes and bags/mini-bags.

Drugs used in addition to I.V. therapy, such as intramuscular and subcutaneous injections (Compazine, insulin, etc.) and subcutaneous therapies for hydration and/or pain management, are not covered under the I.V. service day rate policy. These medications and their associated DME supplies must be ordered and billed separately according to current Medicaid guidelines.

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DME Service Authorization

The designated HCPCS codes for DME services do not require initial service authorization, but will have a limit of three months. If the service is needed beyond the three-month-limit, it must be service authorized by DMAS' Service Authorization contractor. Special Considerations: Providers of I.V. therapy services to those members enrolled in special or waived Medicaid programs must abide by all the guidelines of the program in which the member is enrolled. For further information review Appendix D of this manual.

Certificate of Medical Necessity (CMN) (DMAS-352)

The CMN must be completed for I.V. therapy DME services. The provider may fill out the CMN, but the physician, nurse practitioner and/or physician's assistant must date and sign the CMN within 60 days of the begin date of service. Medicaid will not reimburse the DME provider for any DME and supplies provided prior to the date of the physician's, nurse practitioner's and/or physician's assistant signature when the signature is not obtained within 60 days of the first date of service.

Under the item/service and HCPCS code on the CMN, list the proper code and therapy service as well as the estimated length of time needed. The I.V. Therapy Implementation Form (DMAS-354) must be completed, signed, and dated by the physician within 60 days of the therapy start date. Additionally, a copy of the doctor's order for discontinuing the therapy must be attached to each CMN and I.V. Therapy Implementation form upon completion of the therapy. The I.V. Therapy Implementation form must be initiated with the beginning of each drug and therapy service provided. The I.V. Therapy Implementation Form may be completed by the provider, but must be signed and dated by the physician.

Post-Payment Review

The Medicaid Program must ensure that only medically necessary I.V. therapy is provided to Medicaid members. For DME services, I.V. therapy providers must maintain records that contain the fully completed CMN, signed and dated by the physician; the I.V. Therapy Implementation Form (DMAS-354), with the begin and end dates for each drug/therapy provided and signed and dated by the physician; and the order to discontinue the therapy (the official end date), signed and dated by the physician. These forms shall be furnished to Medicaid staff upon request. The absence of documentation to support I.V. therapy services may result in the retraction of moneys.

Code to Use for Incompatible Drug Therapy

In the event of incompatible drug administration, a separate HCPCS code has been developed to allow for the rental of a second infusion pump and the purchase of an extra administration tubing for each day of service. When applicable, this code may be billed in addition to the other service day rate codes. There must be documentation to support the use of this code on the I.V. Therapy Implementation Form (DMAS-354). Proper documentation includes the need for pump administration of the medications ordered, the frequency of administration to support that they are ordered simultaneously, and an indication of incompatibility.

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CLIENT MEDICAL MANAGEMENT PROGRAM

As described in Chapter I of this manual, the State may designate certain members to be restricted to specific physicians and pharmacies. When this occurs, it is noted on the Medicaid member's ID card. A Medicaid-enrolled physician who is not the designated primary provider 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.
- A written referral from the primary health care provider using the Practitioner Referral Form (DMAS-70). This also applies to covering physicians who have not been affiliated with the PCP.
- For other services covered by Medicaid which are excluded from the Client Medical Management Program requirements.

See “Exhibits” in Chapter I for details.

EMERGENCY ROOM SERVICES UNDER CLIENT MEDICAL MANAGEMENT

Reimbursement for emergency room services for Client Medical Management (CMM) members will be automatically paid if the Admitting (presenting signs/symptoms) diagnosis appears on Diagnoses to Be Paid at Emergency Rate by ICD CM Code (see “exhibits” at the end of this chapter for the list.)

Client Medical Management (CMM) members must have a written primary care provider (PCP) referral in order for non-emergency services provided in the emergency room to be reimbursed at the all-inclusive rate for facilities of \$ 30. 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.

When billing for emergency room services, the attending physician bills evaluation and management codes with CPT codes and enters “Y” in Block 24C. When the PCP has referred the member to the emergency room, place the PCP’s NPI in Block 17B on the CMS-1500 (08-05) and attach the Practitioner Referral Form, DMAS-70. PCP referral IS required for reimbursement to CONSULTING physicians who treat a CMM client in the emergency room setting.

The following requirements will be applied either individually or in combination to determine the payment for medical services provided in the outpatient hospital emergency room setting. Flexibility with individual patient status and conditions is taken into consideration in the use of these guidelines. The member's age and the time of admission to the emergency room do not determine the emergency status. The conditions relating to the emergency visit will determine the emergency status. The requirement of non-scheduled medical treatment for the stabilization of an injury or condition will support an emergency.

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The Department of Medical Assistance Services uses the prudent layperson standard as defined in the Balanced Budget Act of 1997 (BBA). Accordingly, emergency services is defined as “a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent lay person, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.” The threat to life or health of the member necessitates the use of the most accessible hospital available that is equipped to furnish the services. The requirement of non-scheduled medical treatment for the stabilization of an injury or condition will support an emergency.

The practice standards of Physician’s Assistants in Hospitals and the Emergency Departments of Hospitals are specifically addressed in the Code of Virginia § 54.1-2952, as amended. These practice standards are unique to these settings. DMAS policy conforms to the standards stipulated in State law regarding the provision of care in a Hospital setting by Physician’s Assistants. Additionally, DMAS requires that the patient’s medical record must be documented sufficiently to clearly show that these unique practice standards have been met.

Telephone or standing orders, or both, do not support emergency treatment.

Emergency room claims that are reviewed by the staff at DMAS will be done in a manner that reflects the prudent lay person requirements. Hospitals and physicians should insure that the documentation to support the medical necessity for the emergency visit is complete and legible.

Emergency Situations:

- Initial treatment following a recent injury. “Recent” is defined as having occurred less than 48 hours prior to the visit.
- An injury sustained over 48 hours prior to the visit and the symptoms have deteriorated to the point of requiring medical treatment for stabilization.

Note: Minor injuries requiring only simple first aid that can be done in the home such as cleansing and bandaging an abrasion, are not considered emergencies. A secondary diagnosis such as Diabetes Mellitus may support the emergent need if substantiated.

- Initial treatment for medical/surgical emergencies, including indications of severe chest pain, dyspnea, gastrointestinal hemorrhage, spontaneous abortion, loss of consciousness, status epilepticus, or other conditions considered “life-threatening.”
- Visit in which the member’s condition requires observation status or immediate hospital admission or transfer to another facility for further treatment or visit.
- Motor Vehicle Accident (MVA) within 48 hours.
- Physical abuse (suspected or confirmed) within 48 hours.
- Epistaxis requiring packing
- Allergic reaction with airway compromise
- Acute vital sign changes including, but not limited to, the following:

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Adult:

- Temperature of 103° F or higher
 - Pulse rate below 40/minute
 - Pulse rate above 140/minute
 - Respiratory rate below 10/minute
 - Respiratory rate above 28/ minute
 - Systolic blood pressure below 90mm Hg
 - Systolic blood pressure above 200mm Hg
 - Diastolic blood pressure below 40mm Hg
 - Diastolic blood pressure above 120mm Hg
 - Pulse Oximetry reading < 91%
- For adults: Use of IV fluids for hydration purposes - rate should be 100ml/hr or greater

Pediatric:

- Temperature of 102° F or higher
 - Pulse rate above 180/minute for patients 1-18months of age
 - Pulse rate above 170/minute in patients 18 months to 12 years
 - Pulse rate below 80/minute in patients 1-18 months of age
 - Pulse rate below 60/minute in patients over 3 months of age
 - Respiratory rate above 50/minute in patients 1 to 10 months
 - Respiratory rate above 40/minute in patients 18 months to 12 years
 - Systolic blood pressure below 65mm Hg in patients 6 months and under
 - Systolic blood pressure below 80mm Hg in patients 6-12 months of age
 - Systolic blood pressure above 120 mm Hg in patients 1-18 months
 - Systolic blood pressure above 140 mm Hg in patients 18 months - 12 years of age
 - Systolic blood pressure above 180 mm Hg in patients 12 years and older
 - Diastolic blood pressure above 80 mm Hg in all pediatric patients
 - Diastolic blood pressure below 40mm Hg in all pediatric patients
 - Pulse Oximetry reading < 93%
- For Pediatrics: Use of IV fluids for hydration purposes - rate should be 75ml/hour or greater

Non-Emergency Conditions (unless the criteria described below have been met):

Depression/Anxiety: Documentation must clearly indicate that the member is an immediate danger to self or others.

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Otitis Media – not an emergency unless one or more of the following is noted:

- The tympanic membrane is ruptured.
- There is drainage from the ear(s).
- A fever is documented while in the emergency room:

Children: Temperature of 102°F or above rectally

Adult: Temperature of 103°F or above orally

- The member is age 2 or under and is crying inconsolably.
- The physician's examination documents the presence of acute otitis media, and there is no access to a physician's office due to being after office hours or on a holiday or a weekend.

Seizures – not an emergency unless:

- The condition was previously undiagnosed, and the visit is immediately following or during a seizure.
- A secondary disorder/diagnosis exists (i.e., hypoglycemia, infection)
- The member is 12 years of age or younger.
- Accompanied to the ER by a law enforcement officer and the condition was unknown.
- The member is in status epilepticus.
- The member is in an epileptic state aggravated by alcohol or drug ingestion

Non-Emergency Situations:

- Non-compliance with previously ordered medications or treatments resulting in continued symptoms of the same condition.
- Refusal to comply with currently ordered procedures or treatments, such as drawing blood for lab work.
- The member had previously been in the same or different emergency room or in a physician's office for the same condition without worsening signs or symptoms of the condition.
- Scheduled visits to the emergency room for procedures, examinations, or medication administration. Examples include, but are not limited to, cast changes, suture removal, dressing changes, follow-up examinations, and consultations for a second opinion.
- Visits made to receive a "tetanus" injection in the absence of other emergency conditions.
- Visits made to obtain medications in the absence of other emergency conditions.
- The conditions or symptoms relating to the visit have been experienced longer than 48 hours or are of a chronic nature, and no emergency medical treatment was provided to stabilize the condition.
- Medical Clearance/Screenings for Psychological or Temporary Detention Order admissions.

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Emergency Room Services Except for Members in the Client Medical Management Program)

Reimbursement for emergency room services for Medicaid members (not enrolled under the Client Medical Management Program) will be automatically paid if the principal diagnosis appears on Diagnoses to Be Paid at Emergency Rate by ICD CM Code (see “Exhibits” at the end of this chapter for this list). Claims for emergency services with the principal diagnosis on Diagnoses to Pend for Review By ICD CM Code will pend for review of the necessary documentation supporting the need for emergency services. (See “Exhibits” at the end of this chapter for this list.) Effective with emergency room claims the Admitting (presenting signs/symptoms) diagnosis will be utilized to determine the pay or pend status of the claim. All claims that are reviewed by the staff at DMAS will be done in a manner that reflects the prudent lay person requirements.

All emergency physician room claims will be paid for emergency CPT codes 99281, 99282, 99284, & 99285 under existing rates. DMAS will pend CPT code 99283 that is submitted with admitting diagnosis code or pend table to determine the emergency situation warranting care. DMAS will pay an all-inclusive fee of \$22.06 to the physician for those claims found not in compliance for emergency room services. All-inclusive is defined as all emergency room and ancillary service charges claimed in association with the emergency room visit, with the exception of laboratory services. Laboratory services will continue to be reimbursed under the existing system of rates. Claims identified as emergencies will also be reimbursed under existing rates. The ordering and interpretation of appropriate diagnostic tests are considered part of the payment to the physician in the emergency department.

A professional component for these services may not be billed separately by a physician in the emergency department, and no separate payment will be made to the physician in the emergency department for a professional component. The professional component will be reimbursed only to those providers who interpret a test and sign and issue the final report.

Follow-Up Care Post ER Visit

Any follow-up outpatient or office consultations for CMM clients require a referral from the primary care physician. Place the PCP’s NPI in Locator 17B on the CMS-1500 (08-05). Attach the written referral form and mark Locator 10D “attachment.”

DURABLE MEDICAL EQUIPMENT

Coverage of Apnea Monitors

As a part of the Quality Care Assurance routine program evaluation of durable medical equipment (DME) and in response to concerns and questions that had been raised, the Department reconvened the Apnea Monitor Task Force to evaluate the appropriateness of the criteria for initial use, continuance of use, discontinuation, and other issues related to the coverage of apnea monitors. The Task Force consisted of physicians representing all regions of the state, respiratory therapists, durable medical equipment providers, and DMAS staff, including medical consultants and other health professionals.

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In addition, an extensive literature search for standards of practice was initiated. The following policy is a result of the work of this Task Force and became effective for claims with dates of service on and after January 1, 1996.

Diagnoses Which Automatically Meet Criteria and Identified-High Risk Conditions

Apnea monitor usage for individuals with the following diagnoses or identified high-risk conditions will be approved for payment if the diagnosis/condition is supported with a completed Certificate of Medical Necessity (CMN) (DMAS-352) with appropriate supporting and verifiable documentation:

- Apparent life-threatening episode(s), i.e., Gastro Esophageal Reflux, severe; apnea; seizures; cardiac arrhythmias;
- Apnea of Prematurity;
- Bronchopulmonary Dysplasia/Chronic Lung Disease of Infancy with oxygen dependency;
- Respiratory Control Disorder such as: Congenital Hypoventilation, Obstructive Sleep Apnea, Central Apnea, Obstructive Airway Disease;
- Infant or child with Tracheostomy;
- Infant of drug-dependent mother, symptomatic for apnea;
- Sibling of SIDS (payment will be made for six months from birth or up to one month beyond age of sibling at time of death); and
- Congenital Anomalies, at risk of airway obstruction.

If the member does not meet the above criteria, the request will be reviewed in accordance with the following criteria.

Criteria for Home Monitoring

The instrument recommended for home use must monitor both cardiac and respiratory status. Apnea mattresses or displacement pads are not appropriate. The member may use either the recording or non-recording monitor.

One or more of the following will be used for selection of patient home monitoring (initial and ongoing continued use), with appropriate supporting individual documentation:

- Observed or recorded episode of prolonged apnea with no identifiable and/or treatable cause or an inadequate response to treatment;
- Documented apnea associated with bradycardia, cyanosis, or pallor;
- History of apnea described by parent or caretaker and documented in the medical records; or
- Evidence of abnormal respiratory control.

Guidelines for Discontinuation of Monitor Reimbursement

Initial approval for payment will be for a period up to four (4) months (120 days). If continued use is indicated by medical necessity, supporting and verifiable medical documentation must be submitted to the Department of Medical Assistance Services Service Authorization contractor for review and service authorization. Reimbursement for apnea monitors will be discontinued when a clinical

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evaluation (including neurological, developmental and physical examinations) shows that the problems or the initial reasons behind the decision to monitor have been resolved or stabilized:

- The patient has been free of events requiring stimulation or resuscitation for 2-4 months; or
- The patient has experienced significant stressors such as respiratory illness or immunizations without apnea; or
- There is normalization of a previously abnormal respiratory pattern or no prolonged apnea episodes for 2-4 months.

Pneumograms/Downloads, Polysomnograms, and Multi-Channel Sleep Studies

Definitions:

Pneumogram is a 2-channel study of breathing and heart rate, including EKG signal and chest wall movement. A download serves the same purpose as a pneumogram if the member is monitored on a recording apnea monitor.

Multi-channel sleep study contains three or more signal sources that may include: cardiac EKG signal, respiratory air flow, body position, oximetry, esophageal pH, and quantitative end tidal CO₂.

Polysomnogram includes cardiac EKG signal, respiratory chest wall movement, respiratory abdominal wall movement, respiratory airflow, body position, oximetry, esophageal pH, and quantitative end tidal CO₂, EEGx2, EOG x2, and EMG, attended by a technologist.

It was determined that reimbursement for these studies should be made based on the number of channels in the study. Criteria for determining the number of appropriate channels to be studied would be determined by the attending or ordering physician.

The certificate of medical necessity documentation must specify the number of signals and what signals are to be done and whether or not interpretation is to be done. Documentation must include the download documentation and a wave form analysis. A summary report must be maintained at the provider's location.

If a recording monitor is being used and downloaded, a pneumogram is not needed to document the continuing need for the monitor. This information will be obtained from the download summary report. If a member with a recording monitor needs a pneumogram, the DME provider must submit a request for service authorization.

Billing Procedures

The DME provider is to use current CPT codes when billing for these studies. HCPCS code E1399 will be used for a two-channel pneumogram or download without interpretation. HCPCS code E1399 will be used for a two-channel pneumogram or download that includes interpretation. HCPCS code E1399 will be used for a multi-channel sleep study or polysomnogram with or without interpretation. The technical component (scoring) must be included in these three codes.

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HCPCS CODES	DESCRIPTION	BILLING UNIT	AUTHORIZAT ION	LIMITS	COMMEN TS
E1399	2-Channel Pneumogram/Downlo ad without interpretation	Each	No	1 per month	See Below.
E1399	2-Channel Pneumogram/Downlo ad with interpretation	Each	No	1 per month	See Below.
E1399	Multi-channel sleep study or polysomnogram with or without interpretation	Channel or Signal	Yes	I.C.	See Below.
If a recording monitor is being used and downloaded, a pneumogram is not needed to document the continuing need for the monitor. If a member with a recording monitor needs a pneumogram, the DME provider must submit a request for service authorization.					

Documentation Requirements for Reimbursement of Apnea Monitors and Diagnostic Studies

For the initial 120 days which do not require service authorization, there must be a Certificate of Medical Necessity (CMN) stating the member's diagnosis that indicates the need for a monitor or a description of the member's condition. The following documentation is required for the continued use of an apnea monitor over 120 days:

1. A CMN and documentation outlining what the member has experienced related to apnea in the previous 120 days of monitoring, including:

- a) The dates and number of occurrences of observed apnea;
- b) An interpretation of any related diagnostic tests;

For example: an upper GI series for GE reflux; pneumograms, or downloads for recording apnea monitors, that are interpreted and indicated that the child had clinically significant apnea during the first 120 days and/or the condition is resolving;

- c) Download reports with clinical interpretation from recording monitors, (the physician is encouraged to order a pneumogram for those children on non-recording apnea monitors in order to get a clear picture of what the child is experiencing);
- d) Adequate and verifiable documentation on the CMN of the oxygen flow rate for those members who continue on oxygen, if applicable; and
- e) Adequate and verifiable documentation of the month of death of any sibling who expired due to Sudden Infant Death Syndrome if the child was placed on the monitor for this reason.

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2. A comprehensive history and record of physical examination, with appropriate work-up including specific pulmonary studies as indicated (i.e., sleep airway studies and fluoroscopy, transcutaneous oxygen, pulse oximetry, recording monitor download analysis, and carbon dioxide monitor or pneumogram studies).

The provider must submit a clinical description to DMAS staff of what happened during the first 120 days and why the monitor continues to be needed. This description is comprised of a history and physical, interpreted downloads or pneumograms that show a test history, indication of special considerations (need for oxygen, need to receive immunization stressors, need to reach significant age for a sibling of SIDS), and a physician's assessment of what happened during the first 120 days of monitoring to warrant continued use. It is the responsibility of the member's physician to interpret the data. It is the responsibility of the DME provider to obtain the interpretation from the physician and submit it to Medicaid.

Documentation for discontinuation of apnea monitor reimbursement will consist of a clinical evaluation (including neurological, developmental, and physical examinations) which shows that the problems or the initial reasons behind the decision to monitor have been resolved or stabilized.

Documentation for pneumograms, polysomnograms, and multi-channel sleep studies must specify the number of signals and what signals are to be done and whether or not interpretation is to be done. Documentation must include the download documentation and a wave form analysis.

The DME provider must maintain all documentation (CMN, summary reports, delivery tickets, billing) on file at the location that is serving the member. Documentation must be maintained on file for five years.

Rental Versus Purchase of an Apnea Monitor Criteria

Medicaid does not require service authorization for the initial 120 days. If the physician determines that the member will need the apnea monitor longer than 120 days but less than eight months, the DME provider must obtain authorization for continued rental from DMAS Service Authorization contractor. To obtain authorization, the DME provider must submit supporting documentation for the additional time requested. If the physician determines that the member will need the apnea monitor eight months or longer, the DME provider must request purchase of the apnea monitor with supporting documentation at the initiation of service or time of determination of long-term usage. At the time of purchase, the DME vendor is required to provide a new monitor with a full manufacturer's warranty.

Non-Compliant Behavior

The provider shall document the non-compliant use of the apnea monitor in the member's file. Non-compliant use of the apnea monitor by the member or the member's caregiver is a refusal to provide care necessary for the child's health and creates a substantial risk of death for the child. The provider shall report non-compliant behavior to the attending physician or health care professional. There shall be compliance with Section 63.1-248.3 of the Code of Virginia.

The Department of Medical Assistance Services shall continue to reimburse for the monitor while reasonable efforts to insure compliant behavior are taken.

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Information about Service Agreements for Purchased Apnea Monitors

HCPCS code E1399 has been developed to cover the service and maintenance of purchased apnea monitors. HCPCS code E1399 requires service authorization. The service maintenance agreement will allow for trouble-shooting and download visits (18 visits per six months). Downloading can be done during a trouble-shooting visit. The vendor can utilize these 18 visits for any combination of trouble-shooting or download visits.

Providers must agree to send the purchased monitor to the manufacturer for necessary servicing. The cost for servicing, shipping, and handling will be covered in HCPCS code E1399 and service authorization is required. A copy of the manufacturer's invoice for servicing must be attached to the invoice. These invoices will pend for manual review before reimbursement is made.

The service maintenance agreement does not include repairs. All repairs must be requested under the established HCPCS code for repairs.

Service Agreement for Purchased Apnea Monitors

The service maintenance agreement requires service authorization by DMAS Service Authorization contractor in order for the provider to be reimbursed. Once service maintenance is authorized, the provider may bill using the HCPCS codes in the DME listing. The following services must be included as part of the service maintenance agreement:

- The provider agrees to employ or contract with staff that will be available to make timely necessary home visits related to the use of the apnea monitor. The DME vendor must assure that the staff being sent into the home is qualified to render the necessary services.
- The provider agrees to perform routine maintenance of the apnea monitor in the home, replacing rib belts, lead wires, and electrodes (disposable or reusable) associated with this routine maintenance. Supplies that must be provided under this agreement are listed in the table below. If the member requires additional supplies that are medically justified, the provider should submit a service authorization request to DMAS Service Authorization contractor with attached medical justification that documents the need for these additional supplies.
- The cost for trouble-shooting and download visits will be included in the service maintenance agreement fee (18 visits per six months). Downloading can be done during a trouble-shooting visit. These 18 visits can be utilized by the vendor for any combination of trouble-shooting or download visits.
- The provider agrees to provide a back-up apnea monitor throughout the period of apnea monitor repairs or services.
- The DME vendor may bill Medicaid for a rental apnea monitor for up to one month during routine repairs/services using the established HCPCS code. The rental must only be for the actual time the monitor is out of the home being serviced by the manufacturer.
- The cost of parts which would constitute a repair may be billed separately as a repair using the established HCPCS codes for repairs.
- The provider agrees to send the apnea monitor for necessary servicing by the manufacturer. The cost for servicing, shipping, and handling will be covered in a separate HCPCS code. The provider must attach a copy of the CMN and manufacturer's invoice to the claim in order for the claim to be paid. Medicaid will pend claims for this HCPCS code for manual adjudication.

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HCPSCS	DESCRIPTION	BILLING	AUTHORIZATION	LIMITS	COMMENTS
CODE		UNIT			
E1399	Service Maintenance Agreement for a Patient-Owned Apnea Monitor	Each	Yes	2/12 Months	
<p align="center">SUPPLIES REQUIRED TO BE PROVIDED WITHIN THE SERVICE MAINTENANCE AGREEMENT</p> <p align="center">12 ELECTRODES DISPOSABLE OR</p> <p align="center">2 REUSABLE ELECTRODES</p> <p align="center">2 LEAD WIRES</p> <p align="center">2 RIB BELTS</p>					

Enteral Nutritional Supplements

Nutritional supplements may only be provided by enrolled durable medical equipment (DME) vendors and be reimbursed based on HCPSCS codes that define categories of supplements. A fixed fee amount is established for the categories.

Coverage of enteral nutrition which does not include a legend drug is limited to when the supplement is the sole source form of nutrition (except for individuals authorized through the Technology-Assisted or through EPSDT where the supplement must be the primary source of nutrition), 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 formulae.

Sole source means that the individual is unable to handle (swallow or absorb) any other form of oral nutrition. Primary source means that nutritional supplements are medically indicated for the treatment of the member's condition if the member is unable to tolerate oral nutrients. The patient may either be unable to take any oral nutrition or the oral intake that can be tolerated is inadequate to maintain life. The focus must be the maintenance of weight and strength commensurate with the patient's condition.

EPSDT COVERAGE OF MEDICAL FORMULA AND NUTRITIONAL SUPPLEMENTS

The Early Periodic Screening Diagnosis and Treatment (EPSDT) program allows the Virginia Department of Medical Assistance Services (DMAS) to provide medically necessary formula and

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medical foods to EPSDT eligible children under the age of 21 based on medical necessity. The current DMAS Durable Medical Equipment (DME) provider manual defines EPSDT formula approval criteria in Chapter 4 of that manual. Routine infant formula is not covered. DMAS will reimburse for medically necessary formula and medical foods when used under physician direction to augment dietary limitations or provide primary nutrition to individuals via enteral or oral feeding methods.

Enrollees under the age of 5 may receive medical formula and nutritional supplements through either DMAS enrolled DME providers or a local Women, Infants and Children (WIC) office. Provision of medically necessary formula and medical foods for children under the age of 21 is not required of DMAS contracted MCO's as this service is carved out from the DMAS Managed Care Contract and covered through DMAS fee-for-service, within DMAS coverage guidelines.

Medical formula and nutritional supplements must be physician recommended to correct or ameliorate a health condition that requires specialized formula and medical foods to supplement diet due to metabolic limitations or provide primary nutrition to individuals via enteral or oral feeding methods. The physician must document medical necessity by using the Certificate of Medical Necessity (DMAS 352) and the Nutritional Status Evaluation when the family uses a DME provider to provide the medical formula. When a local WIC office provides the formula for children under the age of 5 then the WIC program forms are used to document medical necessity.

Documentation Requirements for Enteral Nutritional Supplements

The physician's order (the Certificate of Medical Necessity [CMN]) must specify either a brand name of the supplement being ordered or the category of enteral nutrition which must be provided.

If a physician orders a specific brand of supplement, the DME provider must supply the brand prescribed. The physician's order must include the daily caloric intake ordered and the route of administration for the supplement. The physician's order (the CMN) is valid for a maximum of six months regardless of the member's age.

A face-to-face nutritional assessment completed by trained clinicians (i.e., physician, registered nurse, registered dietitian) must be completed as required documentation of enteral nutrition for both the initial order and every six months. The DME provider/ordering practitioner can use the CMN or a Letter of Medical Necessity that contains all of the required assessment elements and then provide this information to the DME provider who will be supplying enteral nutrition; however, providers may use any format, provided that all the elements are addressed. Home health visits for the sole purpose of performing a nutritional assessment for members whose conditions are stable and chronic in nature will not be covered under the home health program.

The nutritional assessment must include the following elements:

1. Height (or length for pediatric members);
2. Weight (if unobtainable, may provide mid-arm circumference and triceps skinfold test data). For initial assessments, indicate the patient weight loss over time;

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3. Formula tolerance (e.g., the patient is experiencing diarrhea, vomiting, constipation). This element is only required if the patient is already receiving a supplement;
4. Tube or stoma site assessment, as applicable;
5. Indication of whether the supplement is the primary or sole source of nutrition;
6. Route of administration; and
7. Section F must include the daily caloric order and the number of calories per package/can/etc.

The DME provider must assure that there is a physician's order and nutritional assessment, completed in accordance with Medicaid policy, on file for any Medicaid member for whom enteral nutrition is provided.

NOTE: The nutritional assessment/supporting documentation does not replace the requirement for a CMN.

BLOOD GLUCOSE MONITORS

DMAS will reimburse for blood glucose monitors and associated supplies for members eligible for the DME program or EPSDT when all of the following criteria are met:

- The member has a condition that requires adjustment of insulin dosage based on at least daily blood glucose findings, or the member has clinically demonstrated unstable glucose readings and must report frequent findings to a practitioner for adjustment of hypoglycemic medications; and
- There must be written verification that the member and/or caregiver have participated in diabetic training (diet, medication, monitoring, etc.) and that the member and/or caregiver have demonstrated the ability to appropriately use the prescribed blood glucose monitor.

(This requirement is applicable for initial blood glucose monitors and is not required for future monitors unless the practitioner feels additional education is necessary).

For Pregnant Women

DMAS will reimburse for blood glucose monitors and test strips for pregnant women suffering from diabetes for which the practitioner determines nutritional counseling alone will not be sufficient to assure a positive pregnancy outcome (effective for dates of service on and after July 1, 1993).

The Certificate of Medical Necessity (CMN) (DMAS-352) is required. As of July 1, 2010, the maternity risk screen is no longer required; however, 12VAC 30-50-510 requires that pregnant

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women who receive a blood glucose meter covered by DMAS must also be referred for nutritional counseling.

COUNSELING, HIV TESTING, AND TREATMENT FOR PREGNANT WOMEN

The Code of Virginia §54.1-2403.01 requires providers to counsel pregnant women on the importance of HIV testing during pregnancy and treatment if the testing results are positive.

As a routine component of prenatal care, every licensed practitioner who renders prenatal care, regardless of the site of such practice, must advise each patient of the value of testing for Human Immunodeficiency Virus (HIV) infection and request that she consent to such testing.

Practitioners must also counsel all pregnant women with HIV-positive test results about the dangers to the fetus and the advisability of receiving treatment in accordance with the current Centers for Disease Control recommendations for HIV-positive pregnant women. All pregnant women shall have the right to refuse consent to testing for HIV infection and any recommended treatment. Documentation of such refusal must be maintained in the patient's medical record.

The HIV/AIDS epidemic is increasing in women of childbearing age and spreading beyond previously defined risk groups and geographic areas. This increase has been paralleled by a similar increase in children. The Health Care Financing Administration estimates that a minimum of 90% of children infected with HIV are Medicaid beneficiaries.

Clinical trials were conducted under the National Institutes of Health on the use of AZT (zidovudine) to prevent perinatal transmission of AIDS. The clinical trials [AIDS Clinical Trial Group 076 (ACTG 076)] demonstrated that participants who received AZT therapy had a 66% reduction in transmission of HIV from the mother to her newborn. The results of this clinical trial were significant because perinatal transmission accounts for most cases of HIV infection among children.

As the primary caretakers of this population, both the American Academy of Pediatrics (AAP) and the American College of Obstetricians and Gynecologists (ACOG) strongly believe that the answer lies in an aggressive HIV education and counseling initiative. They have issued a joint statement stating "clear medical benefits of knowing the HIV status of pregnant women and newborns have been documented. Treatments are currently available to significantly reduce the HIV transmission from mother to infant (zidovudine/AZT). This finding represents the most important medical breakthrough in this area in recent years. In addition, the lives of the infants, not protected by the AZT treatments in utero, may be prolonged by initiating medical care within the first months of life. For newborns whose mother's HIV status was not determined during pregnancy, the infant's health care provider should educate the parent(s) concerning HIV testing and recommend HIV testing for the newborn."

The combined strategy of HIV counseling for all pregnant women and voluntary HIV testing is already proving effective in several communities. Voluntary testing means that after a woman receives appropriate counseling from her health care provider, she is able to make an informed decision about having a test for HIV. Studies show that when her health care provider talks with a pregnant woman about the test and what it means for her and her baby, most women choose to be tested and then to be

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treated as their doctor recommends. For example, in one inner-city hospital, 96% of women chose to be tested after receiving HIV counseling.

Printed copies of the “U.S. Public Health Service Recommendations for HIV Counseling and Voluntary Testing for Pregnant Women” and “Recommendations of the U.S. Public Health Service Task Force on the Use of Zidovudine to Reduce Perinatal Transmission of Human Immunodeficiency Virus” (MMWR 1994; 44[RR-11]) which have more information about AZT treatment during pregnancy are available from the CDC National AIDS Clearinghouse (CDC NAC). Printed copies may be ordered by calling the CDC National AIDS Hotline (1-800-342-AIDS). The Hotline can also provide information about any AIDS-related issue.

The guidelines are also available electronically through CDC NAC on-line bulletin board as well as through other HIV/AIDS bulletin boards, including the Internet.

For specific information regarding the 076 Clinical Trial or any other HIV/AIDS clinical trial, call the AIDS Clinical Trial Information Service (ACTIS) at 1-800-TRIALS A. For information regarding treatment and care of HIV infection and AIDS, including the use of AZT in pregnant women, call the HIV/AIDS Treatment Service (ACTIS) at 1-800-448-0440.

BILLING PROCEDURES FOR NEWBORN SCREENING TEST KITS

Enrolled Medicaid providers would use CPT code 99070 for the newborn PKU test kit only, for testing done outside of the initial newborn hospitalization or for one done in an outpatient setting for necessary follow up. The enrolled Medicaid provider will use the CMS-1500 (08-05) claim form and would need to have an attachment that contains the member name and ID number, date of service and the actual charge for the PKU Kit from the state lab. The test kit and actual laboratory test would be part of the initial newborn hospital facility charges and reimbursed to the facility under the established facility reimbursement, if done with the hospitalization of the birth, the actual laboratory blood test would be billed by the performing laboratory using CPT code 84030- Phenylalanine.

BABY-CARE SERVICES

The BabyCare program includes the following components:

- Behavioral health screenings by a physician, physician assistant or nurse practitioner as defined in the BabyCare Provider Manual, Chapter II;
- Case management for high risk pregnant women and infants up to two years of age, by registered nurse or social worker as defined in Chapter II of the BabyCare provider manual; and
- Expanded prenatal services for pregnant women including member education classes (including tobacco dependence education), nutrition services, homemaker services and substance abuse treatment services (SATS) by a DMAS approved provider as detailed in Chapter II of the BabyCare provider manual.

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BabyCare services described in this chapter are covered under the Virginia Medical Assistance Program. Forms referenced in this chapter may be found under the Maternal and Child Health / BabyCare section on the DMAS website at <http://dmasva.dmas.virginia.gov>.

The physician is an essential link in identifying high-risk members and referring for services. Behavioral health screenings and case management services are available for pregnant women and infants who are enrolled in Fee-for-Service (FFS) or Primary Care Case Management (PCCM) for Medicaid, Family Access to Medical Insurance Security (FAMIS), FAMIS Plus or FAMIS MOMS programs. Expanded prenatal services are available to pregnant members in FFS or PCCM Medicaid, FAMIS, FAMIS Plus or FAMIS MOMS programs. The covered services available to enrollees in a MCO are described below. Pregnant women are eligible for BabyCare services during pregnancy and up to the end of the month following their 60th day post-partum. Infants are eligible for BabyCare services up to their second birthday.

BEHAVIORAL HEALTH SCREENINGS

The physician is the critical link between the high-risk pregnant woman or infant and the services available through the BabyCare program. The physician is responsible for identifying potential or existing problems through the systematic review of the pregnant woman or infant's medical/obstetrical/developmental conditions, as well as lifestyle and environmental factors, and making referrals for care directed at preventing or ameliorating those problems.

DMAS reimburses for administration and interpretation of the *Behavioral Health Risks Screening Tool for Women of Child Bearing Age*. The purpose for the screening is to identify and assist pregnant women as well as new mothers who may be at risk for mental health, substance use or intimate partner violence as well as infants who may be at risk for developmental issues secondary to their family situation and mother's risks. Early identification and referral for intervention of these risks are paramount in helping improve the outcomes of pregnancy as well as health/well-being of the infant. BabyCare reimburses for administration of this instrument for pregnant/postpartum women who are enrolled in a fee-for-service or primary care case management program using Current Procedural Terminology (CPT) code 99420.

BabyCare will reimburse pediatricians for administering the *Behavioral Health Risks Screening Tool for Women of Childbearing Age* to mothers of infants up to age two, under the infant's medical benefit for FFS or PCCM Medicaid, FAMIS or FAMIS Plus. The purpose is to identify mothers of infants who may be experiencing depression, substance abuse or intimate personal violence and thus increasing the risk that the child will have developmental issues as a result. BabyCare reimburses for administration of this instrument for postpartum women and when billed under the infants up to two years of age who are enrolled in a fee-for-service or primary care case management program using CPT code 99420.

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Managed Care Organization High Risk Maternity and Infant Programs

MCOs participating with the Virginia Medical Assistance Program have their own high risk maternity and infant programs including case management and expanded prenatal services (services comparable to those identified in 12VAC30-50-410 and 12VAC30-50-510). Each MCO has established authorization and approval requirements for these programs. In addition, in order to provide and be reimbursed for services to a managed care member, providers must have a contract with the MCO. Providers should contact the appropriate MCO about the requirements of their maternity and infant program. A list of the MCO High Risk Maternity and Infant Programs can be located on the DMAS website under Managed Care / Contact Information / High Risk Maternity and Infant Programs: (http://dmasva.dmas.virginia.gov/Content_atchs/mc/mc-guide_p2.pdf).

The major goals of BabyCare services are to:

1. Reduce infant mortality and morbidity by improving pregnancy outcomes;
2. Ensure access to comprehensive preventive and therapeutic services by pregnant women and their infants; and
3. Assist pregnant women and infants under age two in meeting other priority needs that affect their well-being and that of their families.

For more information about BabyCare and the referral process, please refer to the BabyCare provider manual available online at: <http://websrvr.dmas.virginia.gov/ProviderManuals/Default.aspx>.

Substance Abuse Therapy Services for Pregnant and Postpartum Women

DMAS provides coverage for the following substance abuse treatment services for pregnant and postpartum women. More information about the substance abuse treatment services may be found in the DMAS Community Mental Health Rehabilitation Provider Manual available online at: <http://websrvr.dmas.virginia.gov/ProviderManuals/Default.aspx>.

Substance abuse treatment services (SATS) for pregnant and postpartum women are described in the DMAS Community Mental Health Rehabilitative Services Manual and are not included in MCO contracts. Members who are pregnant may access substance abuse treatment through any approved DMAS-enrolled SATS provider. Also, the MCO may refer a member to these services. It is the responsibility of the provider of these services to coordinate service delivery and the member's needs with the MCO.

MEDICAL EQUIPMENT AND SUPPLIES

Expendable medical supplies normally used in the physician's office, such as gauze, dressings, syringes, and culture plates, are included in the Medicaid Program's reimbursement for the office visit or test performed. Only the actual cost of special expendable medical supplies, such as an ace bandage or a surgical tray, can be billed to Medicaid. DME and supplies are a covered service available to the

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entire Medicaid population. In addition, Medicaid may cover DME services when any of the following are met:

- The member is under age 21 and the item or supply could be covered under the Virginia State Plan for Medical Assistance (the State Plan) through the Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT); or
- The member is enrolled in the CCC Plus Waiver Program.

All medically necessary medical equipment and supplies under the State Plan may be covered only if they are necessary to carry out a treatment prescribed by a physician. Unusual amounts, types, and duration of usage must be authorized by Medicaid in accordance with published policies and procedures. When determined to be cost-effective by Medicaid, payment may be made for rental of the equipment in lieu of purchase. (Virginia State Plan for Medical Assistance, Supplement 1 to Attachment 3.1-A&B, 7-D, 1.a.) Durable medical equipment (DME) and supplies that are on a Certificate of Medical Necessity (DMAS-352) and are physician ordered for the home environment are reimbursable for the general Medicaid populations. The non-covered DME and supplies are outlined in the State Plan for Medical Assistance and the Durable Medical Equipment and Supplies Manual. DME and supplies for home use do not require that the member meet the home health criteria by being classified as homebound; therefore, DME and supplies may be obtained through an enrolled DME provider who must request service authorization when required.

Procedure Codes for Medical Supplies and Equipment Used in the Practitioner's Office

In the course of treatment in a practitioner's office, it may be necessary to use supplies and/or equipment beyond those routinely included in the office visit. The applicable CPT/HCPCS code may be used when billing for a specific supply item. The following procedure code may be used:

<u>Item</u>	<u>Procedure Code</u>
* Unlisted Supplies	99070

- * Note: When using procedure code 99070, Unlisted Supplies, an explanation provided as an attachment to the CMS-1500 (08-05) claim form must describe the item and its actual invoice cost. The manufacturer's invoice should also be attached.

MATERNITY AND NEWBORN INPATIENT CARE

Refer to the Appendix D of the Physician/Practitioner Manual.

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NURSING FACILITY VISITS

Nursing facility visits are covered as medical conditions require. However, subsequent nursing facility services are limited to one per month unless the medical necessity for more frequent visits is explained as an attachment to the CMS-1500 (08-05) claim form and is indicated through the use of the procedure modifier "22" ("Unusual Services") in Locator 24D.

PHYSICAL THERAPY

Medically necessary physical therapy treatments are covered. The physician may only charge for physical therapy provided in his or her office by the physician or by a licensed physical therapist under his or her supervision. When only physical therapy is provided, an office visit charge may not be submitted to the Program.

PROSTHETIC DEVICES

Refer to the Prosthetic Device Provider Manual.

All hospital admissions at the acute care level, associated with or determined to have developed as a result of substance abuse are covered services. Examples of these are acute gastritis, hematemesis, seizures, and coma as a result of the abuse of alcohol.

Also covered is the treatment of chronic problems attributable to substance abuse. Examples of these are peptic ulcer, pancreatitis, cirrhosis, polyneuropathy, cardiomyopathy, and delirium tremens caused by abuse of alcohol.

Please refer to the Community Mental Health Rehabilitative Services Manual and the Psychiatric Services Manual for covered substance abuse services. Medicaid provides coverage for substance abuse services for pregnant and postpartum women. Refer to the Community Mental Health Rehabilitative Services Provider Manual available online at: <http://websrvr.dmas.virginia.gov/ProviderManuals/Default.aspx> for information regarding these services. For persons under the age of 21 EPSDT may provide medically necessary treatment to correct or ameliorate health or mental health conditions as diagnosed during an EPSDT screening.

SURGERY

Covered surgical procedures which are medically necessary are compensable.

Abortion (Elective)

As of July 1, 2010, induced (elective) abortions will be paid for by the Department of Medical Assistance Services **only** upon the physician's certification that in his or her professional medical judgment the life of the mother would be substantially endangered if the fetus were carried to term.

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

If, in the physician's professional judgment, the woman's life would be endangered by carrying the fetus to term, an abortion certification form, MAP-3006 (See "Exhibits" at the end of the chapter for a sample of the form), must accompany each claim for an induced (elective) abortion. Note that, if a woman's life would be endangered by carrying the fetus to term, the attending physician must so certify.

The originating physician is required to supply a copy of the proper certification to other billing providers. Any claim submitted using the following procedure codes without the appropriate physician certification or required documentation will be pended. If the appropriate information is not attached, the claim will be denied.

- Abortions Performed During a Period of Retroactive Eligibility - Reimbursement is available for those abortions performed during periods of retroactive eligibility if the physician certifies in writing on the MAP-3006 form that, in his or her professional judgment, the life of the mother would have been endangered if the fetus had been carried to term. The certification must also contain the name and address of the patient.
- Abortion Procedure Codes - CPT/HCPCS procedure codes, 01966, 59840, 59841, 59850, 59851, 59852, 59855, 59856, 59857, or 59866 must be used as appropriate in submitting all physician and hospital claims for induced (elective) abortions.

Regardless of the service authorization for the hospitalization, if the invoice reflects an abortion procedure, the claim will pend for Medicaid manual review. If the forms are not properly completed, or not attached to the bill, the claim will be denied or reduced according to Medicaid policy.

Assistant Surgeon

Assistant surgeon fees are covered when services of an assistant surgeon are considered medically necessary due to the complexity of the procedure. The assistant surgeon must be an enrolled provider and is to bill the procedure using the appropriate procedure code and procedure modifier "80", "81", or "82" in Locator 24D of the CMS-1500 (08-05) claim form. Note: Assistant at Surgery is not covered by Virginia Medicaid.

Breast Reconstruction/Prosthesis following Mastectomy and Breast Reduction

Refer to Appendix D (Service Authorization Information) of the Physician Provider Manual.

Biopsy

Biopsy procedures performed concurrently with major surgical procedures are included in the payment for the major procedure.

Cosmetic Surgery

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Refer to Appendix D (Service Authorization Information) of the Physician Provider Manual.

Elective Surgery

Refer to Appendix D (Service Authorization Information) of the Physician Provider Manual.

Transplant Surgery

Refer to Appendix D (Service Authorization Information) of the Physician Provider Manual.

Endoscopy

Payment for diagnostic endoscopy procedures performed concurrently with a related major surgical procedure is included in the payment for the major procedure.

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Experimental Surgery

Surgery considered experimental in nature is not covered.

Hysterectomies

According to federal regulations, hysterectomy is not a sterilization procedure. Medicaid does not cover hysterectomies performed solely for the purpose of rendering an individual incapable of reproducing. Payment may be made for hysterectomies as follows:

- Medically Necessary - A medically necessary hysterectomy may be covered only when the person securing the authorization to perform the hysterectomy has informed the individual or her representative, if applicable, orally and in writing before the surgery is performed that the hysterectomy will render the individual permanently incapable of reproducing, and the individual or her representative has signed a written Acknowledgment of Receipt of Hysterectomy Information Form, DMAS-3005. (See “Exhibits” at the end of the chapter for a sample of the form).
- The Physician Statement must be completed and signed by the physician, and in this situation, Block A must be marked. When a hysterectomy is performed as a consequence of abdominal exploratory surgery or biopsy, the Acknowledgment of Receipt of Hysterectomy Information Form (DMAS-3005) is also required. Therefore, it is advisable to inform the patient or her representative prior to the exploratory surgery or biopsy. Again, Block A of the Physician Statement must be completed.
- Emergency - When a hysterectomy is performed on an emergency basis because of life-threatening circumstances, Block B of the Physician Statement must be marked and a description of the nature of the emergency must be included. The completed Physician Statement must be attached to each claim form related to the hysterectomy (e.g., surgeon, hospital, anesthesiologist). The patient does not have to sign this form. An example of this situation would be when the patient is admitted to the hospital through the emergency room for immediate medical care and the patient is unable to understand and respond to information pertaining to the acknowledgment of receipt of hysterectomy information due to the emergency nature of the admission.
- Sterility - If the patient is sterile prior to the hysterectomy, Block C of the Physician Statement must be marked and a statement regarding the cause of the sterility must be included. The completed Physician Statement must be attached to each invoice related to the hysterectomy (e.g., surgeon, hospital, anesthesiologist). The patient does not have to sign the form. (For example, this form would be used when the sterility was post-menopausal or the result of a previous surgical procedure.)
- A copy of the form DMAS-3005 must be attached to each provider's invoice for a hysterectomy procedure if Medicaid is to consider the claim for payment. Failure to provide the appropriate acknowledgment or certification will result in the denial of the claim.

Regardless of the service authorization for the hospitalization, if the invoice reflects a hysterectomy, the claims will pend for Medicaid manual review. If the forms are not properly completed, or not attached to the bill, the claim will be denied or reduced according to Medicaid

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policy. The originating physician is required to supply other billing providers with a copy of the DMAS-3005.

- CPT/HCPCS Hysterectomy Procedure Codes

- 00846 Anesthesia for intra peritoneal procedures in lower abdomen including laparoscopy; radical hysterectomy
- 00944 Vaginal hysterectomy
- 01962 Anesthesia for urgent hysterectomy following delivery
- 01963 Anesthesia for cesarean hysterectomy without any labor analgesia/anesthesia care
- 01969 Anesthesia for cesarean hysterectomy following neuraxial labor analgesia/anesthesia
- 51597 Pelvic exenteration, complete, for vesical, prostatic, or urethral malignancy, with removal of bladder and ureteral transplantations, with or without hysterectomy and/or abdominoperineal resection of rectum and colon and colostomy, or any combination thereof;
- 51925 Closure of vesicouterine fistula with hysterectomy;
- 58150 Total abdominal hysterectomy (corpus and cervix), with or without removal of tube(s), with or without removal of ovary(s);
- 58152 with colpo-urethrocystopexy (Marshall-Marchetti-Krantz, Burch);
- 58180 Supracervical abdominal hysterectomy (subtotal hysterectomy), with or without removal of tube(s), with or without removal of ovary(s);
- 58200 Total abdominal hysterectomy, including partial vaginectomy, with para-aortic and pelvic lymph node sampling, with or without removal of tube(s), with or without removal of ovary(s);
- 58210 Radical abdominal hysterectomy, with bilateral total pelvic lymphadenectomy and para-aortic lymph node sampling (biopsy), with or without removal of tube(s), with or without removal of ovary(s);
- 58240 Pelvic exenteration for gynecologic malignancy, with total abdominal hysterectomy or cervicectomy, with or without removal of tube(s), with or without removal of ovary(s), with removal of bladder and ureteral transplantations, and/or abdominoperineal resection of rectum and colon and colostomy, or any combination thereof;
- 58260 Vaginal hysterectomy; for uterus 250g or less;
- 58262 with removal of tube(s), and/or ovary(s);
- 58263 with removal of tube(s), and/or ovary(s), with repair of enterocele;
- 58267 with colpo-urethrocystopexy (Marshall-Marchetti-Krantz type, Pereyra type, with or without endoscopic control);
- 58270 with repair of enterocele;
- 58275 Vaginal hysterectomy, with total or partial colectomy; Vaginectomy;
- 58280 with repair of enterocele;
- 58285 Vaginal hysterectomy, radical; (Schauta type operation);
- 58290 Vaginal hysterectomy, for uterus greater than 250 grams;
- 58291 with removal of tube(s) and/or ovary(s)
- 58292 with removal of tube(s) and/or ovary(s), with repair of enterocele
- 58293 with colpo-urethrocystopexy (Marshall-Marchetti-Krantz type, Pereyra type) with or without endoscopic control

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- 58294 with repair of enterocele
- 58541 Laparoscopy, surgical; supracervical hysterectomy, for uterus 250g or less
- 58542 with removal of tube(s) and/or ovary(ies)
- 58543 Laparoscopy, surgical; supracervical hysterectomy, for uterus greater than 250g
- 58544 with removal of tube(s) and/or ovary(ies)
- 58548
- 58550 Laparoscopy surgical, with vaginal hysterectomy, for uterus 250 grams or less;
- 58552 with removal of tube(s) and/or ovary(s), for uterus
- 58553 Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250 grams;
- 58554 with removal of tube(s) and/or ovary(s), for uterus greater than 250 grams
- 58570 Laparoscopy, surgical, with total hysterectomy, for uterus 250 g or less;
- 58571 with removal of tube(s) and/or ovary(s)
- 58572 Laparoscopy, surgical, with total hysterectomy, for uterus greater than 250 g;
- 58573 with removal of tube(s) and/or ovary(s)
- 58575 Laparoscopy, surgical, total hysterectomy for resection of malignancy (tumor debulking), with omentectomy including salpingo-oophorectomy, unilateral or bilateral, when performed
- 58951 Resection of ovarian malignancy with bilateral salpingo-oophorectomy and omentectomy; with total abdominal hysterectomy, pelvic and limited para-aortic lymphadenectomy;
- 58953 Bilateral salpingo-oophorectomy with omentectomy, total abdominal hysterectomy and radical dissection for debulking;
- 58954 with pelvic lymphadenectomy and limited para-aortic lymphadenectomy
- 58956 Bilateral salpingo-oophorectomy with total omentectomy, total abdominal hysterectomy for malignancy
- 59135 Surgical treatment of ectopic pregnancy; interstitial, uterine pregnancy requiring total hysterectomy;
- 59525 Subtotal or total hysterectomy after cesarean delivery;

- Hysterectomies Performed During a Period of Retroactive Eligibility - Reimbursement is available for hysterectomies performed during periods of retroactive eligibility if the physician will certify on the DMAS-3005 that one of the following conditions was met:
 - 1) He or she informed the member before the operation that the procedure would make her sterile. In this case, the patient and the physician must sign the DMAS-3005; or
 - 2) The member met one of the exceptions provided in the Physician Statement Section of the DMAS-3005. In this case, no member signature is required.

Multiple Procedures

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Multiple surgical procedures may require manual review during the payment process. The major procedure is given maximum payment of 100% DMAS fee file and all other related procedures reimbursed at 50 percent of the DMAS fee file. Surgical procedures incidental to the primary procedure are not covered. For example: an appendectomy incidental to gall bladder surgery is not covered.

Preoperative and Postoperative Care

Routine, uncomplicated preoperative and postoperative medical care that is related to the primary surgery considered included as part of the surgical reimbursement allowance and therefore may not be billed separately.

Mandatory Outpatient Surgical and Diagnostic Procedures

The Department of Medical Assistance Services will not reimburse the hospital and/or practitioner for the outpatient surgical or diagnostic procedures listed in Appendix B when performed on an inpatient basis unless the procedure meets one of the exceptions to this policy. This policy applies to all Medicaid-eligible patients regardless of any other medical coverage, except for those members in the retroactive eligibility period. The exceptions as defined below must be well-documented and support the medical necessity for these procedures when performed on an inpatient basis.

- An existing medical condition which requires prolonged post-operative observation by skilled medical personnel (e.g., heart disease or severe diabetes).
- The member had been admitted to a hospital for another procedure or condition and the surgeon decides that one of the listed procedures is also necessary or is done in conjunction with the procedure requiring hospitalization.
- Another procedure, which requires the inpatient setting, may follow the initial procedure (e.g., gynecological laparoscopy followed by oophorectomy).• Adequate outpatient facilities are not available within a reasonable distance (i.e., 50 miles), requiring the procedure to be rendered on an inpatient basis; in this case, a one-day inpatient hospital stay would be allowed unless a longer stay is medically necessary.

All physician claims will pend for review when the site of the service is inpatient and a listed outpatient surgical or diagnostic procedure code is used. Complete case documentation must support the medical necessity for these procedures when performed on an inpatient basis. Payment will only be approved when appropriate justification for the inpatient necessity is provided on (or accompanies) the invoice.

STERILIZATION

Human Reproductive Sterilization

Human reproductive sterilization is defined by the Department of Medical Assistance Services as any medical treatment, procedure, or operation for the purpose of rendering an individual permanently incapable of reproducing.

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Sterilizations that are performed because pregnancy would be life-threatening to the mother ("therapeutic" sterilizations) are included in this definition. The term sterilization means only human reproductive sterilization, as defined above.

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

Conditions of Coverage

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

The Virginia Medicaid Program does not cover sterilization procedures for mentally incompetent or institutionalized individuals or an individual under age 21.

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

- The individual is at least 21 years old at the time consent for sterilization is obtained.

Note: A patient must be 21 years old to give consent to sterilization. This is a federal requirement for sterilizations only and is not affected by any other State law regarding the ability to give consent to medical treatment generally. The age limit is an absolute requirement.

There are no exceptions for marital status, number of children, or for a therapeutic sterilization.

- The individual is not a mentally incompetent individual. For Virginia Medical Assistance Program purposes, a mentally incompetent individual is a person who has been declared mentally incompetent by the federal, State, or local court of competent jurisdiction for any purpose, unless the individual has been declared competent for purposes that include the ability to consent to sterilization. The competency requirement is an absolute requirement. There are no exceptions.
- The individual is able to understand the content and nature of the informed consent process as specified in this section. A patient considered mentally ill or mentally retarded may sign the consent form if it is determined by a physician that the individual is capable of understanding the nature and significance of the sterilizing procedure.
- The individual is not institutionalized. For the purposes of Medicaid reimbursement for sterilization, an institutionalized individual is a person who is:

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- Involuntarily confined or detained under civil or criminal statute in a correctional or rehabilitative facility, including a mental hospital or other facility for the care and treatment of mental illness, or
- Confined under a voluntary commitment in a mental hospital or other facility for the care and treatment of mental illness.
- The individual has voluntarily given informed consent in accordance with all the requirements prescribed in this section.
- At least 30 days, but not more than 180 days, have passed between the date of informed consent and the date of the sterilization, except in the following instances:
 - Sterilization may be performed at the time of emergency abdominal surgery if the patient consented to the sterilization at least 30 days before the intended date of sterilization and at least 72 hours have passed after written informed consent was given and the performance of the emergency surgery.
 - Sterilization may be performed at the time of premature delivery if the following requirements are met: the written informed consent was given at least 30 days before the expected date of the delivery, and at least 72 hours have passed after written informed consent to be sterilized was given.
- Regardless of the service authorization for the hospitalization, if the invoice reflects a sterilization, the claim will pend for Medicaid manual review.
- If the forms are not properly completed, or not attached to the bill, the claim will be denied or reduced according to Medicaid policy.
- A completed DMAS-3004, Sterilization Consent Form must accompany all claims for sterilization services. This requirement extends to all providers:

attending physicians or surgeons, assistant surgeons, anesthesiologists, and facilities. Only claims directly related to the sterilization surgery, however, require consent documentation. Claims for presurgical visits and tests or services related to postsurgical complications do not require consent documentation.

Informed Consent Process for Sterilization

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

An individual has given informed consent only if:

- The person who obtained consent for the sterilization procedure:

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- Offered to answer any questions the individual may have had concerning the sterilization procedure;
- Provided the individual with a copy of the consent form;
- Provided orally all of the following information to the individual to be sterilized;
- Advice that the individual is free to withhold or withdraw consent to the procedure at any time before the sterilization without affecting the right to future care or treatment and without loss or withdrawal of any federally-funded program benefits to which the individual might be otherwise entitled;
- A description of available alternative methods of family planning and birth control;
- Advice that the sterilization procedure is considered to be irreversible;
- A thorough explanation of the specific sterilization procedure to be performed;
- A full description of the discomforts and risks that may accompany or follow the performing of the procedure, including an explanation of the type and possible effects of any anesthetic to be used;
- A full description of the benefits or advantages that may be expected as a result of the sterilization; and
- Advice that the sterilization will not be performed for at least 30 days, except under the circumstances of premature delivery or emergency abdominal surgery, in which case 72 hours must have passed between the informed consent and surgery; also, in the case of premature delivery, consent must have been given at least 30 days prior to the expected date of delivery.
- Suitable arrangements were made to ensure that the information specified above was effectively communicated to a blind, deaf, or otherwise impaired individual to be sterilized.
- An interpreter was provided if the individual to be sterilized did not understand the language used on the consent form or the language used by the person obtaining consent.
- The individual to be sterilized was permitted to have a witness of the individual's choice present when consent was obtained.
- The sterilization operation was requested without fraud, duress, or undue influence.
- All other State and local requirements were followed.

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- The appropriate consent form was properly filled out and signed (see below).
- Informed consent may not be obtained while the individual to be sterilized is:
 - In labor or within 24 hours postpartum or post-abortion;
 - Seeking to obtain or obtaining an abortion; or
 - "Seeking to obtain" means that period of time during which the abortion decision and the arrangements for the abortion are being made.
 - "Obtaining an abortion" means that period of time during which an individual is undergoing the abortion procedure, including any period during which preoperative medication is administered.

The Virginia Medical Assistance Program prohibits the giving of consent to sterilization at the same time a patient is seeking to obtain or obtaining an abortion. This does not mean, however, that the two procedures may never be performed at the same time. If a patient gives consent to sterilization, then later wishes to obtain an abortion, the procedures may be done concurrently. An elective abortion does not qualify as emergency abdominal surgery, and this procedure does not affect the 30-day minimum wait.

- Under the influence of alcohol or other substances that affect the individual's state of awareness.

Sterilization Consent Document

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

Instructions for completing the form are shown on the next page:

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Instructions for Completing the Sterilization Consent Form (DMAS-3004)

Ref.

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

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Ref.

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

Use of the Sterilization Consent Form

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

- The individual to be sterilized;
- The interpreter, if one is provided;
- The individual who obtains the consent; and

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- The physician who will perform the sterilization procedure.

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

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

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

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

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

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

A copy of the signed consent form must be:

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

Claims for Service

Any claim submitted without a properly-executed consent form or documentation showing medical necessity will be pended. If appropriate information is not received within 30 days of the request for the information, the claim will be denied. The originating physician is required to supply a copy of the DMAS-3004 to other billing providers.

CPT/HCPCS Sterilization Procedure Codes

- 00851 Anesthesia for intraperitoneal procedures in lower abdomen, including laparoscopy, tubal ligation/ transection
- 00921 Anesthesia for procedures on male genitalia (including open urethral procedures); vasectomy, unilateral or bilateral
- 54690 Laparoscopy, surgical; orchiectomy
- 55250 Vasectomy, unilateral or bilateral (separate procedure), including postoperative semen examination(s)
- 55450 Ligation (percutaneous) of vas deferens, unilateral or bilateral (separate procedure)

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58565	Hysteroscopy Sterilization
58600	Ligation or transection of fallopian tube(s), abdominal or vaginal approach, unilateral or bilateral
58605	Ligation or transection of fallopian tube(s), abdominal or vaginal approach, postpartum, unilateral or bilateral, during same hospitalization (separate procedure)
58611	Ligation or transection of fallopian tube(s) when done at the time of cesarean delivery or intra-abdominal surgery (not a separate procedure) List separately in addition to code for primary procedure.
58615	Occlusion of fallopian tube(s) by device (e.g., band, clip, or Falope ring), vaginal or suprapubic approach
58661	Laparoscopy, surgical; with removal of adnexal structures (partial or total oophorectomy and/or salpingectomy)
58670	Laparoscopy, surgical; with fulguration of oviducts (with or without transection)
58671	Laparoscopy, surgical; with occlusion of oviducts by device (e.g., band, clip, or Falope ring)
58700	Salpingectomy, complete or partial, unilateral or bilateral (separate procedure)
58720	Salpingo-oophorectomy, complete or partial, unilateral or bilateral (separate procedure)

Retroactive Coverage

Providers are reminded that sterilization is covered only if all applicable requirements are met at the time the operation is performed:

- The requirements related to the time period required between the date of informed consent and the date of sterilization;
- The informed consent requirements for the individual to be sterilized; and
- The certification requirements for signatures of the individual to be sterilized, the interpreter (if applicable), the person obtaining consent, and the physician who performed the sterilization procedure that must be present on the DMAS-3004.

If a patient obtains retroactive Program coverage, previously provided sterilization services cannot be billed unless the applicable requirements have been met. There are no exceptions made for retroactive eligibility in regard to the requirements for sterilization.

Surgery for Morbid Obesity

Refer to Appendix D of the Physician/Practitioner Manual.

VACCINES

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Routine immunizations including the annual pneumococcal vaccination are covered for children under the age of 19 as part of the EPSDT program. Immunizations to all other individuals are limited except for instances when:

- It is necessary for the direct treatment of an injury, or
- The immunization is a pneumococcal or influenza vaccination that is reasonable and necessary for the prevention of illness.

Physicians can be reimbursed for the cost of adult pneumococcal or influenza vaccines given as part of a plan of treatment which has as its objective preventing the occurrence of more serious illness in an individual "at risk." This allows for the administration of influenza and/or pneumococcal vaccinations when these vaccinations are indicated as medically necessary. The medical treatment record, upon review, must clearly indicate the valid medical reason(s) justifying the administration of these vaccines.

VACCINES FOR CHILDREN PROGRAM

The Vaccines for Children (VFC) Program is a federal program established in 1984 to help raise childhood immunization rates in Virginia. VFC provides federally purchased vaccine, at no cost to health care providers, for administration to eligible children. Childhood immunizations and annual pneumococcal vaccinations are covered according to the most current Advisory Committee for Immunization Practices (ACIP) schedule.

To be eligible for free vaccine from the VFC Program, children must be under the age of 19. VFC eligibles must also meet one of the following criteria:

- Medicaid, enrolled, including Medicaid MCOs,
- Uninsured (no health third party insurance),
- Native American or Native Alaskans (no proof required) and
- Underinsured (those whose insurance does not cover immunizations).

Requirement to Enroll in VFC

To participate, a provider must complete the enrollment and provider profile forms provided by VDH. At this point, the provider is eligible to receive free vaccines under the VFC.

Upon enrollment, the Department of Medical Assistance Services will not reimburse the provider for the acquisition cost for vaccines covered under VFC. Medicaid will reimburse providers the administration fee for routine childhood vaccines that are available under VFC (up to the age of 19). Medicaid will reimburse the provider an administration fee per injection.

Billing Codes for the Administration Fee

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Providers must use Medicaid-specific billing codes when billing Medicaid for the administration fee for free vaccines under VFC. These codes identify the VFC vaccine provided and will assist VDH with its accountability plan which the Health Care Financing Administration (CMS) requires. The billing codes are provided in the Current Procedural Terminology (CPT-4) books.

Billing Medicaid as Primary Insurance

For immunizations, Medicaid should be billed first for the vaccine administration. This is regardless of any other coverage that the child may have, even if the other coverage would reimburse the vaccine administration costs. Medicaid will then seek reimbursement from other appropriate payers. When a child has other insurance, check “YES” in Block 11-D (Is there another health benefit plan?) on the CMS-1500 (08-05) (08-05) claim form.

Reimbursement for Children Ages 19 and 20

Since Medicaid policy provides coverage for vaccines for children up to the age of 21, and VFC provides coverage only up to the age of 19, there may be instances where the provider will provide immunizations to children who are ages 19 and 20. Bill Medicaid with the appropriate CPT/HCPCS code and Medicaid will reimburse the acquisition cost for these vaccines. Medicaid will not reimburse an administration fee since these vaccines were not provided under the VFC Program to this age group.

Vaccines Not Available Under VFC

The Virginia Department of Health has no contracts with the Centers for Disease Control (CDC) for the VFC distributor to provide Diphtheria Tetanus and Pertussis (DTP) and Hepatitis B for dialysis patients. Therefore, Medicaid will reimburse for the acquisition cost for these vaccines under CPT codes 90701 and 90747, respectively. No administration fee will be reimbursed under code since this vaccine is not available under VFC.

Single Antigen Vaccines

Single antigen vaccines (such as measles, mumps, and rubella) are available from the VFC contractor but must be ordered by the provider with special justification since the combined antigen vaccine (MMR) is available. This is consistent with Medicaid policy to require medical justification for single antigen vaccines.

Pneumococcal and Influenza Vaccines

Medicaid will provide reimbursement for these vaccines only if they are reasonable and necessary for the prevention of illness. Medical justification needs to be attached to the claim. The physician’s treatment plan on file in the patient’s medical record must indicate that the vaccine was provided to prevent the occurrence of more serious illness in an individual “at risk.”

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Situations Where Vaccines Are Not Covered Under VFC

There may be some situations where a child is attempting to “catch-up” on vaccines that have been missed. In some cases, the VFC program will not provide coverage for these “catch-up” vaccines, and the provider will have to purchase them from his or her normal vaccine distributor. If this occurs, Medicaid will continue to reimburse the provider for the acquisition cost of these vaccines as long as there is information attached to the claim indicating the reason for billing Medicaid for the acquisition cost. In addition to the attachment to the claim, use modifier 22 in Block 24-D of the CMS-1500 (08-05) claim form.

Vaccines Provided Outside of the EPSDT Periodicity Schedule

Virginia Medicaid covers childhood immunizations under the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program based upon a periodicity schedule. This schedule was developed by the Advisory Committee on Immunization Practices (ACIP) and the American Academy of Pediatrics along with representatives from the American Academy of Family Physicians. See Supplement B - EPSDT for a copy of the immunization schedule. If the provider provides a vaccine to a child that falls outside of this immunization schedule and the vaccine does not meet the criteria for coverage under the VFC Program, Medicaid cannot reimburse for immunizations unless documentation is sent along with the claim to explain the circumstances under which the vaccine was provided. In addition to the attachment to the claim, use modifier 22 in Locator 24-D to bill Medicaid for the acquisition cost.

Questions

For questions relating specifically to the VFC program, call the Virginia Department of Health Hotline at 1-800-568-1929. The VDH Hotline is available Monday through Friday from 7:00 a.m. to 5:00 p.m. For other questions, call the Medicaid HELPLINE.

Orthotics

Please refer to Appendix D, in the “Physician/Practitioner Manual”.

Rehabilitation Program

Items made for the member by an occupational therapist, including splints, slings, and any normally stocked supplies, are part of the cost of the Medicaid-approved rehabilitation visit. These ancillary charges are not reimbursed separately for Rehabilitation Agencies.

Intensive Rehabilitation

Please refer to Appendix D, in the “Rehabilitation Manual”.

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EPSDT (Children Under 21 Years of Age)

Children do not have to be enrolled in Children's Specialty Services to receive orthotics. All medically necessary orthotics are covered for children under the age of 21 years. The orthotist participating as a Medicaid DME provider coordinates the completion of the DMAS-352 (CMN) with the prescribing physician using the correct HCPCS "L" procedure codes. Service authorization is required and may be submitted to DMAS' Service Authorization contractor. Refer to the Physician/Practitioner Manual, Appendix D. Documentation of provider cost will be required for "L" procedure codes that do not have an established reimbursement allowance. Reimbursement (under HCPCS "L" codes) to the DME orthotic provider is all inclusive; no supplemental reimbursement will be made for the time involved in fitting, measuring, and designing the orthotic, or for providing the member with instructions for the proper use.

Service Authorization

Refer to Appendix D of the Physician/Practitioner Manual.

REIMBURSEMENT

Payments for covered services submitted by physicians are based on the individual physician's usual and customary fees, within Program limitations.

Reimbursement for the administration of vaccines/immunizations is included in the office visit when a medical service is rendered. When an immunization is the only service performed, an appropriate minimal office visit (e.g., CPT/HCPCS code 99211), may be listed in addition to the injection. When billing for immunizations, only the actual acquisition cost of the injectable is to be billed separately using the appropriate CPT/HCPCS code. Special supplies beyond those routinely included in the office visit are to be billed reflecting the provider's acquisition cost and using the appropriate HCPCS/CPT codes are listed in this chapter.

When there are extenuating circumstances, individual consideration, if requested, is given to additional allowances in compensation. However, payment by Medicaid cannot exceed the Medicare allowance for the same or similar service. It should be noted that the payment allowance for covered professional services includes the necessary administrative services as required for the care of a member, i.e., the preparation of records, plan of treatment, and certification for services, etc. Therefore, separate payment, in addition to the professional visit, will not be made for these services.

To request individual consideration, enter "ATTACHMENT" in Locator 10D and procedure modifier "22" ("Unusual Service") in Locator 24D of the CMS-1500 (08-05) claim form, and attach sufficient documentation to support the claim that is being billed.

Payment Basis

Payment for physician services is the lowest of the Program's fee schedule, actual charge, or Medicare allowances.

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Payment in Full

In accepting payment from the Program, a physician must agree to accept Program payment as payment in full for all covered services rendered to the patient and billed to the Program. The physician may not bill Medicaid or the member for the difference (if any) between the allowed charge and the actual billed charge. The provider may not bill the member for missed or broken appointments. The physician must bill any other possibly liable third-party payer prior to billing the Program. The Program will pay the difference between the Program's allowable fee and the amount paid by another third party, except for Medicare. When Medicare (Title XVIII) makes a payment for physician's covered services, the physician may claim payment of any deductible and coinsurance amounts due from the Program. However, he or she may not claim payment of the difference (if any) between the Medicare-allowed fee and his or her actual fee for services. Also, Medicaid payments for Medicare Part B coinsurance are limited to the difference between Medicaid's maximum fee for a given procedure and 80 per cent of Medicare's allowance. The combined payments by Medicare and Medicaid will not exceed Medicaid's allowed charge for that procedure.

Implementation of a New Physician Fee Schedule

The fee schedule effective July 1, 1995 was based in many respects on the Medicare Resource Based Relative Value Scale (RBRVS) fee schedule. The calculation of RBRVS fees for Virginia Medicaid uses Medicare's Relative Value Units (RVUs) and Conversion Factors (CFs), with an additional "budget neutrality" adjustment to ensure that total Medicaid expenditures do not increase solely due to the updates to the Medicare fee schedule. Multiple budget neutrality factors by service category are now used. Starting in 1996, the Medicaid fee schedule was updated each January to reflect modifications to the Medicare Relative Value Units (RVUs). Effective July 1, 2005, the Medicaid fee schedule is updated each July to reflect modifications to Medicare RVUs. Effective July 1, 2008, the Medicaid fee schedule reflects different rates for services depending on the site of service, facility or non-facility, based on the relative value units for procedure codes published by the Medicare.

Adjusting fees for Geographic Practice Cost Indices (GPCIs) is not part of the Medicaid fee schedule. Medicaid fees will continue to be applied on a statewide basis. All of the payment rules adopted by Medicare at the time RBRVS was first implemented and over time have not been adopted by Medicaid.

COPAYMENT REQUIREMENTS

As required by the Appropriations Act of 1992, the copays are the same for categorically needy members, Qualified Medicare Beneficiaries (QMBs), and medically needy members. The services and copay amounts are:

<u>SERVICE</u>	<u>COPAY AMOUNT</u>
Inpatient hospital	\$100.00 per admission
Outpatient hospital clinic	3.00 per visit
Clinic visit	1.00 per visit

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<u>SERVICE</u>	<u>COPAY AMOUNT</u>
Physician office visit	1.00 per visit
Other physician visit	3.00 per visit
Eye examination	1.00 per examination
Prescription	1.00 for multi-source generic; 3.00 for brand per prescription or refill for dates of service on or after September 1, 2002
Home health visit	3.00 per day
Rehabilitation service	3.00 per day

For purposes of copays, a visit is defined as a patient encounter in the place of treatment, by the same provider on the same day regardless of the number of procedures performed. The encounter may be indirect. For example, if on July 15, 2009, the physician in a hospital performs an interpretation and report for an electrocardiogram (CPT/HCPCS code 93010) and an interpretation and report for an electrocardiogram (CPT/HCPCS code 93018); this would be considered one visit and would be subject to a \$3.00 copay for a member who was not exempt. If the physician performed one procedure on July 15, 2006, and the other on July 16, 2009, the procedures would be considered two visits and would be subject to two \$3.00 copays.

The copays apply to all members except the following:

- Children under 21 years of age (identified by a Special Indicator code “A” on their Medicaid identification cards);
- Individuals receiving long-term care service or hospice care (identified by a Special Indicator code “B” on their Medicaid identification cards); and
- Individuals participating in health maintenance organizations under the Managed Care program.

The following services are never subject to copays:

- Emergency services;
- Members in waived programs (hospice, LTC, E&D waiver)
- Family planning services including office visits, drugs and supplies; and
- Pregnancy-related services (services delivered to pregnant women if such services are related to the pregnancy or to any other medical condition which may complicate the pregnancy, e.g., prenatal, delivery, postpartum care.)

A provider may not deny services to a member solely because of his or her inability to pay any applicable copayment charge. This does not relieve the member of the responsibility to pay nor does it prevent the provider from attempting to collect any applicable copayment from the member.

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MCO/HMO Copayments

DMAS allows the submission of claims and the reimbursement of the co-payment for Medicaid enrollees who have a Managed Care/Health Maintenance Organization (MCO/HMO) as their primary carrier. These claims are submitted on the CMS-1500 (08-05) (08-05) claim form. The following locators would need to be completed, in addition to the other required locators as indicated in Chapter V of this manual.

- Locator 10d – Write “Attachment”.
- Locator 11c – Enter “HMO Copay”.
- Locator 24D – Enter the CPT/HCPCS code that was billed as the primary procedure to the MCO/HMO.
- Locator 24F. - Enter the actual enrollee’s co-payment amount as the charged amount.

The Explanation of Benefits (EOB) must be attached to the claim if the billed charge is greater than \$25.00.

The billing and reimbursement of the MCO/HMO co-payment does not apply for enrollees in a Medicaid MCO/HMO, e.g. Medallion 3.0. DMAS will apply the Medicaid co-payment amounts for enrollees age 21 or up. Therefore, a Medicaid co-payment will be deducted from the MCO/HMO charged co-payment. Example: Medicaid enrollee with MCO/HMO primary insurance may have a \$20.00 co-payment for an office visit. Medicaid’s co-payment for the office visit is \$1.00. The Medicaid allowance will be \$19.00 for this office visit. The remaining \$1.00 should be collected from the enrollee at the time of service. For electronic data interchange (EDI) claims filers; please refer to the EDI companion guide. Companion guides can be found at: (<https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/EDICompanionGuides>).

SUBMISSION OF CLAIMS FOR NONRESIDENT ALIENS

Chapters I and III contain information on the coverage and eligibility requirements for nonresident aliens. To submit a claim for covered emergency services for a nonresident alien:

- Complete the appropriate Medicaid billing form (and any other required forms) in the usual manner.
- Attach a copy of the completed Emergency Medical Certification Form to the invoice. Other relevant documentation to justify the approval has already been submitted and reviewed and; therefore, does not need to be duplicated with this claim.
- Submit the claim to appropriate post office box as indicated in the billing chapter.

NOTE: The same procedures apply for adjusted or voided claims.

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All claims for nonresident aliens will pend for certification to verify that they were related to the emergency situation which has been approved. All claims not related to the emergency treatment will be denied. The documentation for a denied claim will be kept by Medicaid for 180 days from the date of receipt to allow for the appeal process for those services which are not approved.

CLAIM INQUIRIES

Inquiries concerning covered benefits, specific billing procedures, or questions regarding Virginia Medicaid policies and procedures should be directed to:

Customer Services
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, VA 23219

A review of additional documentation may sustain the original determination or result in an approval or denial.

Telephone Numbers:

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

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EXHIBITS

Please use this link to search for DMAS Forms:

<https://www.viriniamedicaid.dmas.virginia.gov/wps/portal/ProviderFormsSearch>

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Disability Evaluation Under Social Security (SSA Publication 64-039) Part III, § 9.09

9.09 Obesity. Weight equal to or greater than the values specified in Table I for males, Table II for females (100 percent above desired level), and one of the following:

- A. History of pain and limitation of motion in any weight-bearing joint or the lumbosacral spine (on physical examination) associated with findings on medically acceptable techniques of arthritis in the affected joint or lumbosacral spine; or
- B. Hypertension with diastolic blood pressure persistently in excess of 100 mm. Hg measured with appropriate size cuff; or
- C. History of congestive heart failure manifested by past evidence of vascular congestion such as hepatomegaly, peripheral or pulmonary edema; or
- D. Chronic venous insufficiency with superficial varicosities in a lower extremity with pain on weight bearing and persistent edema; or
- E. Respiratory disease with total force vital capacity equal to or less than 2.0 L. or a level of hypoxemia at rest equal to or less than the values specified in Table-III A or III-B or III-C.

DISABILITY CRITERIA FOR THE COVERAGE OF
ANOREXIC DRUGS FOR OBESITY

PART I

Table I - Men
(metric)

<u>Height without shoes (centimeters)</u>	<u>Weight (kilograms)</u>
152	112
155	115
157	117
160	120
163	123
165	125
168	129
170	134
173	137
175	141
178	145
180	149
183	153
185	157
188	162
190	165
193	170

Table II - Women
(metric)

<u>Height without shoes (centimeters)</u>	<u>Weight (kilograms)</u>
142	95
145	96
147	99
150	102
152	105
155	107
157	110
160	114
163	117
165	121
168	125
170	128
173	132
175	135
178	139
180	143
183	146

Table I - Men

<u>Height without shoes (inches)</u>	<u>Weight (pounds)</u>
60	246
61	252
62	258
63	264
64	270
65	276
66	284
67	294
68	302
69	310
70	318
71	328
72	336
73	346
74	356
75	364
76	374

Table II - Women

<u>Height without shoes (inches)</u>	<u>Weight (pounds)</u>
56	208
57	212
58	218
59	224
60	230
61	236
62	242
63	250
64	258
65	266
66	274
67	282
68	290
69	298
70	306
71	314
72	322

DISABILITY CRITERIA FOR THE COVERAGE OF ANOREXIANT DRUGS FOR OBESITY

PART II

Table III – A
(Applicable at test sites less than
3000 above sea level)

<u>Arterial PCO2</u> <u>(mm.Hg.) and</u>	<u>Arterial PO2</u> <u>Equal to or less</u> <u>than (mm.Hg.)</u>
30 or below	65
31	64
32	63
33	62
34	61
35	60
36	59
37	58
38	57
39	56
40 or above	55

Table III – B
(Applicable at test sites 3000
through 6000 feet above sea level)

<u>Arterial PCO2</u> <u>(mm.Hg.) and</u>	<u>Arterial PO2</u> <u>Equal to or less</u> <u>less than(mm.Hg.)</u>
30 or below	60
31	59
32	58
33	57
34	56
35	55
36	54
37	53
38	52
39	51
40 or above	50

Table III – C
(Applicable at test sites over
6000 feet above sea level)

<u>Arterial PCO2</u> <u>(mm.Hg.) and</u>	<u>Arterial PO2</u> <u>(Equal to or less</u> <u>than (mm.Hg.)</u>
30 or below	55
31	54
32	53
33	52
34	51
35	50
36	49
37	48
38	47
39	46
40 or above	45

CASE EXAMPLE: MARY NEEDY

Mary Needy is a 42-year-old insulin dependent diabetic who has a right leg below the knee amputation. In June, 1998, she injured her left knee in a fall that resulted in a puncture wound, and she eventually developed osteomyelitis in the knee joint. After attempting to treat her on oral medication without success, her physician admitted her to the hospital, and on June 5, 1998, he sent her home from the hospital with a Hickman line in place. She was to receive two IV medications: Keflin 250mg q 4 hours and Vancomycin 250mg q 12 hours. On June 8, 1998, the recipient developed a rash, and the Keflin was discontinued. On June 14, 1998, the recipient became dehydrated due to nausea and vomiting from a virus and was started on hydration therapy for two days to correct this problem. Hydration therapy was discontinued on 6/15/98 at 8 p.m. The recipient remained on Vancomycin until July 5, 1998, when laboratory values determined that the infection had resolved.

Billing by the DME provider: The recipient received DME Drug Therapy from 6/5/98 to 7/5/98 for a total of 31 days (only one service day rate for each of the days she received two antibiotics). The recipient received DME Hydration Therapy from 6/14/98 to 6/15/98 for a total of two days. Therefore, the DME provider may bill the full service day rate for DME Drug Therapy for 29 days (6/5/98 through 6/13/98 and 6/16/98 through 7/5/98). For the two days of multiple therapies (Drug and Hydration Therapy on June 14-June 15, 1998), the provider may bill the full DME Drug Therapy service day rate and 50% of the DME Hydration Therapy service day rate for each of the 2 days.

Billing by the pharmacy provider: The pharmacy provider may bill for a total of 31 days of Pharmacy Drug Therapy and two days of Pharmacy Hydration Therapy at 100% reimbursement for each day of service. The individual antibiotics/active ingredients are billed separately at the Medicaid allowable cost.

I.V. THERAPY IMPLEMENTATION FORM (DMAS-354)

I.V. THERAPY IMPLEMENTATION FORM

SECTION I:

Recipient Name	
Recipient Medical Number	
Physician Name	
Type of Therapy	
Primary Diagnosis	
Secondary Diagnosis	
Recipient History (as relates to I.V. therapy)	
Therapy Start Date	
Anticipated Therapy End Date	
Route of Administration (type of line and device)	

SECTION II:

MEDICATION	DOSAGE	FREQUENCY	DURATION	START DATE	END DATE

SECTION III:

For TPN ONLY USUAL BODY WEIGHT-----
CURRENT BODY WEIGHT-----

Diagnosis related to GI dysfunction:	
Dietary consultation:	yes no
Enteral Nutrition attempted:	yes no

SECTION IV:

Physician Signature: _____ Date: _____

SECTION V:

Actual End Date of Therapy: _____

Physician Signature: _____ Date: _____

*Note: A new form must be filled out for each new drug added and each new therapy initiated.

PRACTITIONER REFERRAL FORM

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

Patient's Name: _____
 Screener's Name: _____
 Reviewed by Qualified Provider: _____

Date: _____
 Date: _____
 Date: _____

Behavioral Health Risks Screening Tool for Pregnant Women and Women of Childbearing Age

Women and their children's health can be affected by emotional problems, alcohol, tobacco, other drug use and violence. Women and their children's health are also affected when these same problems are present in people who are close to them. Alcohol includes beer, wine, wine coolers, liquor and spirits. Tobacco products include cigarettes, cigars, snuff and chewing tobacco.

Have you smoked any cigarettes or used any tobacco products in the past three months?	TOBACCO	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Did any of your parents have a problem with alcohol or other drug use?	PARENTS	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Do any of your friends have a problem with alcohol or other drug use?	PEERS	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Does your partner have a problem with alcohol or other drug use?	PARTNER	YES <input type="checkbox"/>	NO <input type="checkbox"/>
In the past, have you had difficulties in your life due to alcohol or other drugs, including prescription medications?	PAST	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Check YES if she agrees with any of these statements. In the past month, have you drunk any alcohol or used other drugs? 1. How many days per month do you drink? _____ 2. How many drinks on any given day ? _____ 3. How often did you have 4 or more drinks per day in the last month ? _____	PRESENT	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Check YES if she agrees with any of these statements. In the past 7 days, have you: - Blamed yourself unnecessarily when things went wrong? - Been anxious or worried for no good reason? - Felt scared or panicky for no good reason?	EMOTIONAL HEALTH	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Are you currently or have you ever been in a relationship where you were physically hurt, choked, threatened, controlled, or made to feel afraid?	VIOLENCE	YES <input type="checkbox"/>	NO <input type="checkbox"/>

PROVIDER USE ONLY

Review risk.

Review substance use, set healthy goals.

Review and/or administer full AAS or WEB screening.
See instructions.

Review and/or administer PHQ-9 if not pregnant / Edinburgh PDS-10 if pregnant.
See instructions.

Develop a follow up plan with patient.

Moderate drinking for non-pregnant women is one drink per day. Women who are pregnant or planning to become pregnant should not use alcohol, tobacco, illicit drugs or prescription medication other than as prescribed.

Brief Intervention/Brief Treatment

	Y	N	NA
Did you State your medical concern?			
Did you Advise to abstain or reduce use?			
Did you Check patient's reaction?			
Did you Refer for further assessment?			
Did you Provide written information?			

Patient's Name: _____
 Reviewed by Qualified Provider: _____

Date: _____
 Date: _____

Behavioral Health Risks Screening Tool

for Pregnant Women and Women of Childbearing Age

Women and their children's health can be affected by emotional problems, alcohol, tobacco, other drug use and violence. Women and their children's health are also affected when these same problems are present in people who are close to them. Alcohol includes beer, wine, wine coolers, liquor and spirits. Tobacco products include cigarettes, cigars, snuff and chewing tobacco.

Have you smoked any cigarettes or used any tobacco products in the past three months?		YES <input type="checkbox"/>	NO <input type="checkbox"/>
Did any of your parents have a problem with alcohol or other drug use?	YES <input type="checkbox"/>		NO <input type="checkbox"/>
Do any of your friends have a problem with alcohol or other drug use?	YES <input type="checkbox"/>		NO <input type="checkbox"/>
Does your partner have a problem with alcohol or other drug use?		YES <input type="checkbox"/>	NO <input type="checkbox"/>
In the past, have you had difficulties in your life due to alcohol or other drugs, including prescription medications?		YES <input type="checkbox"/>	NO <input type="checkbox"/>
Check YES if you agree with any of these statements. In the past month, have you drunk any alcohol or used other drugs? 1. How many days per month do you drink? _____ 2. How many drinks on any given day ? _____ 3. How often did you have 4 or more drinks per day in the last month? _____		YES <input type="checkbox"/>	NO <input type="checkbox"/>
Check YES if you agree with any of these statements. In the past 7 days, have you: - Blamed yourself unnecessarily when things went wrong? - Been anxious or worried for no good reason? - Felt scared or panicky for no good reason?			YES <input type="checkbox"/> NO <input type="checkbox"/>
Are you currently or have you ever been in a relationship where you were physically hurt, choked, threatened, controlled, or made to feel afraid?		YES <input type="checkbox"/>	NO <input type="checkbox"/>


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VIRGINIA MEDICAL ASSISTANCE PROGRAM

Abortion Certification

I, Doctor _____, certify that on the

basis of my professional judgment the life of _____ of

(Member Name)

_____ would be substantially endangered if the

(Address)

fetus was carried to term.

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

[illegible]

Signature

Address

Address

National Provider Identifier (NPI)

ACKNOWLEDGMENT OF RECEIPT OF HYSTERECTOMY INFORMATION FORM (DMAS-3005)

VIRGINIA MEDICAL ASSISTANCE PROGRAM

ACKNOWLEDGMENT OF RECEIPT OF HYSTERECTOMY INFORMATION

PATIENT ACKNOWLEDGMENT

Recipient Eligibility Number: _____

It has been explained to _____ of
(Recipient's Name)

_____, _____, _____
(Address) (City & State) (Zip Code)

that the hysterectomy to be performed on her will render her permanently incapable of reproducing.

(Recipient's or Representative's Signature) (Date)

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

PHYSICIAN STATEMENT

I, Doctor _____, certify that the hysterectomy
performed _____ on _____ of
(Date of Operation) (Recipient's Name)

_____, _____, _____
(Address) (City & State) (Zip Code)

(X) MARK THE APPROPRIATE BLOCK

- A ☐ was not performed solely for the purpose of rendering the above mentioned recipient permanently incapable of reproducing nor was the hysterectomy done for medical purposes which by themselves do not mandate a hysterectomy.
- B ☐ was performed under a life-threatening emergency situation which precluded explaining to her that the hysterectomy to be performed would render her permanently incapable of reproducing and obtaining an Acknowledgment of Receipt of Hysterectomy Information. The life-threatening emergency situation was

(A Description of the Nature of the Emergency)

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

(Physician's Signature) (Date)

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

MAP-3005 R 8/84

PHYSICIAN COPY

STERILIZATION CONSENT FORM

NOTICE: YOUR DECISION AT ANY TIME NOT TO BE STERILIZED WILL NOT RESULT IN THE WITHDRAWAL OR WITHHOLDING OF ANY BENEFITS PROVIDED BY PROGRAMS OR PROJECTS RECEIVING FEDERAL FUNDS

■CONSENT TO STERILIZATION■

I have asked for and received information about sterilization from _____.

_____. When I first asked for the
Doctor or Clinic

information, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized. If I decide not to be sterilized, my decision will not affect my right to future care or treatment. I will not lose any help or benefits from programs receiving Federal funds, such as Temporary Assistance for Needy Families (TANF) or Medicaid that I am now getting or for which I may become eligible.

I UNDERSTAND THAT THE STERILIZATION MUST BE CONSIDERED PERMANENT AND NOT REVERSIBLE. I HAVE DECIDED THAT I DO NOT WANT TO BECOME PREGNANT, BEAR CHILDREN OR FATHER CHILDREN.

I was told about those temporary methods of birth control that are available and could be provided to me which will allow me to bear or father a child in the future. I have rejected these alternatives and chosen to be sterilized. I understand that I will be sterilized by an operation known as a _____.

Specify Type of Operation

The discomforts, risks and benefits associated with the operation have been explained to me. All my questions have been answered to my satisfaction. I understand that the operation will not be done until at least thirty days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the withholding of any benefits or medical services provided by federally funded programs.

I am at least 21 years of age and was born on: ____ / ____ / ____ (mm/dd/yy)

I, _____, hereby consent of my own

free will to be sterilized by _____
Doctor or Clinic

by a method called _____
Specify Type of Operation

My consent expires 180 days from the date of my signature below. I also consent to the release of this form and other medical records about the operation to: Representatives of the Department of Health and Human Services or Employees of programs or projects funded by the Department but only for determining if Federal laws were observed. I have received a copy of this form.

Signature (mm/dd/yy)

You are requested to supply the following information, but it is not required:

Race and ethnicity designation (please check):

- ☐ American Indian or Alaska Native
☐ Black (not of Hispanic origin) ☐ Hispanic
☐ Asian or Pacific Islander ☐ White (not of Hispanic origin)

■INTERPRETER'S STATEMENT■

If an interpreter is provided to assist the individual to be sterilized:

I have translated the information and advice presented orally to the individual to be sterilized by the person obtaining this consent. I have also read him/her the consent form in _____ language and

explained its contents to him/her. To the best of my knowledge and belief he/she understood this explanation.

Interpreter's Signature _____ *Date*

■STATEMENT OF PERSON OBTAINING CONSENT■

Before _____ signed
Name of Individual
the consent form, I explained to him/her the nature of sterilization operation

_____ the fact that it is intended

Specify Type of Operation

be a final and irreversible procedure and the discomforts, risks and benefits associated with it. I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent. I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds. To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequences of the procedure.

Signature of Person Obtaining Consent _____ *Date*

Facility

Address

**■PHYSICIAN'S STATEMENT■
(TO BE COMPLETED FOLLOWING SURGERY)**

Shortly before I performed a sterilization operation upon

_____ on ____ / ____ / ____
Name of individual to be sterilized *Date of sterilization*

I explained to him/her the nature of the sterilization operation

_____, the fact that it is intended to

Specify Type of Operation

be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appeared to understand the nature and consequences of the procedure.

(Instructions for use of alternative final paragraph: Use the first paragraph below except in the case of premature delivery or emergency abdominal surgery where the sterilization is performed less than 30 days after the date of the individual's signature on the consent form. In those cases, the second paragraph below must be used. Cross out the paragraph which is not used.)

(1) At least thirty days have passed between the date of the individual's signature on this consent form and the date the sterilization was performed.

(2) This sterilization was performed less than 30 days but more than 72 hours after the date of the individual's signature on this consent form because of the following circumstances (check applicable box and fill in information requested):

☐ Premature delivery / Individual's expected date of delivery: ____ / ____ / ____
(mm/dd/yy)

☐ Emergency abdominal surgery (describe circumstances): _____

Physician's Signature _____ *Date*

ALL APPLICABLE BLANKS MUST BE COMPLETED. STAMPED SIGNATURES ARE NOT ACCEPTABLE. ONE COPY OF THIS FORM MUST BE GIVEN TO THE PATIENT, AND ONE COPY MUST BE ATTACHED TO EACH INVOICE SUBMITTED TO THE VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES FOR PAYMENT.

DMA5 3004 RVSD04052011

Virginia Department of Medical Assistance Services

CONSENTIMIENTO PARA LA ESTERILIZACIÓN

NOTA: LA DECISIÓN DE NO ESTERILIZARSE QUE USTED PUEDE TOMAR EN CUALQUIER MOMENTO, NO CAUSARÁ EL RETIRO O LA RETENCIÓN DE NINGÚN BENEFICIO QUE LE SEA PROPORCIONADO POR PROGRAMAS O PROYECTOS QUE RECIBEN FONDOS FEDERALES.

■CONSENTIMIENTO PARA ESTERILIZACIÓN■

Yo he solicitado y he recibido información de _____
(médico o clínica)

sobre la esterilización. Cuando inicialmente solicité esta información, me dijeron que la decisión de ser esterilizada/o es completamente mía. Me dijeron que yo podía decidir no ser esterilizada/o. Si decido no esterilizarme, mi decisión no afectará mi derecho a recibir tratamiento o cuidados médicos en el futuro. No perderé ninguna asistencia o beneficios de programas patrocinados con fondos federales, tales como el programa de asistencia temporal para familias necesitadas. (TANF) o Medicaid, que recibo actualmente o para los cuales seré elegible.

ENTIENDO QUE LA ESTERILIZACIÓN SE CONSIDERA UNA OPERACIÓN PERMANENTE E IRREVERSIBLE. YO HE DECIDIDO QUE NO QUIERO QUEDAR EMBARAZADA, NO QUIERO TENER HIJOS O NO QUIERO PROCREAR HIJOS.

Me informaron que me pueden proporcionar otros métodos de anticoncepción disponibles que son temporales y que permitirán que pueda tener o procrear hijos en el futuro. He rechazado estas opciones y he decidido ser esterilizada/o.

Entiendo que seré esterilizada/o por medio de una operación conocida como _____. Me han explicado las molestias, los riesgos y los beneficios asociados con la operación. Han respondido satisfactoriamente a todas mis preguntas.

Entiendo que la operación no se realizará hasta que hayan pasado 30 días, como mínimo, a partir de la fecha en la que firme esta Forma. Entiendo que puedo cambiar de opinión en cualquier momento y que mi decisión en cualquier momento de no ser esterilizada/o no resultará en la retención de beneficios o servicios médicos proporcionados a través de programas que reciben fondos federales.

Tengo por lo menos 21 años y nací el: _____
(Día, mes, año)

Yo, _____, por medio de la presente doy mi consentimiento de mi libre voluntad para ser esterilizada/o por _____ por el método
(médico)

llamado _____. Mi consentimiento vence 180 días a partir de la fecha en la que firme este documento.

También doy mi consentimiento para que se presente esta Forma y otros expediente médicos sobre la operación a:

Representantes del Departamento de Salud y Servicios Sociales, o Empleados de programas o proyectos financiados por ese Departamento, pero sólo para que puedan determinar si se han cumplido las leyes federales.

He recibido una copia de esta Forma.

(firma) fecha: _____
(día, mes, año)

Se ruega proporcione la siguiente información, aunque no es obligatorio hacerlo:

Definición de raza y origen étnico (marque uno)

- ☐ Indio Americano/ Nativa de Alaska
☐ Asiático
☐ Negro (No de origen Hispano)
☐ Hispano o latino
☐ Blanco (No de origen Hispano)

■DECLARACIÓN DEL INTÉRPRETE■

Si se han proporcionado los servicios de un intérprete para asistir a la persona que será esterilizada:

He interpretado la información y los consejos que verbalmente se le han presentado a la persona que será esterilizada/o por el individuo que ha obtenido este consentimiento. También le he leído a el/ella la Forma de consentimiento en idioma _____ y le he explicado el contenido de esta forma.

A mi mejor saber y entender, ella/él ha entendido esta explicación.

(firma del intérprete) Fecha: _____
(día, mes, año)

■DECLARACIÓN DE LA PERSONA QUE OBTIENE CONSENTIMIENTO■

Antes de que _____
(nombre de persona)

firmara la Forma de Consentimiento para la Esterilización, le he explicado a ella/él los detalles de la operación _____, para la esterilización, el hecho de que el resultado de este procedimiento es final e irreversible, y las molestias, los riesgos y los beneficios asociados con este procedimiento.

He aconsejado a la persona que será esterilizada que hay disponibles otros métodos de anticoncepción que son temporales. Le he explicado que la esterilización es diferente porque es permanente.

Le he explicado a la persona que será esterilizada que puede retirar su consentimiento en cualquier momento y que ella/él no perderá ningún servicio de salud o beneficio proporcionado con el patrocinio de fondos federales.

A mi mejor saber y entender, la persona que será esterilizada tiene por lo menos 21 años de edad y parece ser mentalmente competente. Ella/él ha solicitado con conocimiento de causa y por libre voluntad ser esterilizada/o y parece entender la naturaleza del procedimiento y sus consecuencias.

(firma de la persona que obtiene el consentimiento) _____
(fecha)

(lugar)

(dirección)

■DECLARACIÓN DEL MÉDICO■

Previamente a realizar la operación para la esterilización a

(nombre de persona esterilizada/o)
en _____
(fecha de esterilización). Le explique a él/ella los detalles de esta operación para la esterilización _____
(especifique tipo de operación)

del hecho de que es un procedimiento con un resultado final e irreversible, y las molestias, los riesgos y los beneficios asociados con esta operación.

Le aconseje a la persona que sería esterilizada que hay disponibles otros métodos de anticoncepción que son temporales. Le expliqué que la esterilización es diferente porque es permanente.

Le informé a la persona que sería esterilizada que podía retirar su consentimiento en cualquier momento y que ella/él no perdería ningún servicio de salud o ningún beneficio proporcionado con el patrocinio de fondos federales.

A mi mejor saber y entender, la persona que será esterilizada tiene por lo menos 21 años de edad y parece ser mentalmente competente. Ella/él ha solicitado con conocimiento de causa y libre voluntad ser esterilizada/o y parece entender el procedimiento y las consecuencias de este procedimiento.

(Instrucciones para uso alternativo de párrafos finales: Utilice el primer párrafo que se presenta a continuación, excepto para casos de parto prematuro y cirugía abdominal de emergencia cuando se ha realizado la esterilización en menos de 30 días después de la fecha en la que la persona firmó la Forma de Consentimiento para la Esterilización. Para esos casos, utilice el segundo párrafo que se presenta a continuación. Tache con una X el párrafo que no se aplique.)

(1) Han transcurrido por lo menos 30 días entre la fecha en la que la persona firmó esta Forma de Consentimiento y la fecha en la que se realizó la esterilización.

(2) La operación para la esterilización se realizó a menos de 30 días, pero a más de 72 horas, después de la fecha en la que la persona firmó la Forma de Consentimiento debido a las siguientes circunstancias

(marque la casilla apropiada y escriba la información requerida):

- ☐ Parto prematuro
 Fecha revista de parto: _____
☐ Cirugía abdominal de urgencia (Describa las circunstancias): _____

(firma del médico) _____
(fecha)

Deberá complete todos los espacios en blanco. No se aceptan firmas por medio de un sello. Una copia de esta forma deberá ser entregada al paciente. Anexar una copia de esta forma en cada factura

**VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
CERTIFICATE OF MEDICAL NECESSITY
DURABLE MEDICAL EQUIPMENT AND SUPPLIES**



SECTION I RECIPIENT DATA

SERVICING PROVIDER

I.D. # _____	I.D. # _____
Name _____	Name _____
D.O.B. _____	Contact Person _____
Phone # () _____	Phone # () _____

Note: The CMN can now be used in place of DMAS-115. The original requirements for justification still apply. Additional questions

SECTION II

RECIPIENT INFORMATION

have been added to the CMN (pg 1-2).

Answer all questions that are applicable to DME service being requested. If answer is yes, you must describe/attach additional information.

DESCRIPTION/ADDITIONAL INFORMATION:
(Additional space on reverse)

Does patient:	<u>YES</u>	<u>NO</u>
1. have impaired mobility?	<input type="checkbox"/>	<input type="checkbox"/>
2. have impaired endurance?	<input type="checkbox"/>	<input type="checkbox"/>
3. have restricted activity?	<input type="checkbox"/>	<input type="checkbox"/>
4. have skin breakdown? (Describe site, size, depth and drainage)	<input type="checkbox"/>	<input type="checkbox"/>
5. have impaired respiration? (Identify most recent PO ₂ _____/Saturation level _____ for patients on oxygen)	<input type="checkbox"/>	<input type="checkbox"/>
6. require assistance with ADL's?	<input type="checkbox"/>	<input type="checkbox"/>
7. have impaired speech?	<input type="checkbox"/>	<input type="checkbox"/>
*** 8. a) require nutritional supplements? (If yes, answer b and c below.)	<input type="checkbox"/>	<input type="checkbox"/>
b) sole source or primary source (circle one)		
c) height _____ weight _____		

IS THE ITEM SUITABLE FOR USE IN HOME, AND DOES THE PATIENT/CAREGIVER DEMONSTRATE WILLINGNESS/ABILITY TO USE THE EQUIPMENT? YES _____ NO _____

Date patient last examined by practitioner _____

ICD9 Code	Clinical Diagnoses	Date of Onset	
		Less than 6 months	Greater than 6 months

SECTION III (ADDITIONAL SPACE ON REVERSE)

Begin Service Date	HCPCS Code	Item Ordered Description*	Length of Time Needed	Quantity Ordered/ x1 Month*	Frequency of Use* Justification/Comments/ Calories Per Day

SECTION IV

PRACTITIONER CERTIFICATION (MUST BE SIGNED AND DATED BY PRACTITIONER)

I CERTIFY THAT THE ORDERED DME AND SUPPLIES ARE PART OF MY TREATMENT PLAN AND, IN MY OPINION, ARE MEDICALLY NECESSARY.

ORDERING PRACTITIONER'S NAME (print)	PRACTITIONER'S SIGNATURE*	DATE*	I.D.#	PHONE #
--	----------------------------------	--------------	--------------	----------------

*Required fields. If any of these fields are blank the CMN is not valid. **Practitioner will be a physician, physician assistant, and a nurse practitioner. Practitioner's signature does not guarantee payment unless all documentation requirements are met. Issuance of a PA does not guarantee payment. Payment is contingent upon all appropriate documentation being readily available for review. ***Complete diet order must be indicated in Section III

RECIPIENT NAME _____	VMAP # _____
SERVICING PROVIDER NAME _____	PROVIDER ID# _____

DESCRIPTION/ADDITIONAL INFORMATION

SECTION II (continued)

*For Nutritional Supplements assessor must document formula tolerance and tube/stoma site assessment if applicable. This can be documented on the CMN or in the supporting documentation, signed and dated by the practitioner. ***Complete diet order must be indicated in Section III

SECTION III (continued)

Begin Service Date	HCPCS Code	*Item Ordered Description	Length of Time Needed	*Quantity Ordered/ x1 Month	Frequency of Use* Justification/Comments/ Caloric Order Per Day

SECTION IV PRACTITIONER CERTIFICATION (MUST BE SIGNED AND DATED BY PRACTITIONER)

I CERTIFY THAT THE ORDERED DME AND SUPPLIES ARE PART OF MY TREATMENT PLAN AND, IN MY OPINION, ARE MEDICALLY NECESSARY.

ORDERING PRACTITIONER'S NAME <small>(print)</small>	PRACTITIONER'S SIGNATURE	DATE	I.D.#	() PHONE #
--	--------------------------	------	-------	---------------------

Section I RECIPIENT DATA

- Complete 12-digit recipient identification number
- Complete recipient full name (last name, first name)
- Complete full date of birth (month, day, year)
- Telephone # (include area code)

SERVICING PROVIDER

- Complete provider number (7-digits)
- Complete provider name
- Complete contact identifying person to call if DMAS has questions

Section II RECIPIENT INFORMATION

- Check **ALL** boxes that apply
- Identify functional limitations related to recipient and need for DME service
- If requesting oxygen, the results of PO₂/Saturation levels must be identified
- Date last examined by practitioner
- ICD9 Code (optional)
- Clinical diagnoses - narrative must be identified. Diagnosis must be related to the item being requested
- Check appropriate line for date of on-set

Section III

- Begin service date (month, day and year)
- Item ordered description: must be narrative description of item ordered (DME vendor may identify by HCPCS Code)
- Length of Time Needed: length of time item will be needed for all durable equipment
- Quantity ordered: identify quantity ordered; for expendable supplies, designate supplies needed for 1 month; if items are required greater than 1 month, note time frame in the Length of Time Needed column (if more than one item is needed but not needed every month then the provider should indicate the appropriate amount (i.e., 1 per 2 month or 1/2M etc.))
- Frequency of Use, Justification/Comments: practitioner's order for frequency of use must be identified

Section IV PRACTITIONER CERTIFICATION

- Practitioner full name (print)
- Must be signed and fully dated by practitioner (**NOTE:** Attached practitioner prescription will **not** be accepted in lieu of practitioner signature/date on this form); **IF ORDERS FOR DME SERVICE ARE WRITTEN ON BOTH SIDES OF FORM, PRACTITIONER MUST SIGN/DATE BOTH SIDES OF FORM**
- Complete practitioner Medicaid provider number (optional)
- Telephone number (include area code)

VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
INFANT HIGH RISK CASE MANAGEMENT
BABY CARE SERVICE AUTHORIZATION REQUEST

Client Information (*Infants up to age 2 only*):

Last Name: _____ First Name: _____ MI: _____

Medicaid/FAMIS ID # _____ Date of birth: ____ / ____ / ____

Case management open date: ____ / ____ / ____ Agency Name: _____

May only begin after face-to-face assessment is completed. Time
spent to initiate contact is not included in case management.

National Provider Identifier: _____

Risk Section: *Check risks that pertain to infant up to age 2.*

Psychosocial	<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>
Hx of or current abuse in home	<input type="checkbox"/>	Caregiver unemployed / lack of financial resources	<input type="checkbox"/>	Needs due to disability	<input type="checkbox"/>
Lack of positive support system	<input type="checkbox"/>	Caregiver communication barriers	<input type="checkbox"/>	Maternal/paternal absence	<input type="checkbox"/>
Unplanned pregnancy	<input type="checkbox"/>	Caregiver did not complete high school	<input type="checkbox"/>	Protective services involvement	<input type="checkbox"/>
Barriers to care present	<input type="checkbox"/>	Caregiver requires parenting education	<input type="checkbox"/>	Poor emotional bonding	<input type="checkbox"/>
Unstable shelter/housing	<input type="checkbox"/>	Multiple medical providers requiring coordination	<input type="checkbox"/>	Caregiver behavioral health dx or symptoms (e.g., PPD)	<input type="checkbox"/>
First time parent/caregiver	<input type="checkbox"/>	Maternal age ≤ 18	<input type="checkbox"/>	Other:	<input type="checkbox"/>
Medical	<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>
Developmental delay concern or diagnosis	<input type="checkbox"/>	Genetic Condition	<input type="checkbox"/>	Caregiver substance use (prescription or illicit)	<input type="checkbox"/>
Fetal alcohol syndrome / substance exposed newborn	<input type="checkbox"/>	Infant chronic illness	<input type="checkbox"/>	Caregiver alcohol abuse	<input type="checkbox"/>
Birth weight ≤ 2500 grams	<input type="checkbox"/>	Significant medical condition (e.g. EBLL)	<input type="checkbox"/>	Caregiver tobacco use	<input type="checkbox"/>
Needs education/support re: following AAP recommended periodicity schedule	<input type="checkbox"/>	Failure to thrive or flattening of growth curve	<input type="checkbox"/>	Other:	<input type="checkbox"/>
Nutritional	<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>
Nutritional education needs	<input type="checkbox"/>	Breast feeding problems	<input type="checkbox"/>	Anemia	<input type="checkbox"/>
Special diet/formula prescribed	<input type="checkbox"/>	Poor use of special formula	<input type="checkbox"/>	Other:	<input type="checkbox"/>
Inadequate sucking	<input type="checkbox"/>	Diet modification need	<input type="checkbox"/>		
<input type="checkbox"/>	Other risks:				

Case Manager's Signature: _____ Date: ____ / ____ / ____

To request BabyCare case management service authorization, please fax completed form to DMAS at 804-612-0043.

VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
MATERNAL HIGH RISK CASE MANAGEMENT
BABY CARE SERVICE AUTHORIZATION REQUEST

Client Information:

Last Name: _____ First Name: _____ MI: _____

Medicaid/FAMIS ID # _____ Prenatal care began: _____

Gravida: _____ Para: _____ AB Elect: _____ AB Spont: _____ EDD: _____ / _____ / _____ (weeks gestation)

Case management open date: _____ / _____ / _____ **Agency Name:** _____

May only begin after face-to-face assessment is completed.
 Time spent to initiate contact is not included in case management.

National Provider Identifier: _____

Risk Section: Check risks that pertain to maternal client.

Psychosocial	<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>
Hx of or current abuse or IPV	<input type="checkbox"/>	Unemployed / lack of financial resources	<input type="checkbox"/>	Needs due to disability	<input type="checkbox"/>
Lack of positive support system	<input type="checkbox"/>	Communication barriers	<input type="checkbox"/>	Maternal/paternal absence	<input type="checkbox"/>
Unplanned pregnancy	<input type="checkbox"/>	Did not complete high school	<input type="checkbox"/>	Protective services involvement	<input type="checkbox"/>
Barriers to care present	<input type="checkbox"/>	Requires increased knowledge re: pregnancy/parenting	<input type="checkbox"/>	Poor emotional bonding / Unwanted pregnancy	<input type="checkbox"/>
Unstable shelter/housing	<input type="checkbox"/>	Multiple medical providers	<input type="checkbox"/>	Behavioral health dx or symptoms (e.g., PPD)	<input type="checkbox"/>
Medical	<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>
Interval from previous pregnancy < 12 months	<input type="checkbox"/>	Uterine anomaly (except fibroids)	<input type="checkbox"/>	Current infection of genital or urinary tract	<input type="checkbox"/>
Multiple gestation	<input type="checkbox"/>	Genetic condition	<input type="checkbox"/>	Substance Use (prescription or illicit)	<input type="checkbox"/>
Previous preterm birth	<input type="checkbox"/>	Previous fetal/infant death	<input type="checkbox"/>	Tobacco Use	<input type="checkbox"/>
Maternal age >35	<input type="checkbox"/>	Previous pregnancy complication	<input type="checkbox"/>	Alcohol Use	<input type="checkbox"/>
Maternal age ≤ 18	<input type="checkbox"/>	Significant medical condition (e.g. DM, PIH, EBLI)	<input type="checkbox"/>		
Nutritional	<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>
Prepregnancy overweight	<input type="checkbox"/>	Nutritional education needs	<input type="checkbox"/>	Anemia	<input type="checkbox"/>
Prepregnancy underweight	<input type="checkbox"/>	Special diet/formula prescribed	<input type="checkbox"/>	Anorexia/Bulimia/Pica	<input type="checkbox"/>
Hyperemesis	<input type="checkbox"/>	Diet modification need	<input type="checkbox"/>	Obesity (BMI ≥ 30)	<input type="checkbox"/>
<input type="checkbox"/>	Other risks:				

Case Manager's Signature: _____ **Date:** _____ / _____ / _____

To request BabyCare case management service authorization, please fax completed form to DMAS at 804-612-0043.

EXCEPTION FOR E/M SERVICES FURNISHED IN CERTAIN PRIMARY CARE CENTERS

Medicare may grant a primary care exception within an approved GME Program in which you are paid for certain E/M services the resident performs when you are not present.

Lower- and Mid-Level E/M Services Included Under Primary Care Exception

New Patient	Established Patient
CPT Code 99201	CPT Code 99211
CPT Code 99202	CPT Code 99212
CPT Code 99203	CPT Code 99213

HCPCS Codes Included Under Primary Care Exception

HCPCS Code	Descriptor
HCPCS Code G0402	Initial preventive physical examination; face-to-face visit, services limited to new beneficiary during the first 12 months of Medicare enrollment
HCPCS Code G0438	Annual wellness visit, includes a personalized prevention plan of service (PPPS), initial visit
HCPCS Code G0439	Annual wellness visit, includes a personalized prevention plan of service (PPPS), subsequent visit

For the exception to apply, a primary care center must attest in writing that all of these conditions are met for a particular residency program:

- The services were furnished in a primary care center located in the outpatient department of a hospital or another ambulatory care entity where the time spent by residents in patient care activities is included in determining DGME payments to a teaching hospital. This requirement is not met when the resident is assigned to a physician's office away from the primary care center or when he or she makes home visits. The non-hospital entity should verify with the MAC that it meets the requirements of a written agreement between the hospital and the entity.
- Residents who furnish billable patient care without your physical presence have completed more than 6 months of an approved residency program.
- You must not supervise more than four residents at any given time and must direct the care from such proximity as to constitute immediate availability.

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- You may include residents who have completed less than 6 months in an approved GME Residency Program in the mix of four residents under your supervision; however, you must be physically present for the critical or key portions of these services (that is, the primary care exception does not apply in the case of residents who have completed less than 6 months in an approved GME Residency Program).
- You must:
 - Have no other responsibilities, including the supervision of other personnel, at the time services are furnished by residents.
 - Have primary medical responsibility for patients cared for by residents.
 - Ensure that the care furnished is reasonable and necessary.
 - Review the care furnished by residents during, or immediately after, each visit. This must include a review of the patient's medical history and diagnosis, the resident's findings on physical examination, and the treatment plan (for example, record of tests and therapies).
 - Document the extent of your participation in the review and direction of the services furnished to each patient.
- The primary care center is considered the patient's primary location for health care services. Residents must be expected to generally furnish care to the same group of established patients during their residency training.

Centers that exercise the primary care exception do not need to obtain prior approval. Primary care centers must maintain records demonstrating that they qualify for the exception.

The types of services furnished by residents under the primary care exception include:

- Acute care for undifferentiated problems or chronic care for ongoing conditions, including chronic mental illness
- Coordination of care furnished by other physicians and providers and
- Comprehensive care not limited by organ system or diagnosis

The residency programs most likely to qualify for the primary care exception include:

- Family practice
- General internal medicine
- Geriatric medicine
- Pediatrics and
- Obstetrics/gynecology

Certain GME Programs in psychiatry may qualify for the primary care exception in special situations (for example, when the Program furnishes comprehensive care for chronically mentally ill patients). The range of services residents are trained to furnish, and actually furnish, at these primary care centers includes comprehensive medical as well as psychiatric care.

§ 32.1-46. Immunization of patients against certain diseases

A. The parent, guardian or person standing in loco parentis of each child within this Commonwealth shall cause such child to be immunized in accordance with the Immunization Schedule developed and published by the Centers for Disease Control and Prevention (CDC), Advisory Committee on Immunization Practices (ACIP), the American Academy of Pediatrics (AAP), and the American Academy of Family Physicians (AAFP). The required immunizations for attendance at a public or private elementary, middle or secondary school, child care center, nursery school, family day care home or developmental center shall be those set forth in the State Board of Health Regulations for the Immunization of School Children. The Board's regulations shall at a minimum require:

1. A minimum of three properly spaced doses of hepatitis B vaccine (HepB).
2. A minimum of three or more properly spaced doses of diphtheria toxoid. One dose shall be administered on or after the fourth birthday.
3. A minimum of three or more properly spaced doses of tetanus toxoid. One dose shall be administered on or after the fourth birthday.
4. A minimum of three or more properly spaced doses of acellular pertussis vaccine. One dose shall be administered on or after the fourth birthday. A booster dose shall be administered prior to entry into the sixth grade.
5. Two or three primary doses of *Haemophilus influenzae* type b (Hib) vaccine, depending on the manufacturer, for children up to 60 months of age.
6. Two properly spaced doses of live attenuated measles (rubeola) vaccine. The first dose shall be administered at age 12 months or older.
7. One dose of live attenuated rubella vaccine shall be administered at age 12 months or older.
8. One dose of live attenuated mumps vaccine shall be administered at age 12 months or older.
9. All children born on and after January 1, 1997, shall be required to have one dose of varicella vaccine on or after 12 months.
10. Three or more properly spaced doses of oral polio vaccine (OPV) or inactivated polio vaccine (IPV). One dose shall be administered on or after the fourth birthday. A fourth dose shall be required if the three dose primary series consisted of a combination of OPV and IPV.
11. One to four doses, dependent on age at first dose, of properly spaced pneumococcal conjugate (PCV) vaccine for children up to 60 months of age.
12. Three doses of properly spaced human papillomavirus (HPV) vaccine for females. The first dose shall be administered before the child enters the sixth grade.

The parent, guardian or person standing in loco parentis may have such child immunized by a physician, physician assistant, nurse practitioner, registered nurse, or licensed practical nurse, or

a pharmacist who administers pursuant to a valid prescription, or may present the child to the appropriate local health department, which shall administer the vaccines required by the State Board of Health Regulations for the Immunization of School Children without charge to the parent of or person standing in loco parentis to the child if (i) the child is eligible for the Vaccines for Children Program or (ii) the child is eligible for coverages issued pursuant to Title XVIII of the Social Security Act, 42 U.S.C. § 1395 et seq. (Medicare), Title XIX of the Social Security Act, 42 U.S.C. § 1396 et seq. (Medicaid), Title XXI of the Social Security Act, 42 U.S.C. § 1397aa et seq. (CHIP), or 10 U.S.C. § 1071 et seq. (CHAMPUS). In all cases in which a child is covered by a health carrier, Medicare, Medicaid, CHIP, or CHAMPUS, the Department shall seek reimbursement from the health carrier, Medicare, Medicaid, CHIP, or CHAMPUS for all allowable costs associated with the provision of the vaccine. For the purposes of this section, the Department shall be deemed a participating provider with a managed care health insurance plan as defined in § 32.1-137.1.

B. A physician, physician assistant, nurse practitioner, registered nurse, licensed practical nurse, pharmacist, or local health department administering a vaccine required by this section shall provide to the person who presents the child for immunizations a certificate that shall state the diseases for which the child has been immunized, the numbers of doses given, the dates when administered and any further immunizations indicated.

C. The vaccines required by this section shall meet the standards prescribed in, and be administered in accordance with, regulations of the Board.

D. The provisions of this section shall not apply if:

1. The parent or guardian of the child objects thereto on the grounds that the administration of immunizing agents conflicts with his religious tenets or practices, unless an emergency or epidemic of disease has been declared by the Board;
2. The parent or guardian presents a statement from a physician licensed to practice medicine in Virginia, a licensed nurse practitioner, or a local health department that states that the physical condition of the child is such that the administration of one or more of the required immunizing agents would be detrimental to the health of the child; or
3. Because the human papillomavirus is not communicable in a school setting, a parent or guardian, at the parent's or guardian's sole discretion, may elect for the parent's or guardian's child not to receive the human papillomavirus vaccine, after having reviewed materials describing the link between the human papillomavirus and cervical cancer approved for such use by the Board.

E. For the purpose of protecting the public health by ensuring that each child receives age-appropriate immunizations, any physician, physician assistant, nurse practitioner, licensed institutional health care provider, local or district health department, the Virginia Immunization Information System, and the Department of Health may share immunization and patient locator information without parental authorization, including, but not limited to, the month, day, and year of each administered immunization; the patient's name, address, telephone number, birth date, and social security number; and the parents' names. The immunization information; the patient's name, address, telephone number, birth date, and social security number; and the parents' names shall be confidential and shall only be shared for the purposes set out in this subsection.

F. The State Board of Health shall review this section annually and make recommendations for

revision by September 1 to the Governor, the General Assembly, and the Joint Commission on Health Care.

Code 1950, § 32-57.1; 1968, c. 592; 1972, c. 558; 1979, c. 711; 1980, c. 410; 1989, c. 382; 1991, c. 133; 1992, cc. 127, 166; 1994, c. [62](#); 1995, cc. [729](#), [742](#); 1996, cc. [67](#), [533](#); 1999, cc. [632](#), [676](#), [738](#); 2000, c. [476](#); 2004, c. [855](#); 2005, cc. [643](#), [684](#); 2006, cc. [364](#), [396](#), [716](#); 2007, cc. [858](#), [922](#); 2011, c. [125](#); 2014, cc. [316](#), [344](#); 2016, c. [81](#).

The chapters of the acts of assembly referenced in the historical citation at the end of this section may not constitute a comprehensive list of such chapters and may exclude chapters whose provisions have expired.

§ 22.1-271.2. Immunization requirements

A. No student shall be admitted by a school unless at the time of admission the student or his parent submits documentary proof of immunization to the admitting official of the school or unless the student is exempted from immunization pursuant to subsection C or is a homeless child or youth as defined in subdivision A 6 of § 22.1-3. If a student does not have documentary proof of immunization, the school shall notify the student or his parent (i) that it has no documentary proof of immunization for the student; (ii) that it may not admit the student without proof unless the student is exempted pursuant to subsection C, including any homeless child or youth as defined in subdivision A 6 of § 22.1-3; (iii) that the student may be immunized and receive certification by a licensed physician, licensed nurse practitioner, registered nurse or an employee of a local health department; and (iv) how to contact the local health department to learn where and when it performs these services. Neither this Commonwealth nor any school or admitting official shall be liable in damages to any person for complying with this section.

Any physician, nurse practitioner, registered nurse or local health department employee performing immunizations shall provide to any person who has been immunized or to his parent, upon request, documentary proof of immunizations conforming with the requirements of this section.

B. Any student whose immunizations are incomplete may be admitted conditionally if that student provides documentary proof at the time of enrollment of having received at least one dose of the required immunizations accompanied by a schedule for completion of the required doses within 90 calendar days. If the student requires more than two doses of hepatitis B vaccine, the conditional enrollment period shall be 180 calendar days.

The immunization record of each student admitted conditionally shall be reviewed periodically until the required immunizations have been received.

Any student admitted conditionally and who fails to comply with his schedule for completion of the required immunizations shall be excluded from school until his immunizations are resumed.

C. No certificate of immunization shall be required for the admission to school of any student if (i) the student or his parent submits an affidavit to the admitting official stating that the administration of immunizing agents conflicts with the student's religious tenets or practices; or (ii) the school has written certification from a licensed physician, licensed nurse practitioner, or local health department that one or more of the required immunizations may be detrimental to the student's health, indicating the specific nature and probable duration of the medical condition or circumstance that contraindicates immunization.

However, if a student is a homeless child or youth as defined in subdivision A 6 of § 22.1-3 and (a) does not have documentary proof of necessary immunizations or has incomplete immunizations and (b) is not exempted from immunization pursuant to clauses (i) or (ii) of this subsection, the school division shall immediately admit such student and shall immediately refer the student to the local school division liaison, as described in the federal McKinney-Vento Homeless Education Assistance Improvements Act of 2001, as amended (42 U.S.C. § 11431 et

seq.)(the Act), who shall assist in obtaining the documentary proof of, or completing, immunization and other services required by such Act.

D. The admitting official of a school shall exclude from the school any student for whom he does not have documentary proof of immunization or notice of exemption pursuant to subsection C, including notice that such student is a homeless child or youth as defined in subdivision A 6 of § 22.1-3.

E. Every school shall record each student's immunizations on the school immunization record. The school immunization record shall be a standardized form provided by the State Department of Health, which shall be a part of the mandatory permanent student record. Such record shall be open to inspection by officials of the State Department of Health and the local health departments.

The school immunization record shall be transferred by the school whenever the school transfers any student's permanent academic or scholastic records.

Within 30 calendar days after the beginning of each school year or entrance of a student, each admitting official shall file a report with the local health department. The report shall be filed on forms prepared by the State Department of Health and shall state the number of students admitted to school with documentary proof of immunization, the number of students who have been admitted with a medical or religious exemption and the number of students who have been conditionally admitted, including those students who are homeless children or youths as defined in subdivision A 6 of § 22.1-3.

F. The requirement for Haemophilus Influenzae Type b immunization as provided in § 32.1-46 shall not apply to any child admitted to any grade level, kindergarten through grade 12.

G. The Board of Health shall promulgate rules and regulations for the implementation of this section in congruence with rules and regulations of the Board of Health promulgated under § 32.1-46 and in cooperation with the Board of Education.

1982, c. 510; 1983, c. 433; 1988, c. 216; 1989, c. 382; 2000, c. 476; 2004, c. 500; 2011, c. 125; 2012, c. 181.

The chapters of the acts of assembly referenced in the historical citation at the end of this section may not constitute a comprehensive list of such chapters and may exclude chapters whose provisions have expired.

12VAC5-110-80. Exemptions from Immunization Requirements.

A. Religious and medical exemptions. No certificate of immunization shall be required of any student for admission to school if:

1. The student or his parent or guardian submits a notarized Certificate of Religious Exemption (Form CRE 1), to the admitting official of the school to which the student is seeking admission. Form CRE 1 is an affidavit stating that the administration of immunizing agents conflicts with the student's religious tenets or practices. The form is available on the Division of Immunization website at <http://www.vdh.virginia.gov/Epidemiology/Immunization/requirements.htm>; or
2. The school has written certification on either of the documents specified under "documentary proof" in 12VAC5-110-10 from a physician, registered nurse, or a local health department that one or more of the required immunizations may be detrimental to the student's health. Such certification of medical exemption shall specify the nature and probable duration of the medical condition or circumstance that contraindicates immunization.
3. Upon the identification of an outbreak, potential epidemic, or epidemic of a vaccine-preventable disease in a public or private school, the commissioner has the authority to require the exclusion from such school of all children who are not immunized against that disease.

B. Demonstration of existing immunity. The demonstration in a student of antibodies against mumps, measles, rubella, or varicella in sufficient quantity to ensure protection of that student against that disease, shall render that student exempt from the immunization requirements contained in 12VAC5-110-70 for the disease in question. Such protection should be demonstrated by means of a serological testing method appropriate for measuring protective antibodies against mumps, measles, rubella, or varicella respectively. Reliable history of chickenpox disease diagnosed or verified by a health care provider shall render students exempt from varicella requirements.

C. HPV vaccine. Because the human papillomavirus is not communicable in a school setting, a parent or guardian, at the parent's or guardian's sole discretion, may elect for the parent's or guardian's child not to receive the HPV vaccine, after having reviewed materials describing the link between the human papillomavirus and cervical cancer approved for such use by the board.

Statutory Authority

§§ 22.1-271.2, 32.1-12, and 32.1-46 of the Code of Virginia.

Historical Notes

Derived from VR355-28-300 § 3.2, eff. August 13, 1992; amended, Virginia Register Volume 26, Issue 11, eff. March 3, 2010; Volume 32, Issue 7, eff. January 14, 2016.

Medical Economics®

When an E/M code can be billed with a physical on the same day

By Renee Dowling

January 25, 2018

Q: Can you clarify when an evaluation and management (E/M) code can be billed with a physical on the same day?

A: This is always a difficult coding scenario to unravel, but there are a couple of things to keep in mind. Current procedural terminology guidelines for preventive medicine state: “If an abnormality is encountered or a preexisting problem is addressed in the process of performing this preventive medicine evaluation and management service and if the problem/abnormality is significant enough to require additional work to perform the key components of a problem oriented E/M service, then the appropriate E/M service should also be reported.”

The guidelines continue: “An insignificant or trivial problem/abnormality that is encountered in the process of performing the preventive medicine evaluation and management service and which does not require additional work and the performance of the key components of a problem-oriented E/M service should not be reported.”

So what does this mean?

Modifier 25 guidance must be followed, as the modifier would need to be appended to the E/M code in this scenario. Medicare and other payers don't expect that a patient, especially an older patient, wouldn't have chronic conditions. However, if those conditions are stable and don't need significant work to address, they would be bundled into the work for the preventive medicine code (99381-99397). Refilling medications and ordering labs for stable chronic conditions are included in the preventive visit. Per the guidelines, this isn't considered significant additional work.

Case Study

A 34-year-old established patient comes in for her yearly physical. During the visit, the physician learns that the patient has gained an abnormal amount of weight since her last appointment. The physician discusses healthy eating habits and exercise with the patient and, with the patient being overweight with a BMI of 26, decides to watch the patient's weight.

In this situation, the preventive visit includes reviewing the patient's weight, anticipatory guidance and risk-factor reduction, so all of the work performed would be included in the preventive medicine code. An additional E/M code would not be supported, so the following would be billed:

99395 (Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; 18-39 years)

- Z00.00 (Encounter for general adult medical exam without abnormal findings)
- R63.5 (Abnormal weight gain)
- E66.3 (Overweight)
- Z68.26 (Body mass index (BMI) 26.0-26.9, adult)

However, if a patient has an acute problem or an exacerbation of a chronic condition that does require additional work that the physician/provider wouldn't normally perform in the course of a physical, an E/M code can be billed in addition to a preventive visit.

In order to code under this scenario, all of the elements performed as part of the physical are counted toward the preventive medicine code. Only those elements that constitute the significant additional work would count toward the E/M code level.

The key is to know when the additional workup is significant enough to warrant a separate code. You must have an illness that requires its own, separate evaluation, with a history or physical exam and medical decision-making all related to that separate problem.

An established E/M code should be billed with a preventive code.



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A BLOG FROM *FPM JOURNAL*

Thursday Apr 19, 2018

How to know when to bill for both preventive and added services

Let's say a patient comes in for a preventive medicine service and you end up also treating an acute or chronic problem. How do you quickly determine if you should add a second service and bill for a separate problem-oriented visit? In other words, when should you bill an office/outpatient service (CPT codes 99212-99215) on the same day as a preventive medicine service (CPT codes 99381-99397) or a Medicare wellness visit (HCPCS codes G0402, G0438, or G0439)?

Here's some quick guidance from CPT: If a new or existing problem is addressed at the time of a preventive service and is significant enough to require additional work to perform the key components of a problem-oriented evaluation and management (E/M) service, you should bill for both services with modifier 25 attached to the latter. Likewise, the Center for Medicare & Medicaid Service's (CMS) guide to wellness visits states that when you furnish a significant, separately identifiable, medically necessary E/M service with a wellness visit, add the E/M service with modifier 25. "That portion of the visit must be medically necessary to treat the beneficiary's illness or injury, or to improve the functioning of a malformed body member," [says CMS](http://www.cms.gov)(www.cms.gov).

In your documentation, you should describe in the history of the present illness all of the patient's acute or chronic conditions and should detail in the assessment and plan how you managed them, making sure to show your extra cognitive work. This could include ordering or reviewing diagnostic tests, renewing prescriptions, making referrals, or implementing other changes to treatment. Note that neither CPT nor CMS requires a change in treatment to support billing for a second separate service.

Family physicians are sometimes reluctant to add this second service because they know the patient will be charged a copay or, depending on the deductible, the full fee for the problem-oriented visit.

However, performing two services but charging for only one isn't reasonable for practice revenue and doesn't follow CPT rules.

— Betsy Nicoletti, a Massachusetts-based coding and billing consultant

Posted at [08:00AM Apr 19, 2018](#) by David Twiddy

https://www.aafp.org/journals/fpm/blogs/gettingpaid/entry/billing_for_preventive_and_added_services.html



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November 16, 2017

How to code for ‘problem’ discovered during preventive medicine visit

from the AAP Division of Health Care Finance

Coding Corner

The *Current Procedural Terminology* (CPT) manual offers guidelines on how to code for a “problem” that is addressed during a preventive medicine service. The guidelines cover “insignificant or trivial” problems as well as those that are “significant.”

“An insignificant or trivial problem/abnormality that is encountered in the process of performing the preventive medicine evaluation and management service and which does not require additional work and the performance of the key components of a problem-oriented E/M service should not be reported,” according to the manual.

“If an abnormality is encountered or a preexisting problem is addressed in the process of performing this preventive medicine E/M service, and if the problem or abnormality is significant enough to require additional work to perform the key components of a problem-oriented E/M service, then the appropriate Office/Outpatient code 99201-99215 should also be reported. Modifier 25 should be added to the Office/Outpatient code to indicate that a significant, separately identifiable E/M service was provided on the same day as the preventive medicine service.”

While CPT does not define what qualifies as “insignificant or trivial” vs. “significant,” consider the following key issues before reporting a separate E/M service in addition to the preventive medicine service:

1. **Significant** – Would the presenting problem have required a separate encounter?

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B W Forsyth et al., *Pediatrics*, 1991

Outcomes of Infant Sleep Problems: A

2. **Separately identifiable** – Did the E/M service require the key components: history, exam and medical decision-making (MDM), or considerable counseling or coordinating care time?

3. **Documentation** – Is there *additional* documentation for the E/M service?

While not absolutes, some issues that can support separate E/M reporting include:

- new condition that requires additional work (e.g., strep throat, depression);
- exacerbation of a chronic condition (e.g., worsening acne);
- new or changed prescription; and
- required follow-up for certain conditions (e.g., asthma, attention-deficit/hyperactivity disorder).

The following are likely to be identified as incidental:

- refill of a medication with no exacerbation (e.g., nasal spray, acne medication);
- minor complaint or finding with very minimal work (e.g., mild diaper rash, mild upper respiratory infection) that may not have resulted in the patient coming in for a separate appointment; and
- chronic condition that is stable and not required to be addressed (e.g., atopic dermatitis).

Coding tips

- Unless billing based on time, history and MDM are the elements typically used to determine the E/M level because more often the exam falls under the “age appropriate exam” subsumed by the accompanying preventive medicine service.
- For new patient encounters, you may bill both codes as “new” patient status; however, you will need to meet the level for all three key components (history, exam and MDM) for the E/M unless billing based on time.
- Separate documentation makes correct E/M code level identification easier for the physician and the auditor.
- You may bill based on time only if the time spent in counseling and/or coordination of care is more than half the total time spent during the encounter. If billing based on time, only count the time spent addressing the “problem”; do not count any time spent on the preventive medicine service.
- The preventive medicine service itself is comprehensive since it includes screening for and anticipatory guidance on age-specific developmental and behavioral risk factors. In pediatrics, physicians follow *Recommendations for Preventive Pediatric Health Care/Bright Futures* in providing preventive medicine services.
- A separate E/M office visit code is required when

Longitudinal Study of Sleep, Behavior, and Maternal Well-Being

Peiyoong Lam et al., Pediatrics, 2003

A quality improvement study to improve inpatient problem list use.

Leigh Anne Bakel et al., Hosp Pediatr, 2014

Are Hospital Characteristics Associated With Parental Views of Pediatric Inpatient Care Quality?

John Patrick T. Co et al., Pediatrics, 2003

Identification and Management of Psychosocial and Developmental Problems in Community-Based, Primary Care Pediatric Practices

Sarah McCue Horwitz et al., Pediatrics, 1992

A singular abstract cauchy problem.

J A Donaldson, Proc Natl Acad Sci U S A, 1970

Three New Versions of the All-ones Problem

Li Xueliang et al., Acta Mathematica Scientia (Series A)

Complexities of Some Problems on Multi-agent Scheduling on a Single Machine

Jin-Jiang Yuan, Journal of the Operations Research Society of China, 2016

The Problem-Oriented Record: Problem Definition

D. Robert Fowler et al., JAMA Psychiatry, 1975

Preexisting Cardiovascular Risk Increases Heart Failure Among Survivors of Non-Hodgkin's Lymphoma

PracticeUpdate, 2017

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management of chronic conditions is needed or new problems are evaluated/treated.

One challenge to reporting preventive medicine services with an office visit to address an acute or chronic problem is that parents may not be prepared for the cost-sharing, for which they most likely will be responsible. It is important to establish an office policy so families are aware of their financial responsibilities (see resources).

Coding examples

A physician spends 45 minutes during a well-adolescent exam for an established patient. The preventive service takes 25 minutes, while 20 minutes is spent addressing the patient's history of depression and thoughts of suicide. Of those 20 minutes, all are documented as counseling time.

99394 [Preventive medicine service, 12 through 17 years] Link to Z00.121 (encounter for routine child health examination with abnormal findings)

99213 25 [20 minutes of time of which more than half was spent in counseling] Link to F33.8 (other recurrent depressive disorders) and Z91.5 (personal history of self-harm)

A physician sees a 6-year-old for a preventive medicine service. During the exam, it is noted that the patient has a red throat. After taking a history of the present illness and looking at the patient's history, a strep test is run and it is positive. The patient is prescribed antibiotics. An expanded problem-focused history and low MDM is documented in addition to the preventive medicine service.

99393[Preventive medicine service, 5 through 11 years] Link to Z00.121

99213 25[History: Expanded Problem Focused; MDM: Low] Link to J02.0 (streptococcal pharyngitis)

Additionally, report the CPT code(s) for the appropriate strep test(s).

Becky Dolan contributed to this article. For coding and billing questions, email AAP coding staff at aapcodinghotline@aap.org.

Resources

- For more information on Recommendations for Preventive Pediatric Health Care/Bright Futures, visit <http://bit.ly/2zUr1vN>.
- For information on developing a cost-sharing policy for your practice, visit <http://bit.ly/2i98JPx>.
- Additional AAP News Coding Corner columns

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19102425D

SENATE BILL NO. 1717

Offered January 15, 2019

A BILL to establish the Commonwealth Care Health Benefits Program; association health plan for the individual market; state innovation waiver.

Patron—Dunnavant

Referred to Committee on Commerce and Labor

Be it enacted by the General Assembly of Virginia:

1. § 1. That the State Corporation Commission (the Commission), through a division within the Commission to be established and designated as the Commonwealth Care Division (the Division), shall establish a nonprofit corporation (the Corporation) that shall have as its purpose the establishment, implementation, and administration of a program to be known as the Commonwealth Care Health Benefits Program (the Program). The Program shall sell and offer for sale individual health insurance coverage through qualifying association health plans. Such health plans shall be offered by the Corporation as a self-insuring entity that will serve as the sponsor of the association health plans. The Corporation shall be subject to oversight by the Division. The implementation of the Program shall occur concurrently with the withdrawal of the Commonwealth from the health benefit exchange (the exchange) operated by the U.S. Secretary of Health and Human Services pursuant to § 1311(b) of the federal Patient Protection and Affordable Care Act, P.L. 111-148, as amended (the ACA). The Division shall work with the Centers for Medicare and Medicaid Services (CMS) to develop and implement the Program. The Program shall include the following elements:

1. Implementation of the Program shall be contingent upon the approval by the U.S. Secretary of Health and Human Services of a state innovation waiver under § 1332 of the ACA (42 U.S.C. § 18052) for the Program that provides federal funding for (i) the Program to offset the elimination of subsidies for eligible individuals previously purchasing health insurance coverage on the health benefit exchange and (ii) a reinsurance program that partially reimburses the Program for high-cost claims, with such attachment points, coinsurance rates, and reinsurance caps as the Corporation's actuary determines appropriate.

2. The Commission shall retain staff sufficient to establish the Division and the Corporation and implement the Program, utilizing such funds, including a treasury loan, as may be appropriated or otherwise made available for such purposes.

3. The Program shall arrange for a number of third-party administrators, sufficient to ensure competition but in no event fewer than two, to process claims, enroll individuals, collect premiums, and otherwise administer the health plans made available through the Program.

4. Each health plan offered through the Program shall provide coverage for health care services provided to enrolled individuals that is not less than the coverage that a large group plan or association health plan subject to the Employee Retirement Income Security Act of 1974 (ERISA) when offered by a self-insuring employer is required to provide, provided that one or more of the health plans shall provide such additional benefits as may be required to provide coverage that is at least as comprehensive and affordable as would be required under health plans currently offered on the exchange pursuant to the ACA or otherwise to comply with the Guardrail requirements of the ACA.

5. The Program shall address the establishment of a reinsurance program as described in clause (ii) of subdivision 1, the selection and compensation of the third-party administrators, the selection and compensation of pharmacy benefits managers, and the establishment of provider networks.

6. The Program shall include subsidization of health plan premiums for individuals with a household income between 100 percent and 400 percent of the federal poverty level, with subsidies weighted for lower-income individuals in a manner consistent with criteria for determining subsidies for policies purchased currently through the exchange.

7. The Program shall include a cost-sharing reduction feature that removes disincentives to Program participation by low-income individuals who are enrolled in the Medicaid program by lowering the copayments, deductibles, and other cost-sharing obligations for which they would otherwise be liable.

8. The establishment of the Program shall not prohibit individuals from purchasing individual health insurance coverage outside the Program.

9. The premiums for the plans offered through the Program shall be set by the third-party administrators, subject to approval by the Commission with assistance of qualified actuaries, and the Program shall address how any shortfall in premiums will be covered.

10. The ongoing costs of the Program are intended to be covered by premiums charged for health

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59 plans offered under the Program and by federal funds provided to the Commonwealth through the state
60 innovation waiver as described in subdivision 1. The Program shall be designed and operated in order
61 to ensure that any shortfall in revenues from such sources is addressed by the reinsurance program
62 described in subdivision 1 (i) and by self-funding a reserve that is determined by the Corporation's
63 actuary to be adequate.

64 11. The Program shall include premium incentives for compliance with wellness or chronic disease
65 management benefit programs.

66 12. The Program shall establish how enrollment is to be conducted, including open enrollment
67 periods, by the Corporation, the third-party administrators, and direct enrollment partners.

68 13. Notwithstanding any provision of Title 38.2 of the Code of Virginia or ERISA to the contrary, the
69 offering or sale by the Corporation of association health plans pursuant to the Program to individuals
70 who are not employees shall be permitted as provided in the Program, provided that the state
71 innovation waiver under § 1332 of the ACA authorizes such activities.

72 **2. That the Commissioner of Insurance shall apply to the U.S. Secretary of Health and Human**
73 **Services under 42 U.S.C. § 18052 for a state innovation waiver to implement the Commonwealth**
74 **Care Health Benefits Program for benefit years beginning January 1, 2021, and future years, to**
75 **maximize federal funding. The waiver application shall clearly state that implementation of the**
76 **Commonwealth Care Health Benefits Program is contingent on approval of the waiver request.**

77 **3. That the Commissioner of Insurance (the Commissioner) shall submit the waiver application to**
78 **the U.S. Secretary of Health and Human Services by January 1, 2020. The Commissioner shall**
79 **make a draft application available for public review and comment by September 1, 2019. The**
80 **Commissioner shall promptly notify the Governor and the Chairmen of the House Committees on**
81 **Appropriations and Commerce and Labor and the Senate Committees on Commerce and Labor**
82 **and Finance of any federal actions regarding the waiver request.**

83 **4. That the provisions of the first enactment of this act shall become effective 30 days following**
84 **the date the Commissioner of Insurance notifies the Governor and the Chairmen of the House**
85 **Committees on Appropriations and Commerce and Labor and the Senate Committees on**
86 **Commerce and Labor and Finance of federal approval of the state innovation request required to**
87 **be submitted by the Commissioner of Insurance pursuant to the second and third enactments of**
88 **this act.**

18102670D

SENATE BILL NO. 732

Offered January 10, 2018

Prefiled January 10, 2018

A BILL to amend and reenact §§ 18.2-308.09, 18.2-308.2:1, 18.2-308.2:2, 18.2-308.2:3, and 19.2-386.28 of the Code of Virginia and to amend the Code of Virginia by adding a section numbered 18.2-308.1:6, relating to purchase, possession, and transport of firearms following certain convictions; permit to restore rights; penalties.

Patron—Favola

Referred to Committee for Courts of Justice

Be it enacted by the General Assembly of Virginia:

1. That §§ 18.2-308.09, 18.2-308.2:1, 18.2-308.2:2, 18.2-308.2:3, and 19.2-386.28 of the Code of Virginia are amended and reenacted and that the Code of Virginia is amended by adding a section numbered 18.2-308.1:6 as follows:

§ 18.2-308.09. Disqualifications for a concealed handgun permit.

The following persons shall be deemed disqualified from obtaining a permit:

1. An individual who is ineligible to possess a firearm pursuant to § 18.2-308.1:1, 18.2-308.1:2, or 18.2-308.1:3, or 18.2-308.1:6 or the substantially similar law of any other state or of the United States.

2. An individual who was ineligible to possess a firearm pursuant to § 18.2-308.1:1 and who was discharged from the custody of the Commissioner pursuant to § 19.2-182.7 less than five years before the date of his application for a concealed handgun permit.

3. An individual who was ineligible to possess a firearm pursuant to § 18.2-308.1:2 and whose competency or capacity was restored pursuant to § 64.2-2012 less than five years before the date of his application for a concealed handgun permit.

4. An individual who was ineligible to possess a firearm under § 18.2-308.1:3 and who was released from commitment less than five years before the date of this application for a concealed handgun permit.

5. An individual who is subject to a restraining order, or to a protective order and prohibited by § 18.2-308.1:4 from purchasing, possessing, or transporting a firearm.

6. An individual who is prohibited by § 18.2-308.2 from possessing or transporting a firearm, except that a permit may be obtained in accordance with subsection C of that section.

7. An individual who has been convicted of two or more misdemeanors within the five-year period immediately preceding the application, if one of the misdemeanors was a Class 1 misdemeanor, but the judge shall have the discretion to deny a permit for two or more misdemeanors that are not Class 1. Traffic infractions and misdemeanors set forth in Title 46.2 shall not be considered for purposes of this disqualification.

8. An individual who is addicted to, or is an unlawful user or distributor of, marijuana, synthetic cannabinoids, or any controlled substance.

9. An individual who has been convicted of a violation of § 18.2-266 or a substantially similar local ordinance, or of public drunkenness, or of a substantially similar offense under the laws of any other state, the District of Columbia, the United States, or its territories within the three-year period immediately preceding the application, or who is a habitual drunkard as determined pursuant to § 4.1-333.

10. An alien other than an alien lawfully admitted for permanent residence in the United States.

11. An individual who has been discharged from the armed forces of the United States under dishonorable conditions.

12. An individual who is a fugitive from justice.

13. An individual who the court finds, by a preponderance of the evidence, based on specific acts by the applicant, is likely to use a weapon unlawfully or negligently to endanger others. The sheriff, chief of police, or attorney for the Commonwealth may submit to the court a sworn, written statement indicating that, in the opinion of such sheriff, chief of police, or attorney for the Commonwealth, based upon a disqualifying conviction or upon the specific acts set forth in the statement, the applicant is likely to use a weapon unlawfully or negligently to endanger others. The statement of the sheriff, chief of police, or the attorney for the Commonwealth shall be based upon personal knowledge of such individual or of a deputy sheriff, police officer, or assistant attorney for the Commonwealth of the specific acts, or upon a written statement made under oath before a notary public of a competent person having personal knowledge of the specific acts.

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14. An individual who has been convicted of any assault, assault and battery, sexual battery, discharging of a firearm in violation of § 18.2-280 or 18.2-286.1 or brandishing of a firearm in violation of § 18.2-282 within the three-year period immediately preceding the application.

15. An individual who has been convicted of stalking.

16. An individual whose previous convictions or adjudications of delinquency were based on an offense that would have been at the time of conviction a felony if committed by an adult under the laws of any state, the District of Columbia, the United States or its territories. For purposes of this disqualifier, only convictions occurring within 16 years following the later of the date of (i) the conviction or adjudication or (ii) release from any incarceration imposed upon such conviction or adjudication shall be deemed to be "previous convictions." Disqualification under this subdivision shall not apply to an individual with previous adjudications of delinquency who has completed a term of service of no less than two years in the Armed Forces of the United States and, if such person has been discharged from the Armed Forces of the United States, received an honorable discharge.

17. An individual who has a felony charge pending or a charge pending for an offense listed in subdivision 14 or 15.

18. An individual who has received mental health treatment or substance abuse treatment in a residential setting within five years prior to the date of his application for a concealed handgun permit.

19. An individual not otherwise ineligible pursuant to this article, who, within the three-year period immediately preceding the application for the permit, was found guilty of any criminal offense set forth in Article 1 (§ 18.2-247 et seq.) or former § 18.2-248.1:1 or of a criminal offense of illegal possession or distribution of marijuana, synthetic cannabinoids, or any controlled substance, under the laws of any state, the District of Columbia, or the United States or its territories.

20. An individual, not otherwise ineligible pursuant to this article, with respect to whom, within the three-year period immediately preceding the application, upon a charge of any criminal offense set forth in Article 1 (§ 18.2-247 et seq.) or former § 18.2-248.1:1 or upon a charge of illegal possession or distribution of marijuana, synthetic cannabinoids, or any controlled substance under the laws of any state, the District of Columbia, or the United States or its territories, the trial court found that the facts of the case were sufficient for a finding of guilt and disposed of the case pursuant to § 18.2-251 or the substantially similar law of any other state, the District of Columbia, or the United States or its territories.

§ 18.2-308.1:6. Purchase, possession, or transportation of firearms following certain criminal convictions; process to restore rights; penalty.

A. 1. Any person who knowingly and intentionally purchases, possesses, or transports any firearm following a misdemeanor conviction for an offense that occurred on or after July 1, 2018, for the offense of (i) stalking in violation of § 18.2-60.3, (ii) sexual battery in violation of § 18.2-67.4, (iii) assault and battery of a family or household member, (iv) brandishing a firearm in violation of § 18.2-282, or (v) any offense substantially similar to clause (i), (ii), (iii), or (iv) in the laws of any other state or of the United States is guilty of a Class 1 misdemeanor.

2. Any person who knowingly and intentionally purchases, possesses, or transports any firearm following two or more misdemeanor convictions for offenses that occurred on or after July 1, 2018, for the offense of (i) assault and battery in violation of § 18.2-57 or (ii) any offense substantially similar to clause (i) in the laws of any other state or of the United States is guilty of a Class 1 misdemeanor.

B. Any person prohibited from purchasing, possessing, or transporting a firearm described under this section may, no earlier than two years from the date of conviction, petition the circuit court of the jurisdiction in which he resides, or the circuit court of the county or city where he was last convicted of an offense listed in subsection A, for a permit to possess or carry a firearm. A copy of the petition shall be mailed or delivered to the attorney for the Commonwealth for the jurisdiction where the petition was filed, who shall be entitled to respond and represent the interests of the Commonwealth. The court shall conduct a hearing if requested by either party. The court may, in its discretion and for good cause shown, grant such petition and issue a permit. The prohibitions of subsection A shall not apply to any person who has been granted a permit pursuant to this subsection. The clerk of court shall certify and forward forthwith to the Central Criminal Records Exchange, on a form provided by the Exchange, a copy of any such order.

C. For the purposes of this section, "family or household member" has the same meaning as in § 16.1-228.

§ 18.2-308.2:1. Prohibiting the selling, etc., of firearms to certain persons.

Any person who sells, barter, gives or furnishes, or has in his possession or under his control with the intent of selling, bartering, giving or furnishing, any firearm to any person he knows is prohibited from possessing or transporting a firearm pursuant to § 18.2-308.1:1, 18.2-308.1:2, 18.2-308.1:3, 18.2-308.1:6, 18.2-308.2, subsection B of § 18.2-308.2:01, or § 18.2-308.7 shall be is guilty of a Class 4 felony. However, this prohibition shall not be applicable when the person convicted of the felony or misdemeanor, adjudicated delinquent or acquitted by reason of insanity has (i) been issued a permit

pursuant to subsection C of § 18.2-308.2 or subsection B of § 18.2-308.1:6 or been granted relief pursuant to subsection B of § 18.2-308.1:1, or § 18.2-308.1:2 or 18.2-308.1:3; (ii) been pardoned or had his political disabilities removed in accordance with subsection B of § 18.2-308.2; or (iii) obtained a permit to ship, transport, possess or receive firearms pursuant to the laws of the United States.

§ 18.2-308.2:2. Criminal history record information check required for the transfer of certain firearms.

A. Any person purchasing from a dealer a firearm as herein defined shall consent in writing, on a form to be provided by the Department of State Police, to have the dealer obtain criminal history record information. Such form shall include only the written consent; the name, birth date, gender, race, citizenship, and social security number and/or any other identification number; the number of firearms by category intended to be sold, rented, traded, or transferred; and answers by the applicant to the following questions: (i) has the applicant been convicted of a felony offense or a misdemeanor listed in § 18.2-308.1:6 or found guilty or adjudicated delinquent as a juvenile 14 years of age or older at the time of the offense of a delinquent act that if committed by an adult would be a felony if committed by an adult or is a misdemeanor listed in § 18.2-308.1:6; (ii) is the applicant subject to a court order restraining the applicant from harassing, stalking, or threatening the applicant's child or intimate partner, or a child of such partner, or is the applicant subject to a protective order; and (iii) has the applicant ever been acquitted by reason of insanity and prohibited from purchasing, possessing or transporting a firearm pursuant to § 18.2-308.1:1 or any substantially similar law of any other jurisdiction, been adjudicated legally incompetent, mentally incapacitated or adjudicated an incapacitated person and prohibited from purchasing a firearm pursuant to § 18.2-308.1:2 or any substantially similar law of any other jurisdiction, or been involuntarily admitted to an inpatient facility or involuntarily ordered to outpatient mental health treatment and prohibited from purchasing a firearm pursuant to § 18.2-308.1:3 or any substantially similar law of any other jurisdiction.

B. 1. No dealer shall sell, rent, trade or transfer from his inventory any such firearm to any other person who is a resident of Virginia until he has (i) obtained written consent and the other information on the consent form specified in subsection A, and provided the Department of State Police with the name, birth date, gender, race, citizenship, and social security and/or any other identification number and the number of firearms by category intended to be sold, rented, traded or transferred and (ii) requested criminal history record information by a telephone call to or other communication authorized by the State Police and is authorized by subdivision 2 to complete the sale or other such transfer. To establish personal identification and residence in Virginia for purposes of this section, a dealer must require any prospective purchaser to present one photo-identification form issued by a governmental agency of the Commonwealth or by the United States Department of Defense that demonstrates that the prospective purchaser resides in Virginia. For the purposes of this section and establishment of residency for firearm purchase, residency of a member of the armed forces shall include both the state in which the member's permanent duty post is located and any nearby state in which the member resides and from which he commutes to the permanent duty post. A member of the armed forces whose photo identification issued by the Department of Defense does not have a Virginia address may establish his Virginia residency with such photo identification and either permanent orders assigning the purchaser to a duty post, including the Pentagon, in Virginia or the purchaser's Leave and Earnings Statement. When the photo identification presented to a dealer by the prospective purchaser is a driver's license or other photo identification issued by the Department of Motor Vehicles, and such identification form contains a date of issue, the dealer shall not, except for a renewed driver's license or other photo identification issued by the Department of Motor Vehicles, sell or otherwise transfer a firearm to the prospective purchaser until 30 days after the date of issue of an original or duplicate driver's license unless the prospective purchaser also presents a copy of his Virginia Department of Motor Vehicles driver's record showing that the original date of issue of the driver's license was more than 30 days prior to the attempted purchase.

In addition, no dealer shall sell, rent, trade, or transfer from his inventory any assault firearm to any person who is not a citizen of the United States or who is not a person lawfully admitted for permanent residence.

Upon receipt of the request for a criminal history record information check, the State Police shall (a) review its criminal history record information to determine if the buyer or transferee is prohibited from possessing or transporting a firearm by state or federal law, (b) inform the dealer if its record indicates that the buyer or transferee is so prohibited, and (c) provide the dealer with a unique reference number for that inquiry.

2. The State Police shall provide its response to the requesting dealer during the dealer's request, or by return call without delay. If the criminal history record information check indicates the prospective purchaser or transferee has a disqualifying criminal record or has been acquitted by reason of insanity and committed to the custody of the Commissioner of Behavioral Health and Developmental Services,

the State Police shall have until the end of the dealer's next business day to advise the dealer if its records indicate the buyer or transferee is prohibited from possessing or transporting a firearm by state or federal law. If not so advised by the end of the dealer's next business day, a dealer who has fulfilled the requirements of subdivision 1 may immediately complete the sale or transfer and shall not be deemed in violation of this section with respect to such sale or transfer. In case of electronic failure or other circumstances beyond the control of the State Police, the dealer shall be advised immediately of the reason for such delay and be given an estimate of the length of such delay. After such notification, the State Police shall, as soon as possible but in no event later than the end of the dealer's next business day, inform the requesting dealer if its records indicate the buyer or transferee is prohibited from possessing or transporting a firearm by state or federal law. A dealer who fulfills the requirements of subdivision 1 and is told by the State Police that a response will not be available by the end of the dealer's next business day may immediately complete the sale or transfer and shall not be deemed in violation of this section with respect to such sale or transfer.

3. Except as required by subsection D of § 9.1-132, the State Police shall not maintain records longer than 30 days, except for multiple handgun transactions for which records shall be maintained for 12 months, from any dealer's request for a criminal history record information check pertaining to a buyer or transferee who is not found to be prohibited from possessing and transporting a firearm under state or federal law. However, the log on requests made may be maintained for a period of 12 months, and such log shall consist of the name of the purchaser, the dealer identification number, the unique approval number and the transaction date.

4. On the last day of the week following the sale or transfer of any firearm, the dealer shall mail or deliver the written consent form required by subsection A to the Department of State Police. The State Police shall immediately initiate a search of all available criminal history record information to determine if the purchaser is prohibited from possessing or transporting a firearm under state or federal law. If the search discloses information indicating that the buyer or transferee is so prohibited from possessing or transporting a firearm, the State Police shall inform the chief law-enforcement officer in the jurisdiction where the sale or transfer occurred and the dealer without delay.

5. Notwithstanding any other provisions of this section, rifles and shotguns may be purchased by persons who are citizens of the United States or persons lawfully admitted for permanent residence but residents of other states under the terms of subsections A and B upon furnishing the dealer with one photo-identification form issued by a governmental agency of the person's state of residence and one other form of identification determined to be acceptable by the Department of Criminal Justice Services.

6. For the purposes of this subsection, the phrase "dealer's next business day" shall not include December 25.

C. No dealer shall sell, rent, trade or transfer from his inventory any firearm, except when the transaction involves a rifle or a shotgun and can be accomplished pursuant to the provisions of subdivision B 5 to any person who is not a resident of Virginia unless he has first obtained from the Department of State Police a report indicating that a search of all available criminal history record information has not disclosed that the person is prohibited from possessing or transporting a firearm under state or federal law. The dealer shall obtain the required report by mailing or delivering the written consent form required under subsection A to the State Police within 24 hours of its execution. If the dealer has complied with the provisions of this subsection and has not received the required report from the State Police within 10 days from the date the written consent form was mailed to the Department of State Police, he shall not be deemed in violation of this section for thereafter completing the sale or transfer.

D. Nothing herein shall prevent a resident of the Commonwealth, at his option, from buying, renting or receiving a firearm from a dealer in Virginia by obtaining a criminal history record information check through the dealer as provided in subsection C.

E. If any buyer or transferee is denied the right to purchase a firearm under this section, he may exercise his right of access to and review and correction of criminal history record information under § 9.1-132 or institute a civil action as provided in § 9.1-135, provided any such action is initiated within 30 days of such denial.

F. Any dealer who willfully and intentionally requests, obtains, or seeks to obtain criminal history record information under false pretenses, or who willfully and intentionally disseminates or seeks to disseminate criminal history record information except as authorized in this section shall be guilty of a Class 2 misdemeanor.

G. For purposes of this section:

"Actual buyer" means a person who executes the consent form required in subsection B or C, or other such firearm transaction records as may be required by federal law.

"Antique firearm" means:

1. Any firearm (including any firearm with a matchlock, flintlock, percussion cap, or similar type of ignition system) manufactured in or before 1898;

2. Any replica of any firearm described in subdivision 1 of this definition if such replica (i) is not designed or redesigned for using rimfire or conventional centerfire fixed ammunition or (ii) uses rimfire or conventional centerfire fixed ammunition that is no longer manufactured in the United States and that is not readily available in the ordinary channels of commercial trade;

3. Any muzzle-loading rifle, muzzle-loading shotgun, or muzzle-loading pistol that is designed to use black powder, or a black powder substitute, and that cannot use fixed ammunition. For purposes of this subdivision, the term "antique firearm" shall not include any weapon that incorporates a firearm frame or receiver, any firearm that is converted into a muzzle-loading weapon, or any muzzle-loading weapon that can be readily converted to fire fixed ammunition by replacing the barrel, bolt, breech-block, or any combination thereof; or

4. Any curio or relic as defined in this subsection.

"Assault firearm" means any semi-automatic center-fire rifle or pistol which expels single or multiple projectiles by action of an explosion of a combustible material and is equipped at the time of the offense with a magazine which will hold more than 20 rounds of ammunition or designed by the manufacturer to accommodate a silencer or equipped with a folding stock.

"Curios or relics" means firearms that are of special interest to collectors by reason of some quality other than is associated with firearms intended for sporting use or as offensive or defensive weapons. To be recognized as curios or relics, firearms must fall within one of the following categories:

1. Firearms that were manufactured at least 50 years prior to the current date, which use rimfire or conventional centerfire fixed ammunition that is no longer manufactured in the United States and that is not readily available in the ordinary channels of commercial trade, but not including replicas thereof;

2. Firearms that are certified by the curator of a municipal, state, or federal museum that exhibits firearms to be curios or relics of museum interest; and

3. Any other firearms that derive a substantial part of their monetary value from the fact that they are novel, rare, bizarre, or because of their association with some historical figure, period, or event. Proof of qualification of a particular firearm under this category may be established by evidence of present value and evidence that like firearms are not available except as collectors' items, or that the value of like firearms available in ordinary commercial channels is substantially less.

"Dealer" means any person licensed as a dealer pursuant to 18 U.S.C. § 921 et seq.

"Firearm" means any handgun, shotgun, or rifle that will or is designed to or may readily be converted to expel single or multiple projectiles by action of an explosion of a combustible material.

"Handgun" means any pistol or revolver or other firearm originally designed, made and intended to fire single or multiple projectiles by means of an explosion of a combustible material from one or more barrels when held in one hand.

"Lawfully admitted for permanent residence" means the status of having been lawfully accorded the privilege of residing permanently in the United States as an immigrant in accordance with the immigration laws, such status not having changed.

H. The Department of Criminal Justice Services shall promulgate regulations to ensure the identity, confidentiality and security of all records and data provided by the Department of State Police pursuant to this section.

I. The provisions of this section shall not apply to (i) transactions between persons who are licensed as firearms importers or collectors, manufacturers or dealers pursuant to 18 U.S.C. § 921 et seq.; (ii) purchases by or sales to any law-enforcement officer or agent of the United States, the Commonwealth or any local government, or any campus police officer appointed under Article 3 (§ 23.1-809 et seq.) of Chapter 8 of Title 23.1; or (iii) antique firearms, curios or relics.

J. The provisions of this section shall not apply to restrict purchase, trade or transfer of firearms by a resident of Virginia when the resident of Virginia makes such purchase, trade or transfer in another state, in which case the laws and regulations of that state and the United States governing the purchase, trade or transfer of firearms shall apply. A National Instant Criminal Background Check System (NICS) check shall be performed prior to such purchase, trade or transfer of firearms.

J1. All licensed firearms dealers shall collect a fee of \$2 for every transaction for which a criminal history record information check is required pursuant to this section, except that a fee of \$5 shall be collected for every transaction involving an out-of-state resident. Such fee shall be transmitted to the Department of State Police by the last day of the month following the sale for deposit in a special fund for use by the State Police to offset the cost of conducting criminal history record information checks under the provisions of this section.

K. Any person willfully and intentionally making a materially false statement on the consent form required in subsection B or C or on such firearm transaction records as may be required by federal law, shall be guilty of a Class 5 felony.

L. Except as provided in § 18.2-308.2:1, any dealer who willfully and intentionally sells, rents, trades or transfers a firearm in violation of this section shall be guilty of a Class 6 felony.

305 L1. Any person who attempts to solicit, persuade, encourage, or entice any dealer to transfer or
306 otherwise convey a firearm other than to the actual buyer, as well as any other person who willfully and
307 intentionally aids or abets such person, shall be guilty of a Class 6 felony. This subsection shall not
308 apply to a federal law-enforcement officer or a law-enforcement officer as defined in § 9.1-101, in the
309 performance of his official duties, or other person under his direct supervision.

310 M. Any person who purchases a firearm with the intent to (i) resell or otherwise provide such
311 firearm to any person who he knows or has reason to believe is ineligible to purchase or otherwise
312 receive from a dealer a firearm for whatever reason or (ii) transport such firearm out of the
313 Commonwealth to be resold or otherwise provided to another person who the transferor knows is
314 ineligible to purchase or otherwise receive a firearm, shall be guilty of a Class 4 felony and sentenced to
315 a mandatory minimum term of imprisonment of one year. However, if the violation of this subsection
316 involves such a transfer of more than one firearm, the person shall be sentenced to a mandatory
317 minimum term of imprisonment of five years. The prohibitions of this subsection shall not apply to the
318 purchase of a firearm by a person for the lawful use, possession, or transport thereof, pursuant to
319 § 18.2-308.7, by his child, grandchild, or individual for whom he is the legal guardian if such child,
320 grandchild, or individual is ineligible, solely because of his age, to purchase a firearm.

321 N. Any person who is ineligible to purchase or otherwise receive or possess a firearm in the
322 Commonwealth who solicits, employs or assists any person in violating subsection M shall be guilty of
323 a Class 4 felony and shall be sentenced to a mandatory minimum term of imprisonment of five years.

324 O. Any mandatory minimum sentence imposed under this section shall be served consecutively with
325 any other sentence.

326 P. All driver's licenses issued on or after July 1, 1994, shall carry a letter designation indicating
327 whether the driver's license is an original, duplicate or renewed driver's license.

328 Q. Prior to selling, renting, trading, or transferring any firearm owned by the dealer but not in his
329 inventory to any other person, a dealer may require such other person to consent to have the dealer
330 obtain criminal history record information to determine if such other person is prohibited from
331 possessing or transporting a firearm by state or federal law. The Department of State Police shall
332 establish policies and procedures in accordance with 28 C.F.R. § 25.6 to permit such determinations to
333 be made by the Department of State Police, and the processes established for making such
334 determinations shall conform to the provisions of this section.

335 **§ 18.2-308.2:3. Criminal background check required for employees of a gun dealer to transfer**
336 **firearms; exemptions; penalties.**

337 A. No person, corporation, or proprietorship licensed as a firearms dealer pursuant to 18 U.S.C.
338 § 921 et seq. shall employ any person to act as a seller, whether full-time or part-time, permanent,
339 temporary, paid or unpaid, for the transfer of firearms under § 18.2-308.2:2, if such employee would be
340 prohibited from possessing a firearm under § 18.2-308.1:1, 18.2-308.1:2, ~~or~~ 18.2-308.1:3, subsection B
341 of § 18.2-308.1:4, or § 18.2-308.1:6, 18.2-308.2, or 18.2-308.2:01, or is an illegal alien, or is prohibited
342 from purchasing or transporting a firearm pursuant to subsection A of § 18.2-308.1:4 or § 18.2-308.1:5.

343 B. Prior to permitting an applicant to begin employment, the dealer shall obtain a written statement
344 or affirmation from the applicant that he is not disqualified from possessing a firearm and shall submit
345 the applicant's fingerprints and personal descriptive information to the Central Criminal Records
346 Exchange to be forwarded to the Federal Bureau of Investigation (FBI) for the purpose of obtaining
347 national criminal history record information regarding the applicant.

348 C. Prior to August 1, 2000, the dealer shall obtain written statements or affirmations from persons
349 employed before July 1, 2000, to act as a seller under § 18.2-308.2:2 that they are not disqualified from
350 possessing a firearm. Within five working days of the employee's next birthday, after August 1, 2000,
351 the dealer shall submit the employee's fingerprints and personal descriptive information to the Central
352 Criminal Records Exchange to be forwarded to the Federal Bureau of Investigation (FBI) for the
353 purpose of obtaining national criminal history record information regarding the request.

354 C1. In lieu of submitting fingerprints pursuant to this section, any dealer holding a valid federal
355 firearms license (FFL) issued by the Bureau of Alcohol, Tobacco and Firearms (ATF) may submit a
356 sworn and notarized affidavit to the Department of State Police on a form provided by the Department,
357 stating that the dealer has been subjected to a record check prior to the issuance and that the FFL was
358 issued by the ATF. The affidavit may also contain the names of any employees that have been subjected
359 to a record check and approved by the ATF. This exemption shall apply regardless of whether the FFL
360 was issued in the name of the dealer or in the name of the business. The affidavit shall contain the valid
361 FFL number, state the name of each person requesting the exemption, together with each person's
362 identifying information, including their social security number and the following statement: "I hereby
363 swear, under the penalty of perjury, that as a condition of obtaining a federal firearms license, each
364 person requesting an exemption in this affidavit has been subjected to a fingerprint identification check
365 by the Bureau of Alcohol, Tobacco and Firearms and the Bureau of Alcohol, Tobacco and Firearms
366 subsequently determined that each person satisfied the requirements of 18 U.S.C. § 921 et seq. I

understand that any person convicted of making a false statement in this affidavit is guilty of a Class 5 felony and that in addition to any other penalties imposed by law, a conviction under this section shall result in the forfeiture of my federal firearms license."

D. The Department of State Police, upon receipt of an individual's record or notification that no record exists, shall submit an eligibility report to the requesting dealer within 30 days of the applicant beginning his duties for new employees or within 30 days of the applicant's birthday for a person employed prior to July 1, 2000.

E. If any applicant is denied employment because of information appearing on the criminal history record and the applicant disputes the information upon which the denial was based, the Central Criminal Records Exchange shall, upon written request, furnish to the applicant the procedures for obtaining a copy of the criminal history record from the Federal Bureau of Investigation. The information provided to the dealer shall not be disseminated except as provided in this section.

F. The applicant shall bear the cost of obtaining the criminal history record unless the dealer, at his option, decides to pay such cost.

G. Upon receipt of the request for a criminal history record information check, the State Police shall establish a unique number for that firearm seller. Beginning September 1, 2001, the firearm seller's signature, firearm seller's number and the dealer's identification number shall be on all firearm transaction forms. The State Police shall void the firearm seller's number when a disqualifying record is discovered. The State Police may suspend a firearm seller's identification number upon the arrest of the firearm seller for a potentially disqualifying crime.

H. This section shall not restrict the transfer of a firearm at any place other than at a dealership or at any event required to be registered as a gun show.

I. Any person who willfully and intentionally requests, obtains, or seeks to obtain criminal history record information under false pretenses, or who willfully and intentionally disseminates or seeks to disseminate criminal history record information except as authorized by this section and § 18.2-308.2:2, shall be guilty of a Class 2 misdemeanor.

J. Any person willfully and intentionally making a materially false statement on the personal descriptive information required in this section shall be guilty of a Class 5 felony. Any person who offers for transfer any firearm in violation of this section shall be guilty of a Class 1 misdemeanor. Any dealer who willfully and knowingly employs or permits a person to act as a firearm seller in violation of this section shall be guilty of a Class 1 misdemeanor.

K. There is no civil liability for any seller for the actions of any purchaser or subsequent transferee of a firearm lawfully transferred pursuant to this section.

L. The provisions of this section requiring a seller's background check shall not apply to a licensed dealer.

M. Any person who willfully and intentionally makes a false statement in the affidavit as set out in subdivision C 1 shall be guilty of a Class 5 felony.

N. For purposes of this section:

"Dealer" means any person, corporation or proprietorship licensed as a dealer pursuant to 18 U.S.C. § 921 et seq.

"Firearm" means any handgun, shotgun, or rifle that will or is designed to or may readily be converted to expel single or multiple projectiles by action of an explosion of a combustible material.

"Place of business" means any place or premises where a dealer may lawfully transfer firearms.

"Seller" means for the purpose of any single sale of a firearm any person who is a dealer or an agent of a dealer, who may lawfully transfer firearms and who actually performs the criminal background check in accordance with the provisions of § 18.2-308.2:2.

"Transfer" means any act performed with intent to sell, rent, barter, trade or otherwise transfer ownership or permanent possession of a firearm at the place of business of a dealer.

§ 19.2-386.28. Forfeiture of weapons that are concealed, possessed, transported or carried in violation of law.

Any firearm, any stun weapon as defined by § 18.2-308.1, or any weapon concealed, possessed, transported, or carried in violation of § 18.2-283.1, 18.2-287.01, 18.2-287.4, 18.2-308.1:2, 18.2-308.1:3, 18.2-308.1:4, 18.2-308.1:6, 18.2-308.2, 18.2-308.2:01, 18.2-308.2:1, 18.2-308.4, 18.2-308.5, 18.2-308.7, or 18.2-308.8 shall be forfeited to the Commonwealth and disposed of as provided in § 19.2-386.29.

2. That the provisions of this act may result in a net increase in periods of imprisonment or commitment. Pursuant to § 30-19.1:4, the estimated amount of the necessary appropriation cannot be determined for periods of imprisonment in state adult correctional facilities; therefore, Chapter 836 of the Acts of Assembly of 2017 requires the Virginia Criminal Sentencing Commission to assign a minimum fiscal impact of \$50,000. Pursuant to § 30-19.1:4, the estimated amount of the necessary appropriation cannot be determined for periods of commitment to the custody of the Department of Juvenile Justice.

Syllabus

NOTE: Where it is feasible, a syllabus (headnote) will be released, as is being done in connection with this case, at the time the opinion is issued. The syllabus constitutes no part of the opinion of the Court but has been prepared by the Reporter of Decisions for the convenience of the reader. See *United States v. Detroit Timber & Lumber Co.*, 200 U. S. 321, 337.

SUPREME COURT OF THE UNITED STATES

Syllabus

DISTRICT OF COLUMBIA ET AL. *v.* HELLERCERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR
THE DISTRICT OF COLUMBIA CIRCUIT

No. 07–290. Argued March 18, 2008—Decided June 26, 2008

District of Columbia law bans handgun possession by making it a crime to carry an unregistered firearm and prohibiting the registration of handguns; provides separately that no person may carry an unlicensed handgun, but authorizes the police chief to issue 1-year licenses; and requires residents to keep lawfully owned firearms unloaded and disassembled or bound by a trigger lock or similar device. Respondent Heller, a D. C. special policeman, applied to register a handgun he wished to keep at home, but the District refused. He filed this suit seeking, on Second Amendment grounds, to enjoin the city from enforcing the bar on handgun registration, the licensing requirement insofar as it prohibits carrying an unlicensed firearm in the home, and the trigger-lock requirement insofar as it prohibits the use of functional firearms in the home. The District Court dismissed the suit, but the D. C. Circuit reversed, holding that the Second Amendment protects an individual's right to possess firearms and that the city's total ban on handguns, as well as its requirement that firearms in the home be kept nonfunctional even when necessary for self-defense, violated that right.

Held:

1. The Second Amendment protects an individual right to possess a firearm unconnected with service in a militia, and to use that arm for traditionally lawful purposes, such as self-defense within the home. Pp. 2–53.

(a) The Amendment's prefatory clause announces a purpose, but does not limit or expand the scope of the second part, the operative clause. The operative clause's text and history demonstrate that it connotes an individual right to keep and bear arms. Pp. 2–22.

(b) The prefatory clause comports with the Court's interpretation

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of the operative clause. The “militia” comprised all males physically capable of acting in concert for the common defense. The Antifederalists feared that the Federal Government would disarm the people in order to disable this citizens’ militia, enabling a politicized standing army or a select militia to rule. The response was to deny Congress power to abridge the ancient right of individuals to keep and bear arms, so that the ideal of a citizens’ militia would be preserved. Pp. 22–28.

(c) The Court’s interpretation is confirmed by analogous arms-bearing rights in state constitutions that preceded and immediately followed the Second Amendment. Pp. 28–30.

(d) The Second Amendment’s drafting history, while of dubious interpretive worth, reveals three state Second Amendment proposals that unequivocally referred to an individual right to bear arms. Pp. 30–32.

(e) Interpretation of the Second Amendment by scholars, courts and legislators, from immediately after its ratification through the late 19th century also supports the Court’s conclusion. Pp. 32–47.

(f) None of the Court’s precedents forecloses the Court’s interpretation. Neither *United States v. Cruikshank*, 92 U. S. 542, 553, nor *Presser v. Illinois*, 116 U. S. 252, 264–265, refutes the individual-rights interpretation. *United States v. Miller*, 307 U. S. 174, does not limit the right to keep and bear arms to militia purposes, but rather limits the type of weapon to which the right applies to those used by the militia, *i.e.*, those in common use for lawful purposes. Pp. 47–54.

2. Like most rights, the Second Amendment right is not unlimited. It is not a right to keep and carry any weapon whatsoever in any manner whatsoever and for whatever purpose: For example, concealed weapons prohibitions have been upheld under the Amendment or state analogues. The Court’s opinion should not be taken to cast doubt on longstanding prohibitions on the possession of firearms by felons and the mentally ill, or laws forbidding the carrying of firearms in sensitive places such as schools and government buildings, or laws imposing conditions and qualifications on the commercial sale of arms. *Miller*’s holding that the sorts of weapons protected are those “in common use at the time” finds support in the historical tradition of prohibiting the carrying of dangerous and unusual weapons. Pp. 54–56.

3. The handgun ban and the trigger-lock requirement (as applied to self-defense) violate the Second Amendment. The District’s total ban on handgun possession in the home amounts to a prohibition on an entire class of “arms” that Americans overwhelmingly choose for the lawful purpose of self-defense. Under any of the standards of scrutiny the Court has applied to enumerated constitutional rights, this

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prohibition—in the place where the importance of the lawful defense of self, family, and property is most acute—would fail constitutional muster. Similarly, the requirement that any lawful firearm in the home be disassembled or bound by a trigger lock makes it impossible for citizens to use arms for the core lawful purpose of self-defense and is hence unconstitutional. Because Heller conceded at oral argument that the D. C. licensing law is permissible if it is not enforced arbitrarily and capriciously, the Court assumes that a license will satisfy his prayer for relief and does not address the licensing requirement. Assuming he is not disqualified from exercising Second Amendment rights, the District must permit Heller to register his handgun and must issue him a license to carry it in the home. Pp. 56–64.

478 F. 3d 370, affirmed.

SCALIA, J., delivered the opinion of the Court, in which ROBERTS, C. J., and KENNEDY, THOMAS, and ALITO, JJ., joined. STEVENS, J., filed a dissenting opinion, in which SOUTER, GINSBURG, and BREYER, JJ., joined. BREYER, J., filed a dissenting opinion, in which STEVENS, SOUTER, and GINSBURG, JJ., joined.