Government of the Virgin Islands of the United States

DEPARTMENT OF HUMAN SERVICES

Medicaid Division

United States Virgin Islands Department of Human Services

Providers' General Information Manual

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1.0 Introduction and Purpose

The VI Medicaid Program Provider Manual contains detailed information about the VI Medicaid Program administered by the VI Department of Human Services (DHS). The manual summarizes the description and administration of the program. The VI Medicaid Program makes every attempt to ensure that the information in the provider manual is reliable as of the date of issuance. Providers must comply with all applicable territory laws, regulations, and administrative guidelines, as well as applicable federal laws and regulations. Specifically, providers must consider the content in this manual, along with applicable federal and state laws and regulations, when determining actions or interpreting guidelines.

The VI Medicaid Program Provider Manual includes requirements that apply to all providers. There might be applicable provider and service-specific information in separate manuals.

This manual includes, but is not limited to:

- Service delivery requirements, including documentation and prior authorization requirements
- Covered services, exclusions, and limitations
- Reimbursement and claims submission, including third-party payer considerations
- Program integrity requirements and processes
- Member considerations

Additional information that pertains to all providers can be found in the Provider Enrollment manual.

2.0 Services

2.1 Covered Services

The VI Medicaid Program covers medically necessary health services provided by enrolled providers to eligible members. The fact that a provider prescribes, recommends, or approves medical care does not in itself make the care medically necessary or a covered service. Covered services include those services described in the Medicaid State Plan and other VI Medicaid Program policy manuals.

Members under age 21 must receive medically necessary healthcare, diagnostic services, treatment, and other measures intended to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services described in the manual sections applicable to Early Periodic Screening Diagnosis and Treatment (EPSDT) whether or not such services are covered under the Medicaid State Plan.

The VI Medicaid Program covers an array of medically necessary healthcare services, including, but not limited to:

- Preventive and wellness services
- Emergency services
- Inpatient and outpatient hospital care
- Physician services
- Mental health and substance use disorder services
- Prescription drugs
- Rehabilitative services such as physical therapy
- Laboratory and imaging services
- Home health services and medical equipment and supplies

2.2 Non-Covered Services

Each section of the manual outlines specific covered and non-covered services related to the service being described. The following list outlines services that are not covered, regardless of the category of service being provided. If there is any apparent conflict between the exclusion listed here and the content of specific manual subchapters, the specific guidance governs.

- Services provided solely for the convenience of the patient or caregivers.
- Services covered by any other insurer or party that has the primary responsibility, other than secondary coverage.
- Services rendered by close family relatives of the member (parents, offspring, siblings, grandparents, grandchildren, or spouses).

- Cosmetic or experimental surgery and treatment, solely to correct defects in the physical appearance, also excluding hospitalization, medical surgical services, and complications associated with this procedure, regardless of other medical justification, except as required by any federal or USVI law or regulation. Breast reconstruction after a mastectomy and surgical procedures that are determined to be medically necessary to treat morbid obesity shall not be regarded as cosmetic procedures.
- Services, diagnostics tests, and/or treatments ordered and/or provided by naturopaths, naturists, and iridologists, as well as sports medicine, musical therapy, acupuncture, and natural medicine.
- Abortion services limitations are outlined in the VI Medicaid Program Physician's Services manual.
- Services that are not reasonable nor required according to the accepted standards of medical practice or services provided in excess of those normally required for the prevention, diagnosis, and treatment of a disease, injury, or dysfunction of the organic system or pregnancy.
- Custodial, rest, or convalescence services, in cases where the acute medical condition requiring inpatient care is under control or in irreversible terminal cases except when provided as part of a hospice benefit.
- Services ordered and/or rendered by non-participating providers, except in cases of emergencies/immediate need.
- Expenses incurred for the treatment of conditions, resulting from procedures or benefits not covered under this program. Maintenance prescriptions and required laboratories for the continuity of a stable health condition, as well as any emergencies that could result after the referred procedures are covered.
- Procedures to change the sex of the member.
- Socialization or recreational services where the basic nature is to provide opportunities for socialization, or those activities that are solely recreational. These non-covered services include, but are not limited to, picnics, dances, ball games, parties, field trips, and social clubs.
- Academic services include, but are not limited to, traditional subjects such as science, history, literature, foreign languages, and mathematics.
- Vocational services include organized programs, such as vocational skills training, or sheltered employment, that prepare individuals for paid or unpaid employment.
- Services for which prerequisites—such as prior authorization and medical eligibility requirements—have not been met, as defined in the appropriate program guidelines.
- Services provided by a psychiatric facility, institution for mental diseases, or institutional service provided for members over age 21. No federal financial participation is available for these services for members between ages 21 and 65.
- Administrative tasks, including verifying eligibility, updating member contact information,

scheduling appointments, performing tasks for the provider's administrative purposes, and similar activities.

- Artificial insemination, in vitro fertilization, infertility services, or sterilization reversal.
- Equipment or supplies that are primarily for patient comfort and/or family or caretaker. convenience.
- Experimental or investigational services or drugs.
- Personal comfort and convenience items or services, whether on an inpatient or outpatient basis, such as television, telephone, barber or beauty service, guest services, and similar incidental services and supplies, even when prescribed by a physician.
- Services rendered by students as part of their clinical or academic training.
- Providers may not bill members for broken or missed appointments, even if providers advised members before the service.

2.3 Non-Payment for Provider-Preventable Conditions

In compliance with federal regulations, the VI Medicaid Program is prohibited from paying for certain conditions that arise during healthcare delivery that could have been prevented. Specifically, Medicaid will not reimburse services related to provider-preventable conditions (PPCs), including healthcare-acquired conditions (HCACs) and other provider-preventable conditions (OPPCs). These policies are designed to encourage adherence to best practices and help ensure public funds are not used for avoidable adverse events.

2.3.1 Types of PPCs

Provider-preventable conditions are defined as two distinct categories:

Category 1 – Healthcare-Acquired Conditions (For Any Inpatient Hospital Settings)

- Foreign object retained after surgery
- Air embolism
- Blood incompatibility
- Stage III and IV pressure ulcers
- Falls and trauma; including fractures, dislocations, intracranial injuries, crushing injuries, burns, electric shock
- Catheter-associated urinary tract infection (UTI)
- Vascular catheter-associated infection
- Manifestations of poor glycemic control, including diabetic ketoacidosis, nonketotic hyperosmolar coma, hypoglycemic coma, secondary diabetes with ketoacidosis, secondary diabetes with hyperosmolarity
- Surgical site infection following:

    - Coronary artery bypass graft (CABG) - mediastinitis
    - Bariatric surgery; including laparoscopic gastric bypass, gastroenterostomy, laparoscopic gastric restrictive surgery
    - Orthopedic procedures, including spine, neck, shoulder, elbow
- Deep vein thrombosis (DVT)/pulmonary embolism following total knee replacement or hip replacement (with pediatric and obstetric exceptions)

Category 2 – Other Provider-Preventable Conditions (For Any Healthcare Setting)

- Wrong surgical or other invasive procedure performed on a patient
- Surgical or other invasive procedure performed on the wrong body part
- Surgical or other invasive procedure performed on the wrong patient

2.3.2 Payment Considerations for PPCs

VI Medicaid will not reimburse providers for PPCs as defined above. This limitation applies to Medicaid members and members who are "dually eligible," i.e., eligible for both Medicaid and Medicare.

Reductions in provider payment will be limited to the extent that the following apply:

- The identified PPC would otherwise result in an increased payment.
- Based on a manual review of medical records for reported PPCs, Medicaid will identify and reduce payment for that portion of the provider's claim or claims that are attributable to the PPC.

No reduction in payment for a PPC will be imposed on a provider when the condition defined as a PPC for a particular patient existed prior to the initiation of treatment.

3.0 Prior Authorization

3.1 General Requirements

To receive payment, a provider must comply with all prior authorization (PA) requirements. The VI Medicaid Program, in its sole discretion, determines what information is necessary to approve a PA request. PA does not, however, guarantee payment. All other requirements must be met for payment. It is the provider's responsibility to verify the member's eligibility for the date a service is rendered.

PA may not be required if the member has Medicare or other insurance coverage. See Section 8: Coordination of Benefits of this manual.

If PA for the service is denied, it must not be billed to Medicaid. The member will be sent a letter notifying them of the denial with an explanation of their appeal rights. Once notified of the denial, the member might still wish to receive the service. The provider must reiterate to the member prior to rendering the service that Medicaid does not cover the service, and the member is financially responsible for the entire service. It is suggested that the member acknowledge this responsibility in writing.

Generally, PA is not required for services performed in the following settings **in the USVI**:

- Inpatient hospital
- Outpatient hospital
- Hospital emergency room (ER)
- Government community clinics
- Federally Qualified Health Centers (FQHCs)

The VI Medicaid Program reserves the right to require PA for exceptional cases.

Services provided outside of these settings, such as physical therapy, require PA.

Providers in these settings refer members to outside providers if they do not have the capacity to treat the member, either because there are not sufficient providers, the wait time is too long given the medical need for services, or the member requires specialized services not available at the facility. These facilities can refer to a specialist or other provider by completing the USVI DHS Authorization Request for Special Services online at VIMMIS.com under the Reference Materials menu item. This system can be used by providers at FQHC and other facilities in the list above, but outside providers (those not at the facilities above) can only refer online to themselves for follow-up. Outside providers must use a paper form to refer to a different provider.

The referral should include, as applicable:

- Member's name and Medicaid number
- Diagnostic codes

- Current Procedural Terminology (CPT) codes for requested services
- Requested units
- Provider who will provide the service, if known
- Clinical notes
- Other necessary information
- Signature by the appropriate clinician

Physician offices in the USVI can accept the ER Discharge Summary, which should contain the same information, instead of a referral. No PA is required. Physicians upload them with their claims.

3.2 Preventive and Specialist Services

Medicaid members should receive preventive care services at government community clinics or FQHCs. Services at physicians' offices require a referral from an authorized government community clinic, except for members who are dually eligible for Medicare and Medicaid or have private insurance coverage that is primary. See Section 8: Coordination of Benefits of this manual.

3.3 Radiology, Imaging, and Laboratory Services

PA is not required for some radiology, imaging, and lab services. PA is required for the following advanced imaging procedures, **regardless of the place of service:**

- Computed Tomography (CT) scans
- Magnetic Resonance Imaging (MRI)
- Magnetic Resonance Angiography **(**MRA)
- Positron Emission Tomography (PET) scans
- Nuclear medicine studies, including nuclear cardiology

When a member has a doctor's order for a medically necessary radiology service, they can take the order directly to the radiology provider. When submitting the claim, the provider will upload the doctor's order/referral to the Medicaid Management Information System (MMIS) portal.

The treating physician must order all diagnostic X-rays, lab tests, and other diagnostic tests for a specific medical problem. When provided as part of preventive visits, the member needs an order from the provider to obtain services.

3.4 Dental Services

PA, also referred to as predetermination, is required for services performed in provider settings with place of service code 11 (physician office), except for some dental services. Dental services are limited to clinics operated by DHS and FQHCs, except by PA from the VI Medicaid Program. Members can go directly to a dental provider, and services will be covered if emergent procedures are needed. The provider must provide documentation to obtain retroactive approval. PA is required for follow-up visits. Members who are dually eligible for Medicare and Medicaid or have primary coverage from private insurance must still obtain prior approval as indicated above.

3.5 Durable Medical Equipment

PA is required for all durable medical equipment, regardless of the place of service.

3.6 Telemedicine Services

All telemedicine services must be prior authorized, regardless of the sites of origin or destination. See Section 9: Telehealth of this manual for further information about allowable telemedicine services.

3.7 Off-Island Services

All off-island services must be prior authorized. For cases involving hospitalization, two authorizations are required: one for the hospital and one for the provider. The form and process used for off-island authorizations are the same as those for on-island services.

3.8 Future Implementation

The VI Medicaid Program expects to move from the process of PA to one of referrals. This new referral process, once implemented, will be administered through DHS and the FQHCs, which will serve as medical homes for all VI Medicaid members. Written notice further describing this policy change will be issued in advance of the effective date.

4.0 Member Participation

4.1 Covered Groups

Medicaid provides full coverage for members of the following groups that meet income, USVI residency, and citizenship criteria; some groups must also meet asset criteria:

- Pregnant women
- Children under age 21
- Temporary Assistance for Needy Families (TANF) children and adults
- Aged, Blind, and Disabled (ABD)
- Adults aged 21 to 64

A newborn child whose mother is Medicaid eligible at the time of the child's birth is eligible for Medicaid services for up to one year from the date of birth. The service must be billed with the newborn's Medicaid identification number rather than the mother's identification number.

Medicaid provides only emergency services to certain illegal or ineligible non-citizens who meet the residence and other Medicaid policy eligibility criteria and are eligible for Medicaid only for treatment of emergency medical conditions.

Medicaid provides secondary coverage to dually eligible members who are eligible for Medicare Part A and/or Part B and Medicaid. Medicare is a federal health insurance program for the aged and disabled. It covers certain hospital services (Part A) and medical benefits (Part B) for eligible members. Medicare is the primary payer for covered hospital and medical benefits. When submitting a claim for a dually eligible member, it must be filed and adjudicated by the Medicare fiscal intermediary or approved carrier before it is submitted for processing to the Medicaid fiscal agent. See Section 8: Coordination of Benefits for additional information on coordination of benefits with Medicare and private insurance.

4.2 Eligibility Process

The main point of entry into the program is through an eligibility determination process performed by DHS.

The VI Medicaid Program has also implemented Presumptive Eligibility (PE) as another enrollment option process for certain applicants, including pregnant women, children, and parents. PE allows uninsured individuals who need medical care to be temporarily determined eligible by hospitals, FQHCs, and public clinic providers when they appear at their facilities needing medical care. The process relies on self-attestation. Members who qualify can receive Medicaid-funded services immediately. The PE benefit period lasts a maximum of 60 days, until the last day of the month following the month in which the case was granted. To continue Medicaid eligibility, the PE member must complete a full Medicaid application with their district office before the end of that 60-day period. Even if the PE member fails to apply at the end of their 60-period, or if they do apply and are found to be ineligible for any reason, Medicaid will

still reimburse providers for any Medicaid-covered services that the member received during their PE period.

4.3 Choice of Provider

Eligible Medicaid members must seek healthcare services provided by DHS health facilities or FQHCs. Despite this limit on freedom of choice of provider, Medicaid members may receive services from other providers (both on-island and off-island) who have a signed provider agreement with the Medicaid agency, with PA.

The Buy-In Program was established under Title XVIII (Medicare) of the Social Security Act. The VI Medicaid Program has an agreement to "Buy-In" to Title XVIII (Medicare) whereby payment of only supplemental medical insurance (Part B premium) is made on behalf of eligible Medicaid members for benefits under Title XVIII-Part B. This group of Medicaid members exercises freedom of choice within Part B, Health Insurance Regulations. However, payments are limited to providers who are qualified to participate under the VI Medicaid Program and have a signed agreement with the VI Medicaid Program.

4.4 Member Payment Responsibility

The VI Medicaid Program has the following policies related to member payment responsibility:

- Members cannot be billed for missed appointments.
- Providers may bill members for non-covered services only if, before providing the service, the provider has clearly explained to the member that Medicaid does not cover the service and that the member will be responsible for the payment. Providers must document in the member's record that the member was told, and members must sign a notice before receiving the service that the service is not a Medicaid-covered service and that the member is responsible for the payment.
- If the member does not inform the provider of his/her Medicaid coverage status until after a service is rendered, the provider is not obligated to bill Medicaid for the service. Should the provider choose to bill Medicaid, the provider must return to the member any prior payments and forego any remaining balance after Medicaid payment is received.
- The VI Medicaid Program does not charge co-payments for any services.
- The member may be billed the amount that the other insurance paid to the policyholder if the member is the policyholder.
- The member is the policyholder of the other insurance, and the member did not follow the rules of the other insurance (e.g., getting PA, using network providers).
- If a provider chooses not to accept the member as a Medicaid member, and the member had prior knowledge of the situation, the member is responsible for payment. It is recommended that providers obtain the member's written acknowledgment of payment responsibility prior to rendering any unauthorized or non-covered service the member elects to receive.

- Providers may not bill members for the difference between the provider's charge and the Medicaid payment for a service (balance billing).
- Providers may not charge members for copying medical records to supply them to another healthcare provider.
- A provider may not impose, bill, or collect any fees in advance of services from the Medicaid member, and monies collected after Medicaid payment is received, including co-payments due from other carriers, must be returned to the member.
- Providers may not void claims and then subsequently bill members for services.

Providers must accept Medicaid payment as payment in full for covered services. A claim is considered paid in full even when the actual Medicaid payment is zero dollars. If the Medicaid payment has been reduced to zero due to payments from Medicare or private insurance, it will be considered paid in full. See Section 8: Coordination of Benefits for additional information on coordination of benefits with Medicare and private insurance. Providers may not impose any additional charges on the member above the Medicaid allowable reimbursement amount.

Medicaid members must not be billed or otherwise held responsible for any claims for which the provider is not paid due to the provider's actions. This includes, but is not limited to:

- Filing claims more than one year after the date of service
- Wrongful billing or missing information
- Failure to obtain PA, if applicable
- Failure to notify the member before the service is provided that it is not covered by Medicaid

Medicaid members, if given prior notice, may be billed for:

- Services received after Medicaid benefits are exhausted
- Services not covered by Medicaid that the member elected to receive. The provider must inform or provide notice to the member prior to rendering services and obtain the member's signature. This includes services that are not medically necessary and/or for convenience only that the member elected to receive
- Non-emergent services not prior-approved, if applicable
- Services rendered when the member is not eligible
- Services provided when the member refuses to use other available insurance

In some cases, Medicaid eligibility may be determined retroactively. If covered services were provided during a period of retroactive eligibility and the member made any payment toward those retroactively-covered services, the provider, if requested to do so by the member within nine (9) months of the date of the original written notification of eligibility, must reimburse the member the full amount paid by the member within 14 days of being notified by the member. Failure to reimburse the member will result in sanctions as defined in Section 1.20. The provider may then submit a claim to the VI Medicaid Program for those same services. If the services

covered were provided during a period of retroactive eligibility and the member has not made payments toward those covered services, the provider has one (1) year from the date the eligibility was granted to file a claim correctly with the VI Medicaid Program.

4.5 Provider Verification of Member Eligibility

It is the provider's responsibility to carefully check the member's Medicaid eligibility when a service is rendered. Eligibility for an actively enrolled member may be verified online at the Virgin Islands Medicaid Management Information System (VIMMIS). The enrolled provider's National Provider Identifier (NPI) number is required to access these systems. The Medicaid member number from the identification (ID) card can be used to verify eligibility. When the member's ID number is not available, the member's Social Security number or a combination of the member's last name and date of birth can be used.

Medicaid eligible members receive ID numbers. The member is responsible for furnishing their Medicaid ID number to the provider at the time of service. Any person requesting services without an ID number should be advised that they are financially liable for all services received until eligibility is verified. Payment will only be made for covered services provided to an actively enrolled member.

Verification of a member's eligibility does not guarantee payment for the services provided. The services provided, in addition to verification of the members' eligibility, must be:

- Determined to be medically necessary
- A covered Medicaid service
- Prior authorized or approved when applicable
- Billed to the appropriate payer
- Properly documented in the provider's office or facility medical records, including but not limited to, the items above, as applicable

5.0 Program Integrity

The VI Medicaid Program operates its Program Integrity (PI) activities under the following federal authorities:

- Title 42 Code of Federal Regulations (CFR), Section 455 Program Integrity: Medicaid – Requirements for a state fraud detection and investigation program.
- Title 42 CFR Section 456 Utilization Control: Requirements concerning control of the utilization of Medicaid services.
- Title 42 CFR Section 455.13, which provides that the Medicaid agency must have:
    - Methods and criteria for identifying suspected fraud cases
    - Methods for investigating these cases that
        - Do not infringe on the legal rights of persons involved; and
        - Afford due process of law; and
    - Procedures developed in cooperation with state legal authorities, for referring suspected fraud cases to law enforcement officials.

Title 42 CFR Section 456.3 provides that the Medicaid agency must implement a statewide surveillance and utilization control program that:

- Safeguards against unnecessary or inappropriate use of Medicaid services and against excess payments;
- Assesses the quality of those services;
- Provides for the control of the utilization of all services provided under the plan in accordance with subpart B of this part; and
- Provides for the control of the utilization of inpatient services in accordance with subparts C through I of this part.

34 V.I.C § 680 - 687 also address program integrity requirements, including the role of the Medicaid Fraud Control Unit (MFCU) and requirements for providers to display information related to methods for reporting fraud.

5.1 Definitions

- **Abuse** means provider practices that are inconsistent with sound fiscal, business, or medical practices and result in unnecessary costs to the VI Medicaid Program or reimbursement for services that are not medically necessary or fail to meet professionally recognized standards for healthcare. It also includes member practices that result in unnecessary costs to the VI Medicaid Program. (42 CFR 455.2)
- **Waste** encompasses the overutilization or inappropriate utilization of services and misuse of resources and is typically not a criminal or intentional act.

- **Fraud** means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to him/herself or some other person. It includes any act that constitutes fraud under applicable federal (42 CFR 455.2) or territory law.

5.2 Coordinated Efforts

The VI Medicaid Program PI coordinates with various federal and contractor efforts aimed at reducing fraud, waste, and abuse, which include the programs listed below.

Unified Program Integrity Contractors (UPICs)

Under the Deficit Reduction Act (DRA) of 2005, the Centers for Medicare & Medicaid Services (CMS) engages contractors referred to as UPICs to audit claims for payment for items or services under a State Plan and identify overpayments to individuals or entities receiving federal funds. The UPICs perform fraud, waste, and abuse detection, deterrence, and prevention activities for Medicare and Medicaid claims processed in the United States. Specifically, the UPICs perform integrity related activities associated with Medicare Parts A, B, Durable Medical Equipment (DME), Home Health and Hospice, Medicaid, and the Medicare-Medicaid data match program (Medi-Medi). The UPIC contracts operate in five separate geographical jurisdictions in the United States and combine and integrate functions previously performed by the Zone Program Integrity Contractor (ZPIC), Program Safeguard Contractor (PSC), and Medicaid Integrity Contractor (MIC) contracts.

U.S. Department of Health and Human Services (DHHS), Office of The Inspector General (OIG) Audits

The VI Medicaid Program assists the DHHS OIG with any audits/reviews they undertake regarding Medicaid providers. These evaluations focus on preventing fraud, waste, and abuse and promoting economy, efficiency, and effectiveness in DHHS programs. Reports include recommendations for improving program operations.

5.3 Reasons for Investigation

It is the policy of the VI Medicaid Program to intake, review, and investigate allegations of Medicaid fraud, waste, and abuse (FWA) that come from several sources, including, but not limited to, the MFCU fraud hotline calls, emails, the DHS web portal, other divisions within DHS, DHS vendors, other government agencies, and results of data analytics queries for improper or aberrant billing.

Alleged actions that might support referral to law enforcement include, but are not limited to:

- Provider noncompliance with Medicaid federal or territory program policies
- Systemic incorrect coding, such as upcoding, unbundling, or misuse of modifiers. The claims section of this manual describes national coding standards that should be followed, including, but not limited to, the National Correct Coding Initiative (NCCI)
- Double billing
- Billing for services not rendered/false claims

- Inappropriate billing of members
- Documentation that fails to support medical necessity or coverage requirements that were not met
- Provider misrepresenting member medical need for items or services
- Falsification or misrepresentation of licensure or credentials
- Unlicensed or non-credentialed staff
- Failure to maintain confidentiality of medical and electronic claims submission records or other violations of the Medicaid Provider Participation Agreement
- Soliciting, offering, or receiving a kickback, bribe, or other financial incentive from/to Medicaid members or prospective employees to "recruit" prospective Medicaid members
- Denying access to services or benefits
- Limiting access to services or benefits
- Services received from a practitioner for member abuse/misuse of prescription drugs (e.g., when members “provider shop” to obtain drugs)
- Failure to refer for needed services or inappropriate self-referral (i.e., the provider refers only to other entities with whom there is a shared ownership or kickback arrangement)
- Suspicious or unusual billing patterns identified through claim surveillance or data analysis

5.4 Determining Credible Allegations of Fraud

A credible allegation of fraud may be an allegation that has been verified by the territory, from any source, including, but not limited to, the following:

a) Fraud hotline complaints.

b) Patterns identified through claims data mining. This may include analysis of MMIS summaries, case files, limited/comprehensive audits, trend and utilization analysis, and identification of providers outside of norms.

c) Patterns identified through provider audits, civil false claims cases, and law enforcement investigations.

Allegations are considered credible when they have indicia of reliability, and the State Medicaid Agency (SMA) has reviewed all allegations, facts, and evidence carefully and acts judiciously on a case-by-case basis. (42 CFR 455.2)

5.5 Preliminary Investigation

If the VI Medicaid Program receives a complaint of Medicaid fraud or abuse from any source or identifies any questionable practices, it must conduct a preliminary investigation to determine whether there is sufficient basis to warrant a full investigation. (42 CFR §455.14)

Referrals regarding possible member or provider fraud are received from many different sources, e.g., members, USVI fraud hotline, providers, MFCU, program staff, other state or federal agencies. As much information as possible is gathered during the initial receipt of the referral.

The initial investigation may result in a determination of the following, described further below:

- A referral that must be forwarded to a different government agency
- No outstanding issue, which results in Program Integrity Unit (PIU) case closure
- An overpayment issue, which results in PIU review
- A potential fraud issue, which results in a MFCU referral

5.6 Full Investigation

If the findings of a preliminary investigation give the agency reason to believe that an incident of fraud or abuse has occurred in the VI Medicaid Program, the agency must take the following action, as appropriate:

a) If a provider is suspected of fraud or abuse, the agency must refer the case to MFCU.

b) If there is reason to believe that a member has defrauded the VI Medicaid Program, the agency must refer the case to an appropriate law enforcement agency.

c) If there is reason to believe that a member has abused the VI Medicaid Program, the agency must conduct a full investigation of the abuse.

5.6.1 Desk Review

Documentation desk reviews may be part of the full or preliminary investigation and refer to the instance when a review of provider records is conducted by PIU staff.

During documentation reviews, a sample of records is requested from the provider and reviewed by staff to determine whether the service was billed and paid in accordance with the appropriate program regulations or policies. Documents requested for a review by PIU may be sent by the provider as electronic or paper copies.

5.7 Outcomes

An outcome is an action, or set of actions, taken to resolve fraud, waste, or abuse. An investigation could result in one or more of the following outcomes, which are described further below.

- Education

- Recoupment/Sanctions
- Payment Suspension
- Pre- and Post-Payment Review
- Corrective Action Plan

Any outcome listed above can be achieved in conjunction with referring the case to MFCU. In limited circumstances, cases may be referred to the OIG or the Attorney General.

5.7.1 Education

Education is the first step for addressing most billing issues. If it is found that the provider is in error when billing, education may be needed to assist them with proper billing practices.

Education topics include, but are not limited to:

- Acceptable standards of practice defined by applicable federal and state laws and regulations
- Health Insurance Portability and Accountability Act (HIPAA) confidentiality requirements and associated documentation requirements
- Unacceptable practices and improper activities
- Legal penalties for improper activities
- How to contact the PIU to ask questions or report suspected noncompliance or FWA
- Non-retaliation policy and confidentiality when reporting noncompliance issues
- Improving the provider's internal monitoring and auditing process

5.7.2 Recoupment

Overpayment might have occurred when Medicaid has paid for encounters where a provider has provided:

- A service without PA when PA is required
- A service not covered under the State Plan
- A service not authorized under the provider's current provider agreement
- A service paid for by another source, or a service eligible for payment by another source
- An amount that the provider or the VI Medicaid Program identifies as an overpayment
- An incorrect amount for services that do not meet standards established for payment of services
- A service provided by someone who is not an enrolled Medicaid provider
- A service provided to a member who is ineligible for Medicaid

- A service that was not rendered

The VI Medicaid Program will send the provider a “Demand Letter” that details the reasons for service disallowance and the provider’s rights of appeal. The provider is expected to reimburse the VI Medicaid Program for all disallowed services. The VI Medicaid Program may arrange with the provider the terms of the provider's repayment of the overpayment. Before the VI Medicaid Program recoups an overpayment, the VI Medicaid Program will notify the provider in writing at least 60 days before the recoupment of the overpayment begins, including:

- The reason for the recoupment
- The amount of the overpayment that the VI Medicaid Program will recoup
- Notice of the provider's right to an appeal

During the 60-day period, the provider will have a chance to see initial findings and provide a response.

If, following receipt of a notice under this section, the provider discontinues billing the VI Medicaid Program for Medicaid services, the VI Medicaid Program will send a written demand to the provider for repayment of the balance of the overpayment. If the provider continues to bill Medicaid, they will typically have the option to have future reimbursement reduced until the recoupment amount is accounted for or make a one-time payment.

5.7.3 Payment Suspension

Terminations are covered in the Provider Enrollment manual.

- Under 42 CFR 455.23, the VI Medicaid Program must suspend all Medicaid payments to a provider after a determination of a credible allegation of fraud for which an investigation is pending under the VI Medicaid Program against an individual or entity, unless the VI Medicaid Program has good cause not to suspend payments or to suspend payment only in part. The VI Medicaid Program will determine all credible allegations of fraud as indicated below, to decide related to the suspension of payment after proper evaluation. Allegations are considered credible when they have indicated reliability, and the Payment Suspension Committee has reviewed all allegations, facts, and evidence carefully and judiciously on a case-by-case basis.
- The PIU will evaluate the case and, in consultation with MFCU and any other applicable agency, will decide related to the suspension of payment. The Payment Suspension Committee is responsible for this determination.
- If the MFCU, OIG, or other agency accepts the fraud referral for investigation and agrees with the payment suspension, the payment suspension may be continued until the investigation and any associated enforcement proceedings are completed.
- If the MFCU, OIG, or other agency declines to accept the fraud referral for investigation, the payment suspension must be discontinued unless PIU has alternative federal and territory authority by which it may impose a suspension or make a fraud referral to another agency.

Basis for Suspension

- The Medicaid agency must suspend all Medicaid payments to a provider after the agency determines there is a credible allegation of fraud for which an investigation is pending under the VI Medicaid Program against an individual or entity, unless the agency has good cause not to suspend payments or to suspend payments only in part.
- The Medicaid agency may suspend payments without first notifying the provider of its intention to suspend such payments.

Duration of Payment Suspension

All suspension of payments under this section will be temporary and will not continue after either of the following:

- The agency or the prosecuting authorities determine that there is insufficient evidence of fraud by the provider.
- Legal proceedings related to the provider's alleged fraud are completed.

Good Cause Not to Suspend Payments

The VI Medicaid Program may find that good cause exists not to suspend payments, or not to continue a payment suspension previously imposed, to an individual or entity against which there is an investigation of a credible allegation of fraud if any of the following are applicable:

1) Law enforcement officials have specifically requested that a payment suspension not be imposed because such a payment suspension may compromise or jeopardize an investigation.
2) Other available remedies implemented by the territory more effectively or quickly protect Medicaid funds.
3) The territory determines, based upon the submission of written evidence by the individual or entity that is the subject of the payment suspension, that the suspension should be removed.
4) Member access to items or services would be jeopardized by a payment suspension because of either of the following:
    i. An individual or entity is the sole community physician or the sole source of essential specialized services in a community.
    ii. The individual or entity serves a large number of Medicaid members within a Health Resources and Services Administration (HRSA)-designated medically underserved area.
5) Law enforcement declines to certify that a matter continues to be under investigation per the requirements of 42 CFR 455.23(d)(3).
6) The territory determines that payment suspension is not in the best interests of the VI Medicaid Program.

Good Cause to Suspend Payment Only in Part

The VI Medicaid Program may find that good cause exists to suspend payments in part, or to convert a payment suspension previously imposed in whole to one only in part, to an individual or entity against which there is an investigation of a credible allegation of fraud, if any of the following are applicable:

1) Member access to items or services would be jeopardized by a payment suspension in whole or part because of either of the following:
    i. An individual or entity is the sole community physician or the sole source of essential specialized services in a community.
    ii. The individual or entity serves a large number of Medicaid members within a U.S. Health Resources and Services Administration (HRSA)-designated medically underserved area.
2) The VI Medicaid Program determines, based upon the submission of written evidence by the individual or entity that is the subject of a whole payment suspension, that such suspension should be imposed only in part.
    i. The credible allegation focuses solely and definitively on only a specific type of claim or arises from only a specific business unit of a provider; and
    ii. The VI Medicaid Program determines and documents in writing that a payment suspension in part would effectively ensure that potentially fraudulent claims were not continuing to be paid.
3) Law enforcement declines to certify that the matter remains under investigation.
4) The territory determines that payment suspension only in part is in the best interests of the VI Medicaid Program.

Notice of Suspension

The Medicaid agency must send notice of its suspension of program payments within the time frames and include the information specified under 42 CFR 455.23. This information includes describing the appeal process.

Termination of Suspension

The termination of a suspension must be provided in writing, including, where applicable and appropriate, any appeal rights available to a provider. The following may lead to a termination of suspension:

- Determination that there is insufficient evidence of fraud by the provider.
- MFCU or OIG decides not to investigate a fraud referral.
- Discontinuance of a pending investigation.
- Legal proceedings related to the provider's alleged fraud are completed.

When the payment suspension process is to be discontinued:

- PIU will notify the provider in writing with an effective date to end payment suspension.
- The PIU must notify the provider in writing of an effective date to end payment suspension and will provide blind copies to previously identified parties.
- The PIU must take the necessary action to remove the payment suspension.

After payment suspension has ended, the VI Medicaid Program is responsible for monitoring claims to determine whether any inappropriate payments were made or to identify aberrant billing patterns, in which case appropriate action will be initiated.

- PIU must send a quarterly report to CMS with summary information on the following:
    - Payment suspensions:
        - The nature of the suspected fraud
        - The basis for suspension
        - The outcome of the suspension
    - Situations in which it was determined that good cause existed to not suspend payments, to suspend payments only in part, or to discontinue a payment suspension:
        - The nature of the suspected fraud
        - The nature of the good cause

5.7.4 Pre- and Post-Payment Review

USVI performs pre-payment and post-payment review of claims to help ensure:

- Conformance to federal and VI Medicaid Program rules and regulations
- Medical necessity and appropriateness
- Payment to an enrolled and qualified provider on behalf of an enrolled member
- Units and services billed match units and services documented in the provider's records

These reviews help identify and measure FWA. The PIU will be responsible for weekly or monthly post-payment reviews. Post-payment reviews can be accomplished by doing an on-site review.

Post-payment reviews are conducted on Medicaid providers and members by using system reports to generate profiles of healthcare providers and member services, including comparison with their peers. Post-payment review analyzes frequency, standard deviations, outliers, spike reports, etc., to identify potential overpayments, questionable billing practices, and/or FWA. The VI Medicaid Program uses post-payment reviews only where known or suspected waste, fraud, or abuse by a provider or member exists.

Post-payment review may include a provider site audit to evaluate records in their totality, or records may be requested for submission to the PIU. Other reviews may be completed by the VI Medicaid Program or its designee.

5.7.5 Corrective Action Plan (CAP)

The CAP describes the actions and methods the provider will use to help ensure it comes into compliance. If a provider is required to submit a CAP and does not do so within 60 days, the territory may withhold payment to the entity until a CAP is received. The CAP designates a contact person within the entity responsible for communicating details about plan implementation.

5.7.6 Appeals

Providers have the right to appeal adverse actions. The VI Medicaid program will send the provider a notice of adverse action in all instances where an investigation results in one of the outcomes described above. Appeal rights will be described in that notice. The provider has 30 days from the date of notification to file an appeal.

5.8 Anti-Kickback Prohibition

It is illegal to provide referrals for any type of compensation. Federal law states, "It is unlawful to knowingly and willfully offer, pay, solicit, or receive any remuneration to induce or reward referrals of items or services reimbursable by Medicaid." See 42 U.S.C. §1320a – 7b(b). When remuneration is paid, received, offered, or solicited purposefully to induce or reward referrals of items or services payable by Medicaid, the Anti-Kickback Statute is violated.

5.9 Requirement to Post Notice

The DHS requires providers to display information about how to report providers and members suspected of fraudulent activity relating to the VI Medicaid Program. Signs must be posted at all locations where Medicaid services are delivered to Medicaid members. The signs must refer to the Attorney General's MFCU phone messaging system and provide its current phone number. The signs must be placed in a conspicuous location within a provider's office. The sign must contain a notification that all reports to the phone messaging system may be filed anonymously by people suspecting fraudulent activity.

5.10 False Claims Act

Under Section 6032 of the DRA of 2005, any entity that receives or makes Medicaid payments of at least $5,000,000 annually must establish written or electronic policies and procedures for the education of employees of affected entities regarding false claims recoveries.

5.11 Future Implementation

Medicaid and the PIU reserve the right to use additional methods to investigate FWA that may not be outlined in this manual.

6.0 Documentation

6.1 Record Retention

All VI Medicaid Program enrolled providers must maintain at their principal place of Medicaid business all records for a minimum of six years from the date of a claimed provision of any goods or services to a Medicaid member. 34 V.I.C. § 685

Providers arranging or rendering services upon the order, prescription, or referral of another provider (e.g., physician) must maintain that order, prescription, and/or referral for six years.

6.2 Availability of Records

Providers are required to permit VI Medicaid personnel, or their authorized agents, access to all information concerning any services that may be covered by Medicaid. This access does not require authorization from the member because the purpose for the disclosure is permitted under the HIPAA Privacy rule.

Providers must, upon request from authorized agents of the state or federal government, make available for examination and photocopying all medical records, quality assurance documents, financial records, administrative records, and other documents and records that must be maintained. Failure to make requested records available for examination and duplication and/or extraction through the method determined by authorized agents of the state or federal government may result in the provider's suspension and/or termination from Medicaid participation.

6.3 Fiscal Records

The following fiscal records must be maintained by the provider:

- Copies of Remittance Advices (RA)
- PA requests and approvals for services and supplies
- Records of third-party payments
- Copies of purchase invoices for items supplied to the member

6.4 Clinical Records

The clinical documentation requirement list below contains general guidelines for clinical documentation that must be maintained by all providers. Clinical records other than those listed might also be needed to clearly document all information pertinent to services rendered to members. Providers are also required to follow any specific documentation requirements outlined in any VI Medicaid manuals specific to their provider specialty type and/or services they provide.

The clinical record must be sufficiently detailed to allow reconstruction of what occurred for each service billed. All documentation for services provided must be signed and dated by the rendering healthcare professional.

For services that are time-specific according to the procedure code billed, providers must indicate in the medical record the actual beginning time and end time of the identified service. For example, some Physical Medicine procedure codes require reporting in 15-minute increments of time. If the procedure started at 3 p.m. and ended at 3:15 p.m., the beginning time and end time must be recorded in the medical record.

The medical record must indicate the specific findings or results of diagnostic or therapeutic procedures. If an abbreviation, symbol, or other mark is used, it must be standard, widely accepted healthcare terminology.

Clinical documentation required elements to be included in patient records, as applicable:

- Date of each visit
- Begin time and end time if service is time-specific according to procedure/revenue code billed
- Presenting symptom(s) or condition(s)
- Diagnosis
- Patient histories, plans of care, progress notes, consultation reports
- Results of exams
- Records of medications, drugs, assistive devices or appliances, therapies, tests and treatments that are ordered, prescribed, referred, or rendered
- Physical assessment and/or nursing activities that pertain to care provided and support the procedures billed
- Orders for tests and test results
- Identification of specimen, type, and source
- Drug name, strength, dosage, quantity and route of drug administration, and time administered
- Ordering, prescribing, or referring physician names
- Other documentation necessary to process requests for reimbursement

6.5 Signature Requirements

Medical record documentation of individuals responsible for providing care for Medicaid members must be signed and dated. If the entries do not meet the signature requirements, the associated claims may be denied.

For pre-payment or post-payment medical review purposes, the VI Medicaid Program requires that the person(s) responsible for the care of the member, including providing/ordering/certifying items/services for the member, be identifiable as such in accordance with Medicaid billing and coverage policies.

Signatures are required upon medical review for two distinct purposes:

1. To satisfy specific signature requirements in statute, regulation, or Medicaid policy
2. To resolve authenticity concerns related to legitimacy or falsity of the documentation

A. Handwritten Signature

A handwritten signature is a mark or sign by an individual on a document signifying knowledge, approval, acceptance, or obligation.

B. Electronic Signatures

Providers using electronic systems shall recognize that there is a potential for misuse or abuse with alternate signature methods. For example, providers need a system and software products that are protected against modification, etc., and should apply adequate administrative procedures that correspond to recognized standards and laws. The individual whose name is on the alternate signature method and the provider bear the responsibility for the authenticity of the information for which an attestation has been provided. Physicians are encouraged to check with their attorneys and malpractice insurers concerning the use of alternative signature methods.

C. Signature Log

Providers will sometimes include a signature log in the documentation they submit that lists the typed or printed name of the author associated with initials or illegible signature. The signature log might be included on the actual page where the initials or illegible signature are used or might be a separate document. Reviewers should encourage providers to list their credentials in the log. However, reviewers shall not deny a claim for a signature log that is missing credentials. Reviewers shall consider all submitted signature logs regardless of the date they were created. Reviewers are encouraged to file signature logs in an easily accessible manner to minimize the cost of future reviews where the signature log might be needed again.

D. Signature Attestation Statement

Providers will sometimes include an attestation statement in the documentation they submit. To be considered valid for VI Medicaid medical review purposes, an attestation statement must be signed and dated by the author of the medical record entry and must contain sufficient information to identify the member.

6.6 Protection of Member Privacy

Providers must safeguard the member's privacy and confidentiality, as required by all applicable territory and federal laws. The use and disclosure of individually identifiable information or protected health information (PHI) must be consistent with HIPAA, using the minimum amount of information necessary for purposes directly related to the administration of Medicaid. PHI includes any health information and confidential information, whether verbal, written, or electronic. It is healthcare data plus identifying information that allows the data to tie the medical information to a particular person. PHI relates to the past, present, and future physical or mental health of any individual or member; the provision of healthcare to an individual; or the past, present, or future payment for the provision of healthcare to an individual. All member

information, including, but not limited to, claims data, PA information, and attachments such as medical records and consent forms, is considered PHI.

If the provider receives a court order, a subpoena, or other authorized request for medical bills, payment, or claims adjudication information, the information should be released. If third-party responsibility for payment might be indicated, the provider should report the request to third-party liability. Otherwise, all records are confidential and should not be released, other than to a member or their representative, unless the provider has a signed release from the member. Copies of all requests for records should be maintained in the provider's files.

As HIPAA permits, a participating provider does not have to obtain a member's consent or authorization for the VI Medicaid Program or its business associates to release sensitive information about the member for purposes of healthcare operations or the payment of claims.

7.0 Claims

All provider claims for reimbursement for Medicaid services must be submitted in accordance with the policies, rules, and procedures as stated in the manual and in compliance with applicable coding guidelines and conventions. These include, but are not limited to, the International Classification of Diseases (ICD), CPT, Healthcare Common Procedure Coding System (HCPCS), and the Medicaid NCCI program.

Providers must not bill Medicaid for services that have not been completed at the time of the billing.

For members with third-party payer coverage, please refer to Section 8: Coordination of Benefits for additional information.

7.1 Claims Submission

The VI Medicaid Program encourages electronic claim submission and requires electronic funds transfer (EFT) from its enrolled providers. Providers may also submit claims on paper.

Claims submitted electronically and accepted are received directly into the VI Medicaid MMIS, resulting in faster payments and fewer claims that suspend or reject.

The Healthcare Payer Administration Solution-OnLine (Health PAS-OnLine) is a web-based Medicaid administration system that permits real-time completion of healthcare transactions over the internet. This portal includes a secure provider site for registered trading partners, allowing them access to information and to submit claims online.

To access the Health PAS-OnLine secure portal, providers are required to become registered trading partners to view and submit healthcare information. The Health PAS-OnLine portal contains PHI. Once the provider becomes a registered trading partner, they are bound by the HIPAA of 1996.

For detailed instructions on provider registration and Health PAS-OnLine, please refer to the User Guides available at http://www.vimmis.com.

7.2 Claims Formats and Attachments

To submit claims for reimbursement, providers are to use the appropriate claims format described below. The Health PAS User Guides are key resources for claim and attachment submission processes and are available at http://www.vimmis.com.

7.2.1 Institutional Claim Format

The following providers must use the ASC (Accredited Standards Committee) X12N 837 5010 institutional format when submitting electronic claims or the National Uniform Billing Committee (NUBC) UB-04 claim form for paper claims.

- Hospitals
- Hospice
- Nursing Facilities

7.2.2 Professional Claim Format

The following providers must use the ASC X12N 837 5010 professional format when submitting electronic claims and the CMS 1500 claim form for paper claims.

- Physicians and non-physicians, professional services, vision, therapists
- Independent Laboratory Services
- Durable Medical Equipment and Supplies (DME)
- Non-Hospital Based Transportation
- FQHC
- Clinics

7.2.3 Dental Claim Format

Dental providers must use the ASC X12N 837 5010 dental format when submitting electronic claims and the 2024 Americans with Disabilities Act (ADA) claim form for paper claims.

7.3 Certification of Claim Form

Providers certify by signature that a claim is true, accurate, and contains no false or erroneous information. The provider's signature or that of the provider's authorized representative may be handwritten, typed, or rubber-stamped on a paper claim.

Providers are held responsible for any errors, omissions, or resulting liabilities that might arise from any claim for medical services submitted to Medicaid under the provider's name or NPI number. Contractual arrangements (verbal or written) with employers, employees, contractors, etc., do not release the provider of responsibility for services billed or signed under the provider's NPI number. Providers are responsible for the supervision of a subordinate, officer, employee, or contracted billing agent who prepares or submits the provider's claims.

Providers certify and agree to keep such records that are necessary to fully disclose the extent of services provided to individuals covered under the Medicaid State Plan and to furnish information regarding payments claimed for providing such services upon request of the VI Medicaid Program or its agents.

7.4 Timely Filing Requirements for Claims

Providers must submit all claims no later than 12 months from the date of service. For claims using the institutional format, the date of service is the "To" or "Through" date indicated on the claim. For all other providers, it is the date the service was rendered or delivered.

Examples of exceptions to the 12-month time limit are:

- Corrected claims that were billed prior to the 12-month time limit and before 24 months from the date of service with a copy of remittance advice (rejections and Return to Provider [RTP] letters are not accepted as proof of timely filing).

- Medicare primary claims billed within 12 months of the Medicare pay date with a copy of the Medicare Explanation of Benefits (EOB).
- Claims for members with Medicaid cards with a retroactive date of eligibility billed within 12 months of the issuance of the Medicaid card with a copy of the Medicaid card.

7.5 Payment Process

The VI Medicaid Program processes claims and issues payments by check or EFT every week. After Medicaid processes a claim for payment, a Medicaid RA is generated. An RA is a paper or electric document that provides information about the status and details of claims submitted to Medicaid for reimbursement. It communicates whether the VI Medicaid Program has paid, partially paid, or denied a claim, along with the reasons for any payment adjustments or denials.

If a claim or claim service line is rejected, a Claim Adjustment Reason/Remark code prints in the Claim Adjustment Reason/Remark column of the RA. Providers should review the definition of the codes to determine the reason for the rejection. The standardized code set is published by the Washington Publishing Company (WPC). https://x12.org/codes

7.6 Claim Replacements, Void/Cancel Claims

Replacement claims are submitted when all or a portion of a claim was paid incorrectly, or a third-party payment was received after Medicaid made a payment. When replacement claims are received, Medicaid deletes the original claim and replaces it with the information from the replacement claim. It is very important to include all service lines on the replacement claim, whether they were paid incorrectly or not. All money paid on the first claim will be recouped, and payment will be based on information reported on the replacement claim only.

If a claim was paid under the wrong provider NPI or Medicaid member ID number, providers must void/cancel the claim. To void/cancel the claim, indicate an “8” in the Type of Bill (xx8) as the third digit frequency. The “8” indicates that the bill is an exact duplicate of a previously paid claim, and the provider wants to void/cancel that claim. The provider must enter the claim number of the last approved claim or adjustment being canceled and enter the reason for the void/cancel in the Remarks section. A new claim may be submitted immediately using the correct provider NPI or Medicaid member ID number. A void/cancel claim must be completed exactly as the original claim.

For detailed instructions on how to adjust, replace, or void/cancel claims, please refer to the USVI Health PAS-OnLine Third-Party Administrator (TPA) Claim Submission User Guide, located on vimmis.com.

7.7 Payment in Full

Providers must accept Medicaid's payment as payment in full for services rendered, except when authorized by Medicaid (e.g., co-payments, patient-pay amounts, other cost-sharing arrangements authorized by the program). Providers must not seek or accept additional or supplemental payment from the Medicaid member, family, or representative in addition to the amount paid by Medicaid, even when a member has signed an agreement to do so as further described above in Section 4.4.

The Medicaid program shall be liable for provider payments up to the applicable Medicaid fee schedule amount for covered services rendered to eligible members. Payment shall be reduced by any amount determined to be the responsibility of other liable third parties through coordination of benefits (COB), in accordance with federal and Medicaid program COB/TPL (Third-Party Liability) policies described herein. In no event shall the Medicaid program pay more than the lesser of:

1. The Medicaid fee schedule amount for the service
2. The amount charged by the provider
3. The net amount remaining after COB has been applied

Providers are required to submit claims reflecting all third-party payments and adjustments. Medicaid will not reimburse amounts that exceed the provider’s actual charge or that duplicate payments made by other payers.

7.8 Pre-Payment and Post-Payment Review and Audits

Providers are subject to pre-payment and post-payment reviews, audits, or adjustments to the claim reimbursement rate during claims processing.

In pre-payment review, the VI Medicaid Program may deny reimbursement for a service until the service meets Medicaid coverage criteria and guidelines.

In pre- and post-payment review/audit, Medicaid may initiate an adjustment to obtain monies paid for services that do not comply with Medicaid coverage, billing, and/or reimbursement policies or that are related to suspensions or disenrollment of the provider from Medicaid.

8.0 Coordination of Benefits

Federal regulations mandate that states identify any potentially liable third-party resource available to pay for a member's medical expenses. The VI Medicaid Program follows federal regulations that require it to "cost avoid" payment of claims where a third party may be responsible for full or partial payment, rather than "pay and chase" potentially liable parties.

The term "third-party payer" includes an individual, institution, corporation, public or private agency that is or may be liable to pay all or part of the medical cost of an injury, disease, or disability of a Medicaid applicant or member. Examples include:

- Medical insurance for USVI government employees
- Medicare - Parts A, B, and D
- Private medical insurance, including employer insurance
- Workers' compensation
- Individual or organization determined liable through legal action
- Air ambulance programs, such as Medical Access & Service Advantage (MASA)
- School accident insurance
- Union benefits
- Veterans Administration benefits
- TRICARE (formerly CHAMPUS)
- Homeowners, automobile, or liability insurance

For members with third-party payer coverage, coordination of benefits is the process that involves determining the order in which payers are billed for a given service. As required by law, Medicaid is the "payer of last resort," meaning that other parties must be billed before Medicaid can be billed for the service. In other words, the other party is the primary payer, and Medicaid is the secondary or perhaps tertiary payer. All third-party resources must be exhausted before Medicaid can consider payment. In addition, no Medicaid payment is made for services associated with medical conditions covered by Workers' Compensation. Federal law includes limited exceptions to the payer of last resort requirement. These exceptions include Ryan White, the Breast and Cervical Cancer Program, and the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC).

Medicaid's liability is limited to the lowest allowable Medicaid amount.

Medicaid is responsible for cost-sharing required by a third-party payer when services have been appropriately obtained under Medicaid.

8.1 Provider Responsibilities

42 CFR 447.20(b) prohibits a provider from refusing to furnish services covered under the Medicaid Plan to an eligible individual because of a third party's potential liability for the service.

Providers must meet all requirements of the third-party payer before billing Medicaid.

8.1.1 Prior Authorization Requirements

Medicaid-covered services that currently require a Medicaid PA will not need a Medicaid PA if the primary insurance approves the service.

If the service is not allowed by the primary insurance but is a covered service for Medicaid, and the service requires a PA under Medicaid, the Medicaid policy will be enforced.

Orthodontic and periodontic services require a Medicaid PA, when applicable, regardless of primary insurance requirements.

8.1.2 Claim Submission

Before submitting a claim to Medicaid, the provider must collect information regarding possible third-party coverage. Once identified, the provider must bill the third party. All requirements of the third-party coverage must be met before Medicaid will make payment, including the use of in-network providers and PA. After receiving payment from the third party, the provider may submit the claim to Medicaid. When submitting medical claims, the provider must report the TPL payment and any member liability amounts.

The provider must attach a copy of the EOB from the primary payer. Medicaid will then reimburse the lesser amount of the remainder of an approved claim up to the Medicaid allowable amount or the cost-sharing amount.

If the third party denies payment for services, the provider must submit a claim on paper along with a copy of the EOB showing the denial of payment, including the denial reason. If a denial code is used, a description of the code must be attached.

If a provider learns of the potential for TPL after Medicaid has paid, the provider must first refund the Medicaid payment using the void/adjustment process. A claim is then submitted to the third-party payer, and if necessary, after the third party processes the claim, the provider rebills Medicaid along with a copy of the third party's EOB. See Section 7: Claims for further information.

8.1.3 Time Frames for Filing Third Party Claims

If a third party is billed for a service, and the third party has provided payment and the one-year timely filing deadline for Medicaid billing is almost exhausted, the provider should bill Medicaid immediately, even though the other third party has not furnished the provider with payment information. The claim should be billed with a note explaining the situation and a copy of relevant documentation attached to the claim. Even if Medicaid denies the claim, the submission will preserve timely filing for the provider by allowing the provider another year (from the one-

year anniversary of the date of service) to file a claim with Medicaid while the primary payer processes the claim.

When providers experience a lack of cooperation from members or third-party payers, they must:

- Wait ninety (90) calendar days from the date of service for a Medicaid member or policyholder to cooperate concerning third-party resources. If after ninety (90) calendar days the member or policyholder has failed to cooperate, Medicaid may then be billed, according to the appropriate billing instructions available from the VI Medicaid Program.
- If no answer from the third-party payer is received within one hundred (100) calendar days of the date of service, providers may then bill Medicaid.

8.2 Member Responsibilities

By signing and submitting the Medicaid application, the applicant gives the VI Medicaid Program the right to pursue third-party payment for Medicaid-covered services and receive payment from third-party payers. Signing the application also gives the VI Medicaid Program the right to pursue and receive medical support from a spouse or parent. Applicants must also cooperate and assist in identifying and pursuing payment from liable third parties, unless the individual has good cause not to do so. See also 8.3, Extenuating Circumstances, below.

The member must do whatever the third-party payer requires to help ensure maximum coverage for services. This includes, but is not limited to:

- Seeing a geographically accessible participating provider
- Seeking referrals from their primary care provider where indicated
- Obtaining PA when required
- Verifying provider enrollment

If the member fails to do what is necessary to maximize benefits from primary payers, Medicaid will not reimburse the provider for the service, and the member may be responsible for payment. Medicaid is, however, liable for Medicaid-covered services that are not part of the third-party payer coverage.

If the member receives payment from a third-party payer or notice of denial, it is the member's responsibility to forward the payment or denial to the provider. The member is considered responsible for payment until the member provides the needed information to the provider.

8.3 Extenuating Circumstances

The VI Medicaid Program recognizes there may be extenuating circumstances where it will reimburse providers for services covered by third-party payers.

Extenuating circumstances may exist when:

- The third party covered services may not be geographically accessible.
- Members do not directly choose a provider, and that provider may not participate with the third-party payer. This may occur, for example, when the provider interprets tests or radiological results or administers anesthesia.
- Good cause has been established under 42 CFR §433.147, “Cooperation in establishing the identity of a child's parents and in obtaining medical support and payments and in identifying and providing information to assist in pursuing third parties who may be liable to pay.”

A member may request an extenuating circumstance. If the member’s request for extenuating circumstances is denied, the VI Medicaid Program shall provide written notice to the member of the member’s right to an administrative hearing.

8.4 Medicare

Medicare, authorized by Title XVIII of the Social Security Act, provides health insurance for most individuals age 65 and over, and for others who meet specified disability requirements. Medicare benefits include hospital insurance and related care (Part A) and supplemental medical insurance (Part B). Medicaid complements and supplements the Medicare Program. Each person eligible for Medicare (Part A and/or Part B) is issued a red, white, and blue Medicare Health Insurance Card showing the member’s Medicare number, Medicare coverage (Part A and/or Part B), and effective date.

A member with both Medicare and Medicaid coverage is identified as “dually eligible.” Medicaid reimburses secondary to Medicare. If a Medicare Supplemental policy exists in addition to Medicare and Medicaid coverage, Medicaid is the third-party payer after Medicare and Medicare Supplemental payments. Providers who serve dually eligible members must enroll in and accept assignment from Medicare when providing Medicare-covered services.

Medicaid covers the applicable co-insurance and deductible amounts to providers accepting Medicare assignment, not to exceed Medicaid’s allowable payment, for services covered by Medicare Parts A and B for all eligible Medicaid members who are also entitled to Medicare benefits. The VI Medicaid Program may also provide payment for services not covered by Medicare.

Providers must indicate acceptance of Medicare assignment by checking the appropriate box on the Medicare invoice. Providers should submit claims for the Medicare co-insurance and deductible to the VI Medicaid Program only after adjudication of the claim by Medicare.

The total payment to the provider from both Medicare and Medicaid cannot exceed the lower of the Medicare allowed amount or the maximum allowance established by the VI Medicaid Program. When assignment is not required, payment will not exceed the maximum allowance established by the VI Medicaid Program for the services provided.

If a member has any other insurance that covers drugs, such as Medicare Part D, those drug coverage policies apply, and that insurance must be billed first. Prescription claims are processed through the pharmacy benefits manager (PBM).

8.5 Individual Providers Balance Billing After Third-Party Payment

When billing Medicaid after receiving a third-party payment, individual providers must follow these procedures:

- Charges must equal the allowed amount as agreed upon with the third-party payer as determined by the EOB.
- The third-party amount must equal the actual third-party payment plus any withheld amount as indicated on the insurance company's EOB.
- Medicaid members are not responsible for any third-party related co-insurance amounts or deductible amounts, even if the claim payment is zero when the claim payment has been reduced to zero as a result of the third-party payment.
- When a third party has paid as primary and Medicaid is paying as secondary, the claims processing system will calculate the Medicaid-allowed amount, compare the co-insurance/co-payment amount and the deductible amount to the difference between the paid amount and the Medicaid-allowed amount, and pay the lesser of these amounts.

  Example 1:

Medicaid-allowed amount	$100.00
Insurance paid amount	$ 50.00
Co-insurance/ co-pay amount due	$20.00
Difference	$ 50.00
Deductible amount due	$10.00
Total amount due	$30.00

  Medicaid would pay $30.00 because that is the lesser amount.

  Example 2:

Medicaid-allowed amount	$100.00
Insurance paid amount	$50.00
Co-insurance/co-pay amount due	$0.00
Difference	$50.00

Deductible amount due	$0.00
Total amount due	$0.00

Medicaid would pay $0.00 because that is the lesser amount.

Example 3:

Medicaid-allowed amount	$100.00
Insurance paid amount	$50.00
Co-insurance/co-pay amount due	$0.00
Difference	$50.00
Deductible amount due	$100.00
Total amount due	$100.00

Medicaid would pay $50.00 because that is the lesser amount.

8.6 Tort Recovery - Other Insurance Settlements

The provider is required to pursue the possibility of TPL if the services provided are a result of an accident or trauma. If, after a reasonable time, a settlement has not been reached or payment from the liable party has not been received, the provider may choose to bill Medicaid. However, the provider must accept the Medicaid payment as payment in full and cannot refund the VI Medicaid Program to pursue reimbursement from any settlement proceeds.

The provider should secure information regarding possible third-party coverage and should require an assignment of benefits before the release of any information that can be used for insurance settlement.

Under Section 1912(b) of the Social Security Act, the member is entitled to any remaining settlement recovery amount after Medicaid has been reimbursed for any related payments it made, including federal and territory shares.

When billing Medicaid, documentation of all recovery efforts, including the name, address, and phone number of any attorney or insurance company, must be submitted. The VI Medicaid Program will then be responsible for recovering the Medicaid payment from the liable third party.

The VI Medicaid Program will recover funds only from the portion of a member's settlement or judgment intended to cover medical expenses and not, for example, payment for pain and suffering or lost wages.

USVI cannot place a lien against property for the collection of excess or improper medical assistance payments made on behalf of an individual who should not have received them in the case of a court judgment, and USVI's rights to third-party payment recoupment.

8.7 Special Circumstances

Unless specified below, “pay and chase” is required for circumstances in which there is a risk that if Medicaid were to cost avoid claims, providers might choose not to participate in Medicaid. Pay and chase means that the VI Medicaid Program pays a healthcare provider for a service and then tries to collect reimbursement from a third-party payer who is also responsible for payment. The following are considered special circumstances:

- The VI Medicaid Program can pay without regard to potential TPL for pediatric preventive services unless it has reviewed issues related to cost-effectiveness and access to care and determined that it warrants cost avoidance for 90 days.
- The VI Medicaid Program may pay without regard to potential TPL after 100 days for claims related to child support enforcement.

9.0 Telehealth

Telehealth or telemedicine services are services a physician provides via two-way, interactive technology (or telehealth). Telehealth substitutes for an in-person visit and generally involves two-way, interactive technology permitting communication between the provider and patient.

For purposes of this section, the definitions and requirements in the U.S. Virgin Islands Code, Title 27, Chapter 1, Subchapter IIa apply:

- "Telemedicine" means the use of medical information exchanged from one Distant Site to another via electronic communications to improve, maintain, or assist patients' health status. Videoconferencing, transmission of still images, and e-health including patient centers are all considered part of telemedicine and telehealth.
- "Telemedicine services" means specialist referral services, patient consultations, remote patient monitoring, medical education, and the provision of consumer medical and health information that are performed as part of a telemedicine procedure.

Generally, the VI Medicaid Program uses the term telehealth, unless quoting another source. Both terms are meant to include the same services.

9.1 Member Eligibility for Services

If a member is eligible for the underlying covered service and delivery of the covered service via telehealth is medically appropriate, as determined by the physician, the member is eligible for telehealth services.

9.2 Provider Eligibility for Reimbursement for Telehealth Services

To be eligible for reimbursement for telehealth services, a provider must:

- Act within the scope of their license
- Be enrolled as a USVI Medicaid provider
- Be otherwise eligible to deliver the covered service according to the requirements of USVI Medicaid

9.3 Services Eligible for Reimbursement Under Telehealth

Any medically necessary physician service may be delivered via telehealth if the following requirements are met:

- The member is otherwise eligible for the covered service.
- The service delivered by telehealth is of comparable quality to what it would be if delivered in-person.
- The service is included in the Medicare list of telehealth services payable under the Medicare Physician Fee Schedule when furnished via telehealth.
- Coverage of services will not be limited based on geography or location.

PA is required for telehealth services only if PA is required for the underlying covered service. If required, the PA is the usual PA for the underlying covered service, rather than a PA for the mode of delivery. Unless otherwise required by law, a face-to-face encounter is not required before delivering telehealth services.

Telehealth services are subject to all conditions and restrictions applicable to all providers described in this General Information manual.

9.4 Off-Island Telehealth Services

For physician providers located outside of USVI, the provider must have been issued a telemedicine license by the USVI Board of Medical Examiners. This license authorizes certain physicians who hold a full and unrestricted license to practice medicine in another state or territory of the United States to provide telehealth services in the Virgin Islands.

9.5 Non-Covered Services and Limitations

The following items or services are not covered:

A. Services otherwise covered but specifically excluded from telehealth coverage include, but are not limited to, the following:

   1. Services that require direct physical contact with a member by a healthcare provider and that cannot be delegated to another provider at the site where the member is located are not covered.

   2. Any service that is medically inappropriate for delivery through telehealth services, e.g., services that include providing medical procedures or administration of medications that must be conducted in person.

B. Communications between healthcare providers when the member is not participating.

C. Communications solely between providers and members when such communications would not otherwise be billable.

9.6 Telehealth Equipment and Technology

Providers must ensure that the telecommunication technology and equipment used at the Distant (provider) Site and the Originating (member) Site are sufficient to allow the provider to appropriately provide services to the member.

9.7 Security

Providers must comply with all federal, state, and local regulations that apply to their business. Any telehealth services that use networked services must comply with HIPAA requirements.

A telehealth service shall be performed on a secure telecommunications line or utilize a method of encryption adequate to protect the confidentiality and integrity of the telehealth service information in accordance with state and federal laws, rules, and regulations.

Both the Originating Site and the Distant Site shall use authentication and identification to ensure confidentiality.

All providers shall implement confidentiality protocols that include, but are not limited to:

1. Identifying personnel who have access to a telehealth transmission
2. Usage of unique passwords or identifiers for each employee or person with access to a telehealth transmission
3. Preventing unauthorized access to a telehealth transmission

A provider's protocols and guidelines shall be available for inspection by DHS upon request.

VI Medicaid will not separately reimburse providers for any charge related to the purchase, installation, or maintenance of telehealth equipment or technology, nor any transmission fees. Providers shall not bill members for such costs or fees.

Members may access services via telehealth through their personal computer by using a vrtual private network (VPN) established and maintained by the provider that meets the equipment standards stated in this policy.

Telehealth services are available via web-based applications and/or Medicaid agency phone applications (apps) as long as they meet the current HIPAA and other federal and territory requirements and use a VPN.

9.8 Required Documentation

Providers must maintain documentation at the Originating Site and the Distant Site to verify services provided, except when the Originating Site is the member's residence. The documentation must indicate the services that were rendered via telehealth and the location of both the Originating and Distant Sites.

9.9 Reimbursement

Services are to be billed in accordance with all other applicable requirements. Payment for services delivered via telehealth will be made in the same manner as when the service is furnished in a face-to-face setting. Providers are to report appropriate place of service codes and applicable modifiers as described below.

A. **Distant (Provider) Site**

1. Except as described below, only the provider at the Distant Site may receive payment for telehealth services. Providers at the Distant Site must bill for the underlying covered service using the same claims they would if it were delivered face-to-face.
2. When billing for Telephone Evaluation and Management Services, providers at the Distant (provider) Site must use the appropriate Evaluation and Management (E/M) code, place of service, and modifier 93, as applicable.

B. **Originating (Member) Site**

1. The provider at the Originating Site may not bill for assisting the provider at the Distant Site with an examination.
2. No separate transmission fees will be paid for telehealth services.
3. The healthcare provider at the Originating (Member) Site may bill for any clinical services provided on-site on the same day that a telehealth service claim is made, except as specifically excluded elsewhere in this section.
4. Telehealth services may be included in the FQHC scope of practice, as approved by USVI. If approved, these facilities may serve as the provider site and bill under the encounter rate.
5. If the technical component of an X-ray, ultrasound, or electrocardiogram is performed at the Originating (member) Site during a telehealth service, the technical components are billed by the healthcare provider at the Originating (member) Site.
6. The professional component of the procedure and the appropriate visit code are billed by the Distant Site.

C. The providers at the Distant and Originating Sites may be part of the same organization.

9.10 Billing: Place of Service (POS)

Report the following POS as appropriate for telehealth services to indicate where the patient was located when receiving telehealth services:

- POS 02 -- Telehealth Provided Other than in Patient's Home
    - Description: The location where health services and health related services are provided or received, through telecommunication technology. Patient is not located in the home when receiving health services or health related services through telecommunication technology.
- POS 10 -- Telehealth Provided in Patient's Home
    - Description: The location where health services and health related services are provided or received through telecommunication technology. Patient is in the home (which is a location other than a hospital or other facility where the patient receives care in a private residence) when receiving health services or health related services through telecommunication technology.

9.11 Billing Modifiers

The following billing modifiers apply to telehealth services:

Modifier	Description	Additional Notes

93	Telehealth modifier defined as synchronous telemedicine service rendered via **telephone** or other real-time interactive **audio-only** telecommunications system.	Modifier 93 is used for **audio-only communication**:
		• Permitted for patients in their home if patient does not have:
		  ○ Technical capacity
		  ○ Availability of real-time audio and visual interactive technology
		• Permitted for patients in their home if patient does not:
		  ○ Consent to the use of two-way, audio/video technology
		Rural Health Clinics (RHCs) and FQHCs can report either modifier 93 or FQ for services provided by audio-only technology.

95	Telehealth modifier defined as synchronous telemedicine service rendered via real-time interactive audio and video telecommunications system.	For institutional billing, use modifier 95 when: • The clinician is in the hospital, and the patient is in their home. • Outpatient therapy provided via telehealth by physical therapists (PTs), occupational therapists (OTs), or speech-language pathologists (SLPs) employed by hospitals.
FQ	The service was furnished using audio-only communication technology.	This modifier is **only** used by RHCs and FQHCs.
G0 (zero)	Telehealth services are furnished for purposes of diagnosis, evaluation, or treatment of symptoms of an acute stroke.	Valid for: • Telehealth Distant Site codes billed with place of service (POS) code 02

10. Additional Provider Requirements

10.1 Anti-Discrimination Policy

Providers must comply with all applicable federal and territory laws and regulations. This includes, but may not be limited to, sections of Title VI of the Civil Rights Act of 1964, as amended by the Age Discrimination Act of 1975, the Americans with Disabilities Act of 1990, and the Rehabilitation Act of 1973. This means that a provider who participates in the VI Medicaid Program may not exclude, deny benefits to, or discriminate against a member on the basis of the member's race, color, national origin, creed, gender, religion, political ideas, marital status, age, disability, or any protected class. Failure to meet these requirements may result in termination of provider participation in the Medicaid program.

10.2 Indemnification

Providers must agree and certify that they will be liable for and indemnify, defend, and hold the Government of the Virgin Islands harmless from all claims, suits, judgments, or damages, including court costs and attorneys' fees, arising out of the negligence or omissions of the provider while providing services to a USVI Medicaid member.

Appendix: Contact Information

Providers may find additional general information about USVI Medicaid at the following sites:

Virgin Islands Department of Human Services, Medical Assistance Program

- www.dhs.gov.vi

United States Virgin Islands Department of Health

- www.healthvi.org

Centers for Medicare & Medicaid Services

- www.cms.gov

United States Virgin Islands Web Portal

- www.vimmis.com

To contact the VI Medicaid Program Office:

- Address: 1303 Hospital Ground, Building A Charlotte Amalie, St. Thomas, VI 00802
- Phone Number: Voice: (340) 715-6929
- Fax: (340) 774-4918
- Email: vimmis@vi.gov

For questions regarding electronic billing practices and all other X12 Transactions contact the Electronic Data Interchange (EDI) Help Desk at 1-855-248-7536.

For questions on PA, see the following contact information:

- **St. Thomas/St. John District**
    - Phone Number: (340) 774-0930 x4352
    - Fax Number: (340) 714-2016
    - Hours of Operation: Monday – Friday, 8 a.m. – 5 p.m. AST
- **St. Croix District**
    - Phone Number: (340) 772-7100
    - Fax Number: (340) 718-9507
    - Hours of Operation: Monday – Friday, 8 a.m. – 5 p.m. AST

To report fraud, please contact the MFCU:

- Hotline: 888-404-MFCU (6328)
- Email: MFCU@doj.vi.gov
- Website: usvi.doj.com
- Website: www.dhs.gov.vi (There is a link to a form to report fraud at the bottom of the page)

For provider appeals, please see the notice of adverse action.

For questions related to provider enrollment, please contact Provider Enrollment Operations:

USVIProviderEnrollment@gainwelltechnologies.com

5328 Yacht Haven Grande

Unit 21

St. Thomas, USVI 00802-5008

888-483-0793 (toll-free)

833-579-9299

Revision History

The revision history identifies the document version number, date, changes made to the document, and a brief description of revisions applied.

Table 1: Version History

Document Version #	Date	Revisions Applied
1.0	TBD	Initial Publication