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Overview of Client Medical Management

The Recipient Monitoring Unit administers the Client Medical Management Program. Medicaid eligible fee-for-service members who utilize services at a frequency or amount that is not medically necessary in accordance with utilization guidelines established by that state are enrolled in CMM for 36 months to designated providers. CMM members must select a primary care physician (PCP) and designated pharmacy to receive services. The PCP must make a written referral on the DMAS-70 form to another physician in order for payment to be made by Medicaid or FAMIS. The only other time a non-designated physician is paid is for a life-threatening emergency. A member may use a pharmacy other than the assigned pharmacy only in emergencies. All other services will be denied. Each member is assigned a case manager in the Recipient Monitoring Unit to assist with problems that arise related to CMM and to educate the member regarding appropriate use of medical services. Members are monitored during the restriction period and a review is completed at the end of the 36 months to determine if enrollment will be extended for an additional 36 months.

Provider Changes

The CMM member's case manager in the Recipient Monitoring Unit must approve provider change requests. Refer CMM members to the toll-free CMM Helpline for provider change requests or any other questions related to CMM. If a member changes providers without going through the appropriate process, Medicaid and FAMIS providers are not paid for their services.

CMM HELPLINE: The toll-free number is 1-888-323-0589. In the Richmond area, call 786-6548.

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Overview of Managed Care

The Virginia Department of Medical Assistance Services (DMAS) provides Medicaid to individuals through three delivery systems.

- Fee-for-Service (FFS) is the standard Medicaid delivery system;
- Two managed care programs: MEDALLION (This program will no longer be available after 07/01/2012) and Medallion II.

Participation in a managed care program is mandatory for Medicaid members in specified eligibility categories including, but not limited to, Families and Children, Medically Indigent and SSI populations. Clients are excluded from managed care participation when they meet one of the exclusion criteria found in 12 VAC 30-120-370 (Medallion II), or 12 VAC 30-120-280 (MEDALLION).

Medallion

The MEDALLION program is administered by DMAS and was Virginia's first Managed Care Program. MEDALLION is a Primary Care Case Management (PCCM) Program where members must seek their services through a contracted primary care case manager.

Effective 7/1/12 with the expansion of Medallion II into far southwest Virginia, the MEDALLION PCCM program will cease to exist as a managed care delivery system option in Virginia.

Medallion II

Medallion II is a program that operated in 119 localities throughout the state. Member's in the specified eligibility categories in Medallion II localities must enroll with one of the Medicaid-contracted managed care organizations (MCOs) available in those localities. (On July 1, 2012, Medallion II will expand to the remaining localities in the far southwest; Medallion will end; and Medallion II will be serve all 134 localities throughout the state.) Members who do not qualify for Medallion II will be served by the DMAS fee-for-service program. Additionally, there are a few services that are not included in Medallion II, including for example; dental, community mental health rehabilitation, and school based services. These services are generally referred to as carved-out services. A listing of the MCO carved-out services is available on the DMAS managed care webpage at: http://dmasva.dmas.virginia.gov/Content_atchs/mc/mc-mdl2_covout.pdf. Carved-out services are covered through DMAS or other DMAS contractors (DMAS fee-for-service, Smiled for Children, BHSA, etc.).

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Managed Care/CMM Assignment Inquiry

To access Managed Care which includes the Client Medical Management (CMM) Program (Lock-In), from the Member Submenu select Managed Care.

The screenshot shows a web browser window displaying the Virginia Medicaid Member Subsystem Menu. The browser address bar shows the URL: https://www.test-dmas-portal.com/wps/myportal/HatsEMMIS!/ut/p/c5/dY7JDoJAEAU_qRuGzeMAyhIchRnZLg - Micr.... The page features the Virginia Medicaid logo and a navigation menu with the following items: Member, Provider, Reference, Claims, Financial, Service Auth, Automated Mailing, SURS, MARS, EPSDT, MICC, TPL, Assessments, and Drugs. Below the navigation menu, the page displays the following information:

Screen ID: RS-S-000
 Trans ID: VE00
 Program ID: RST000VA

**VIRGINIA MEDICAID
 MEMBER SUBSYSTEM MENU**

Date: 02/08/2012
 Time: 12:17

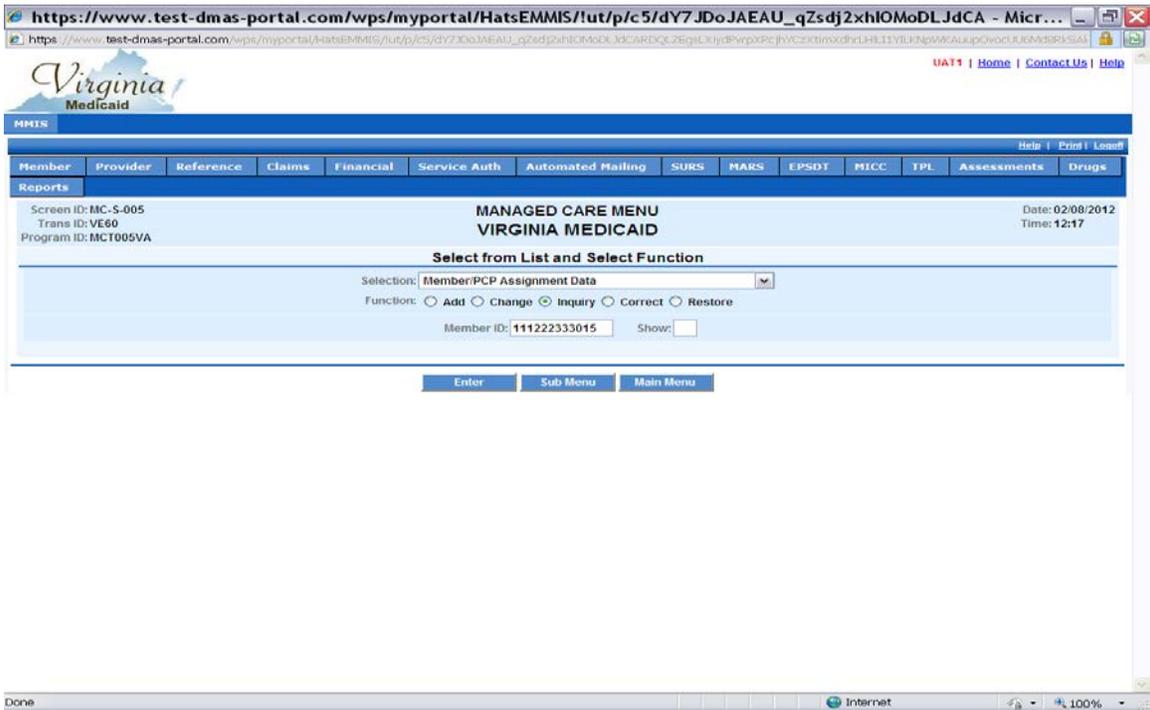
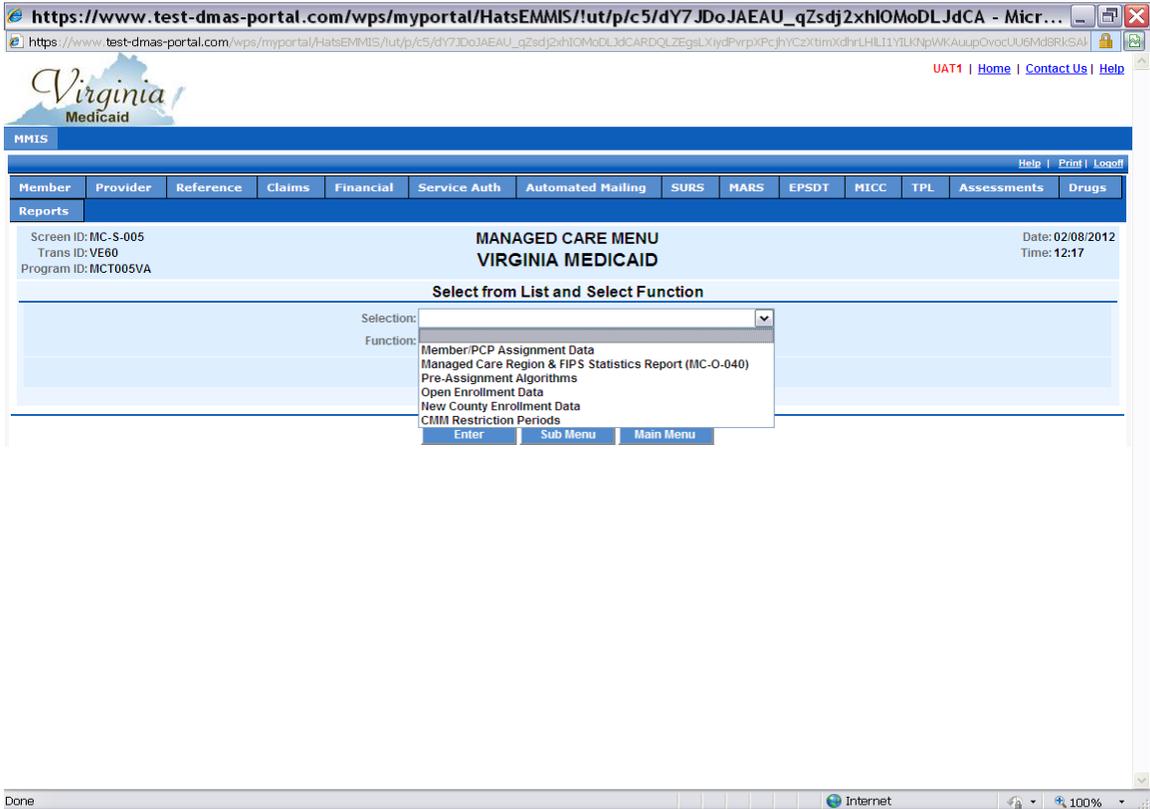
Select Function

- Enrollment
- Managed Care
- Medicare
- Benefit Definition
- Spend Down
- Verification
- Duplicate Member Link
- Input Request Data

Sub Menu Main Menu

From the drop-down menu demonstrated in the screen print below:

- Choose Member/PCP Assignment Data
- Select Inquiry
- Enter the member ID #
- Select [Enter]



Screen ID: MC-S-010
 Trans ID: VE62
 Program ID: MCT010

**VIRGINIA MEDICAID
 MANAGED CARE ASSIGNMENT - INQUIRY**

Date: 02/08/2012
 Time: 12:26
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Member ID: Name (F, L, MI): MMA TEST P
 Sub Program: SEX: F DOB: 01/01/1990 FIPS: 111
 Member Phone: () - Preassignment Reason: Cancel Date: 12/31/9999
 Type: Restriction Period Begin Date: End Date: Restriction End Reason: Status Date:
 CMM Level: Review Date: CMM Status Code:

Select	Benefit Plan Init FIPS	Exception	Provider Init Psn Prov	Begin Date End Date	Assignment Data	Re-Assignment Data	Status Data	Change Code

NO ASSIGNMENT DETAILS FOUND FOR THE ENROLLEE.

Enter Update CMM Restriction Member Prov Search Prov Loc Sub Menu Main Menu

Managed Care Assignment Screen Data Fields and Descriptions

- Member ID:** 12-digit identification number that is used to tie all claims for a single member together.
- Name:** The first and last name and middle initial of the eligible individual.
- Sub Program:** The second level of the coding structure of the Benefit Plan that defines the delivery system for providing benefits under the Program. If the field is left blank, all managed care pre-assignment, assignments, and CMM assignments are shown with the most recent assignments first.

01	Fee For Service (CMM)
02	MEDALLION I
03	MEDALLION II
04	MEDALLION III MCO
07	MEDALLION III PCP

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Sex: A code indicating the sex of the member.

F	Female
M	Male
U	Unknown

DOB: The member's date of birth.

FIPS code: (from the demographics screen) indicating the geographic or geopolitical statistical reporting area in which the member resides within the Commonwealth of Virginia. See MMIS Help for valid values.

Member Phone: The telephone number of the member as given to the enrolling agency.

Preasn Rsn: A code that describes the member's current status in managed care/CMM.

' '	Currently Not pre-assigned/assigned
01	Currently assigned to a CMM Provider
04	Exempt from managed care by DMAS
05	Member currently pre-assigned
06	60 day re-enrollment
07	Member not in Medicaid
08	Department exempt special
09	Member not in a managed care region/locality
10	Member currently assigned to Managed Care
11	Nursing home or Waiver
12	Invalid managed care Aid Category
13	Exempt due to hospital related prior authorization(s)
14	Member has TPL
15	Default Benefit Package not valid for Managed Care
16	No HMO in member's locality
17	Special Indicator 'AA/FC' not valid for Managed Care
44	Temporary flag for exempting from managed care by DMAS
CM	Member is exempt from managed care because of CMM enrollment
'X'	Bypass locality edits when validating pre-assignment or assignment

Cancel Date: The date of termination of an member's eligibility under an aid category.

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Type: A code that describes the type and length of the CMM restriction period.

C18	Continue 18 months
C36	Continue 36 months
I18	Initial 18 months
I36	Initial 36 months
R24	Reenroll 24 months
R36	Reenroll 36 months

Restriction Prds: The begin date of the CMM restriction period established for a specific member. The restriction period is a span of time in which DMAS wishes to restrict an member to the use of a specific physician, pharmacy, or transportation provider, or any combination of the three. This range is setup by the Member Monitoring Unit.

Thru (date): The member restriction end date of the CMM restriction period established for a specific member. This range is setup by the Member Monitoring Unit.

Restriction End Reason: A reason code that identifies why the member's CMM restriction period was ended.

0 1	Inactive Due Appeal
0 2	Inactive Due Mandatory Managed Care
0 3	Released from CMM-No Abuse
0 4	Released from CMM-Not eligible
0 5	Data Entry Error
0 6	Inactive - Enter Long Term Care
0 7	Continued Lock-in
0 8	Change of CMM Level
0 9	Cancel for Part D Eligibility
9 9	Conversion

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CMM Level: A code that identifies the member as being restricted to a specific physician, pharmacist, transportation provider, or any combination of the three including all. Levels 008 – 012 identify Medicare dual-eligible members who have been enrolled in CMM for over-utilization of medications which continue to be covered by Medicaid.

00 1	Physician and Pharmacy
00 2	Pharmacy and Transportation
00 3	Physician and Transportation
00 4	Physician Only
00 5	Pharmacy Only
00 6	Transportation Only
00 7	Physician, Pharmacy, and Transportation
00 8	Part D Pharmacy Only
00 9	Part D Transportation Only
01 0	Part D Pharmacy and Transportation
01 1	Part D Physician and Pharmacy
01 2	Part D Physician, Pharmacy, and Transportation

Review: A date used by the system to identify when member data is to appear on specific CMM reports for DMAS review.

CMM Status Code: A code that identifies the restriction period as active, pending (for when a member appeals the decision by DMAS to restrict them), and void.

A	Active
P	Pending
V	Void

Status Date: The date the CMM Restriction Status Code entry was made.

Benefit Plan: An integer code that represents the group level, three-tiered code describing the benefit plan under which services for an enrolled

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individual may be reimbursed. The three fields have numeric values only. See MMIS Help for valid values.

Exception: A code used as a modifier to the Benefit Plan Code that indicates:

- level of care for long-term care;
- receipt of other non-LTC services; or
- CMM restriction levels.

1	ICF
2	SNF
4*	CMM Physician
5*	CMM Pharmacy
6*	CMM Transportation
7*	Out of State Provider
9	Elderly or Disabled Waiver with Consumer Direction
A	Technology Assisted Waiver
D	Hospice
E	AIDS Waiver
EI*	Early Intervention, <i>effective October 2009</i>
F*	Regular Assisted Living (program ended 06/30/10)
J*	Intensive Assisted Living (program ended 06/30/10)
L	Long Stay Hospital
M*	Children's Mental Health
MP*	Money Follows the Person
MW*	Medicaid Works, <i>effective July 2009</i>
PP	PACE, <i>effective April 2009</i>
Q	CDPAS Waiver (no longer used)
R	IFDDS Waiver
S	Day Support Waiver
T	Alzheimer's Assisted Living Waiver
Y	ID Waiver (formerly the MR Waiver)
blank or spaces	N/A

***Non-LTC Exception Indicators**

Provider: The 10-digit Provider Identification Number of the provider assigned by the Benefit Plan to the member, especially related to Managed Care and CMM Lock-in

Begin Date: The begin date of the enrollment in the Benefit Plan. For managed care, this represents the beginning date of an assignment between a MCO provider and a member.

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Assignment Data: The method by which the member is assigned to the current Benefit Plan.

01	Member selected PCP
02	PCP automatically selected/assigned
03	PCP submitted member selection
04	Automatic mass Re-Assignment
05	DMAS selected/assigned
07	Unknown

Re-Asnmnt Data: A member benefits closure reason code indicating the reason that the member's benefit period was ended. See MMIS Help for valid values.

Status Data: A code that indicates the disposition of the associated benefit. The acceptable coding depends upon the benefit, but could include benefit approved (A), preassigned (P), or (V) void.

Change CD: Source that provided the information resulting in a change of benefit data (specifically, nursing home, community based care or mental retardation information); or a specific type of benefit. Must be entered on any change.

00	No Change Source
01	Provider
02	Member
03	Utilization Review Analyst
04	Other MSS Staff
05	Department of Social Services
06	DBHDS
07	DMAS- Managed Care
08	DMAS - CMM
86	Vent
87	AIDS
88	System Generated (manual entry not allowed)
89	Complex
91	TBI
92	Rehab
99	Unknown
CD	Converted Data (used only during conversion)
DF	Default benefit which may not be modified manually

Init FIPS: A code indicating the geographic or geopolitical statistical reporting area in which the member resided at the time of their initial pre-assignment. See MMIS Help for valid values.

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- Init Psn** A unique identification number assigned to a provider. This field is updated through a batch process and comes from the initial pre-assignments. It is listed on the screen for display purposes only.
- Prov:**
- End Date:** The end date of enrollment in the Benefit Plan. For managed care and CMM, this represents the end date of an assignment between a provider and an member.
- Assignment** The date of the most recent update to the Benefit Assignment
Data Date: Code. Used for research back through the audit trails.
- Re-Assignment** The date of the most recent update to the Benefit
Data Date: Reassignment/Disassociation Code. Used for research back through the audit trails.
- Status Date:** The date the Status Code entry was made.

CMM Restriction Period Screen

From the Managed Care Assignment Screen, the CMM Restriction Screen may also be accessed for members who have been placed under CMM restrictions. This screen contains just the data that is relevant to the members CMM restriction period. Refer to the data field's descriptions for the Managed Care Assignment Screen for details regarding the data fields on this screen.

- Select the CMM Restriction Button as noted above

Screen ID: MC-S-050
 Trans ID: VE75
 Program ID: MCT050VA

VIRGINIA MEDICAID
CMM RESTRICTION PERIOD DATA - INQUIRY

Date: 02/08/2012
 Time: 12:38
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Member ID:
 Name (F, MI, L): IMA P TEST

CMM Type	CMM Level	End Reason	Plan Period Begin Date	Plan Period End Date	Review Date	Status Code

Scroll Up Scroll Down

CMM RESTRICTION PERIOD HISTORY NOT FOUND.

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MCO Contact Information

The MCO Members Services numbers are provided below. An member should always be referred to his/her MCO Member Services whenever he/she has questions about coverage, claims, finding a provider, getting a new (MCO) ID card, and any other issues regarding the MCO.

<u>MCO</u>	<u>Provider</u>	<u>Member Services Phone Numbers</u>
Anthem HealthKeepers Plus		800-901-0020
HealthKeepers	004700325	
Peninsula	004700074	
Priority	004700066	
 Amerigroup	 1790768380	 800-600-4441
 CareNet	 004700317	 800-279-1878
 Optima Family Care	 004700082	 800-881-2166
 Virginia Premier	 004700104	 800-828- 7989- Tidewater 800- 727-7536- Richmond 888-338-4579- Western/Southwestern
 MajestaCare	 1578841060	 1-866-996-9140
 UniCare	 004700333 (merged with Anthem – no longer active)	

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Data that affects Managed Care Enrollment

MMIS Critical Field(s)	Managed-Care Impact Area(s)	Comments
Member ID Number	<ul style="list-style-type: none"> * Continuity * Capitation Payments * Provider payments * Access to Care 	<ul style="list-style-type: none"> * Use one member ID number when enrolling * Rarely would it be appropriate to change Name, DOB, and gender. This causes overlays of member eligibility coverage
Case / Member FIPS	<ul style="list-style-type: none"> * Enrollment * Access to Care * Capitation Payments 	<ul style="list-style-type: none"> * Case FIPS code MUST be that of the city/county owning the case. * Member FIPS MUST be that of the city/county in which the member resides. **MCOs are assigned based on member FIPS**
Sex, Date of Birth, and Name	<ul style="list-style-type: none"> * Capitation Payments * Identification * Provider payments * Access to Care 	<ul style="list-style-type: none"> * Sex, date of birth, and name must be accurate to ensure payment and identification. * Information should be consistent with information in ADAPT, if case is also in ADAPT.
Newborns: Mother ID Field on Demographics Screen	<ul style="list-style-type: none"> * Enrollment * Access to Care * Capitation Payments * Provider payments 	<ul style="list-style-type: none"> * MCO enrollment is determined for a newborn based upon the mother's program- eligibility at birth. The mother's MCO at birth is responsible for the baby for the birth month plus two months, unless mom elects to change plans. This is in effect for mothers enrolled in Medicaid, FAMIS, or FAMIS MOMS. * Populating this field with an <u>accurate ID</u> number for the mother ensures the MMIS enrolls the newborn into the same MCO as the mother.
Relationship to Case Head	<ul style="list-style-type: none"> * Enrollment * Access to Care * Capitation Payments * Correct MCO Assignment for Newborns 	<ul style="list-style-type: none"> * If a newborn is not assigned a relationship code '02' meaning child to case head, or if the newborn is not in the same case as the mother, the MMIS cannot assign correct managed care enrollment unless the Infant Mother ID field is populated.
Aid Category	<ul style="list-style-type: none"> * Enrollment * Capitation Payments * Continuity of Care * Access to Care 	<ul style="list-style-type: none"> * Aid Categories included in managed care enrollment: FAMIS – 005,006, 007, 008, 009; Families & Children - 081, 083, 090, 091, 092, 093, 094; Aged - 011, 012, 021, 029; Blind - 031, 032, 039, 040,041; 042

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		<p>Disabled – 049, 051, 052, 059, 060, 061,062</p> <p>**Changes to the member's aid category may create a lapse in MCO coverage for a one month period.</p> <p>*Foster Care Pilot 074, 076 for FIPS 760 ONLY, effective 12/1/11.</p>
TPL Coverage Types	<ul style="list-style-type: none"> * Enrollment * Capitation Payments * Coordination of Benefits *Provider Payments 	<ul style="list-style-type: none"> * TPL information needs to accurately entered or closed on an member's case timely. TPL Coverage codes that exempt member from managed care enrollment: A, B, H, K, L, M, P, R, and U. All other coverage codes have no effect upon managed care. * The addition of TPL coverage does NOT retroactively disenroll member from MCO assignment. MCO disenrollment occurs at the end of the month TPL data is entered into VaMMIS.

Activities that Affect Managed Care Enrollment

- Enrolling newborns late (not following up on pregnancy outcomes) and failing to include correct mother's member ID on child's demographic information screen.
- Unless there is a specific eligibility restriction, newborns should be enrolled with an effective eligibility date the same as the date of birth.
- Address and FIPS codes need to be changed immediately after receiving notification.
- FIPS code of residence must correspond to member's current location. Failure to do so results in members not receiving their mail and/or the case being canceled. Additionally, members may receive enrollment for an MCO in an area where they no longer live, which affects their access to care.
- Member for whom an out-of-state address is entered should have eligibility updated/closed accordingly.
- Mailing ID Cards late. Members indicate they initiate several requests for replacement cards before they receive one. This negatively impacts access to care. Providers often refuse to see members without a card despite the fact that eligibility can be verified through other means.
- In order to maintain consistency and continuity of coverage and services, any changes/additions to a member's file should be completed in VaMMIS by the close of

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business on the 18th of the month, prior to the Managed Care “run.” If the 18th is a weekend or holiday, changes/additions should be completed in VaMMIS by close of business the last business day prior to the 18th.

Managed Care Addresses and Letters

- Managed Care assignment is based on the FIPS code that is entered on the Member Demographic screen. The Member Demographic FIPS should always be the FIPS in which the member is physically located to allow for assignment in the correct Managed Care region.
- The address fields in the Member Demographic screen should reflect the member's physical address. This is the address where the member's MCO and Medicaid cards as well as most DMAS generated letters will be sent. This is also the address that the MCO will see as the member's physical address.
- The address on the Case screen can reflect a mailing address, if different from the member's physical address. The MCO pre-assignment letter is mailed to this address.
- Managed care pre-assignment letters are mailed by the end of the month with assignment effective the first of the month after the month following pre-assignment.

Example:

- Assignment is effective 1/1/XX
 - Pre-assignment letter is mailed by 11/30/XX
 - Member must call the Enrollment Broker by 12/18/XX to change pre-assignment otherwise the member is “assigned” to that MCO effective 1/1/XX
- The MCO's then mail the members a MCO ID card to the address on the Member Demographics Screen based on a file received from DMAS after MCO processing on the 18th of the month.