Government of the Virgin Islands of the United States
DEPARTMENT OF HUMAN SERVICES
Medicaid Division

Medicaid Referral Process by Provider Type - On-Island Services

As of 9/23/2024

Hospital Services On-Island – Inpatient and Outpatient Services

- Prior authorization (PA) document is not required for services performed in provider settings with place of service codes 21 and 22.
- This provider can refer members directly to a Specialist by completing the United States Virgin Islands (USVI) Department of Human Services (DHS) Authorization Form (Authorization Request for Special Services).
- The referral completion should include diagnostic and Current Procedural Terminology (CPT) codes, requested units, and clinical notes, among other necessary information.
- The attending physician and clinical director must sign the referral for services outside the hospital.

1. ROY L. SCHNEIDER HOSPITAL
2. GOVERNOR JUAN F LUIS HOSPITAL
3. MYRAH KEATING SMITH COMMUNITY HOSPITAL

Emergency Room – Hospital

- PA is not required for services performed in provider settings with place of service code 23.
- Physician offices can accept the Emergency Room (ER) Discharge Summary document in lieu of the referral.
- ER notes must include the diagnostic and CPT codes, requested units, and other necessary information. This will help the physicians evaluate and treat the member properly.

Government Community Clinics

- PA is not required for services performed in provider settings with place of service code 71.
- This provider can refer members directly to a Specialist by completing the USVI DHS Authorization Form (Authorization Request for Special Services).
- The referral completion should include diagnostic and CPT codes, requested units, and clinical notes, among other necessary information.
- The attending physician and clinical director must sign the referral for services outside the clinic.
- Medicaid members should receive preventive care services at these facilities.

1. RLS COMMUNITY HEALTH CENTER
2. FAMILY PLANNING, DEPARTMENT OF HEALTH
3. MCH CLINIC ELAINE CO.

Federally Qualified Health Center (FQHC)

- PA is not required for services performed in provider settings with place of service code 50, except for some dental services.
- This provider can refer members directly to a Specialist by completing the USVI DHS Authorization Form (Authorization Request for Special Services).
- The referral completion should include diagnostic and CPT codes, requested units, and clinical notes, among other necessary information.
- The attending physician and clinical director must sign the referral for services outside the clinic.
- Medicaid members should receive preventive care services at these facilities.
    1. ST THOMAS EAST END MEDICAL CENTER CORP
    2. FREDERIKSTED HEALTH CARE, INC.

Physician Office (Specialist) Visits – Medical

- PA is required for services performed in provider settings with place of service code 11 for members for whom Medicaid is the primary payer. **Dual Medicaid members do not require PA (Medicaid is the payor of last resort). The provider must attach the explanation of benefits (EOB) when submitting the claim.**
- **To start service, Medicaid members will receive a referral from one of the authorized government community clinics.**
- The referral and any medical notes will be emailed or delivered to a Medicaid provider.
- Without a PA number, the provider can evaluate the member and bill Medicaid for the Evaluation and Management (E/M) visit.
- Follow-up visit: The physician's office must submit a request for a PA number via the Medicaid Management Information System (MMIS) portal. It is necessary to attach medical notes.

Dental Services

- PA/Predetermination is required for services performed in provider settings with place of service code 11, except for some dental services.
- Dental services are limited to clinics operated by the Department of Health and FQHC, except by PA from the USVI Medicaid Program.
- **Emergent procedures are covered.** USVI Medicaid considers a situation an emergency when immediate service must be provided to relieve the recipient from

pain, an acute infection, swelling, fever, or trauma. The provider shall document the emergency in the recipient's dental record. This documentation shall include a diagnosis with signs and symptoms, a description of the treatment provided, and post-operative instructions and prescriptions.

- The provider can evaluate the member and bill Medicaid for the visit without a PA.
- If a follow-up visit is needed, the treatment plan must be submitted to the Medicaid program for review and approval. Dental notes and any images must be attached.

Members/Recipients Under Age 21

- Dental services are covered for members under the age of 21. Enrollees are provided with Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services (CMS 2016b). PA is required; services must be medically necessary.

Members/Recipients Adults 21 Years and Older – Limited Dental Services

- Dental cleanings – once every six months
- Annual check-ups – once a year

PA is necessary for the follow-up of emergent procedures and when service limits are exceeded.

Radiology and Imaging

- PA is not required for some services performed in this provider setting.
- PA may be required for these advanced imaging procedures:
    1. CT scans
    2. MRIs
    3. MRAs
    4. PET scans
    5. Nuclear medicine studies, including nuclear cardiology
- Radiological covered services available to Medicaid members may be provided in a hospital, Independent Diagnostic Testing Facility (IDTF), office, or clinic setting.
- 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 MMIS portal.

Labs

- PA is not required for some services performed in this provider setting.
- Tests must meet medical necessity criteria to be covered.
- The physician treating a patient must order all diagnostic X-rays, lab tests, and other diagnostic tests for a specific medical problem.

- When a member has a doctor's order for medically necessary lab services, they can take the order directly to the lab provider. When submitting the claim, the provider will upload the doctor's order/referral to the MMIS portal.
- The treating physician must sign the order (or progress note to support intent to order) and document the medical necessity of ordered services.

PROGRAM INTEGRITY

The USVI Medicaid Program has established methods, criteria, and procedures for identifying fraud and abuse situations throughout the program. We are dedicated to simplifying this process and will meet with organizations individually to address concerns.

Should you have questions regarding the above, please contact the following**:**

Karen Virgil, Medicaid Assistant Director Karen.Virgil@dhs.vi.gov

Beverly Joseph, Medicaid Director of Operations Beverly.Joseph@dhs.vi.gov

Carla Huggins Richards, Medicaid Claims/Provider Relations Carla.Huggins@dhs.vi.gov

Ishmael Rodriquez, Medicaid Special Service Supervisor Ishmael.Rodriquez@dhs.vi.gov

Please take note of the following information:

The content of this document is in progress and will undergo frequent updates to ensure accuracy and completeness. Your careful attention to these revisions is valued and will contribute to the overall quality of the document.