

Questions Presented at the May 2nd Public Forum Regarding the MCO Expansion into Far South West VA and MCO Responses

Revised 7/5/2012 as shown in green font - #6

	Subject	Question/Answer					
1	Non Emergency Transportation	What is the mileage rate that your plan reimburses individual members / providers for non-emergency transportation? Is it the same as the Medicaid fee-for-service rate? Coverage for non-emergency transportation is not available for FAMIS members.					
		Amerigroup Providers are reimbursed in the same manner as reimbursed by DMAS. The per mile rate varies based upon specific proc code used for transportation. Standard mileage rates apply in the instance a member is being reimbursed for driving their personal car for applicable instances.	Anthem Provider – Negotiated by contract. Members - \$.40 per mile is the rate to members or family on behalf of members that express hardship such as they have a vehicle but cannot afford the gas. In this case we will pay them to drive their own vehicle.	Coventry/CareNet Provider – Negotiated by Contract. Members - \$.40 per mile is the rate to members or family on behalf of members that express hardship such as they have a vehicle but cannot afford the gas. In this case we will pay them to drive their own vehicle.	MajestaCare Provider – negotiated by contract. Members - \$.40 per mile is the rate to members or family on behalf of members that express hardship such as they have a vehicle but cannot afford the gas. In this case we will pay them to drive their own vehicle.	Optima Providers – negotiated rate per contract. Members - \$.40 per mile is the rate to members or family on behalf of members that express hardship such as they have a vehicle but cannot afford the gas. In this case we will pay them to drive their own vehicle.	Virginia Premier Provider – Negotiated by contract. Members - \$.51per mile is the rate to members or family on behalf of members that express hardship such as they have a vehicle but cannot afford the gas. In this case we will pay them to drive their own vehicle.
2	MRI/CT Scan	What is the turn-around response time (TAT) for authorization of an MRI/CT Scan? How do providers request authorization for a STAT scan?					
		Amerigroup TAT is less than 24 hours. Expedited review is available and can be turned around in less than one day.	Anthem TAT for radiology typically follows the same parameters for all utilization management procedures. If it is a pre-service, then it would be handled within 24 hours. If the provider calls into the UM unit, they would generally get an immediate response assuming that all criteria are met.	Coventry/CareNet TAT for all urgent requests is 24 hours or less. TAT for Non-urgent requests is within 72 hours, however, we typically turn around all requests within 1 business day. Providers can request an urgent review at the time of the call.	MajestaCare Generally within 48 hours. All urgent auth requests should be called in to our service auth department.	Optima Use the forms posted for advanced imaging found on www.optimahealth.com with all clinical information having been received, response is generally within 4 days. STAT request should be called into the Department and will require diagnosis and cpt code of the test. Phone# 800-229-5522.	Virginia Premier TAT is within 48 hours of receipt of the request. If a STAT scan is needed, please contact NIA by phone instead of submitting the request on-line. The phone number for NIA is 800-642-7578.

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3	<p>Authorizations for procedures needed during the first week of July</p>	<p>Providers understand that MCOs will honor DMAS/KePRO issued authorizations. Describe your health plans transition process especially as related to service authorizations that are too late to submit to KePRO but too early to submit to the MCO. For example, ARS and MediCall will show MCO enrollment for July 1 by June 18th. How will your plan handle service authorization requests for services needed on or around July 1? What is the earliest date that a provider can contact the MCO to request service authorization for care that is needed in early July? Will your plan allow for retro authorizations during the transient? Explain.</p>												
		<table border="1"> <thead> <tr> <th data-bbox="354 376 666 410">Amerigroup</th> <th data-bbox="666 376 970 410">Anthem</th> <th data-bbox="970 376 1274 410">Coventry/CareNet</th> <th data-bbox="1274 376 1577 410">MajestaCare</th> <th data-bbox="1577 376 1881 410">Optima</th> <th data-bbox="1881 376 2182 410">Virginia Premier</th> </tr> </thead> <tbody> <tr> <td data-bbox="354 410 666 1433"> <p>In order to ensure that members are receiving care that they need, Amerigroup will be available to respond to requests for new members as of June 18th, 2012. During the ramp-up phase for our new service area, authorizations will be managed on a prospective and retrospective basis while adhering to predetermined clinical guidelines. Additionally an authorization waiver is in place during the transition period to ensure claims payment is not impacted.</p> </td> <td data-bbox="666 410 970 1433"> <p>Service auths from DMAS/KEPRO will be honored. For services starting on or after June 26, 2012, please contact Anthem for a service authorization. During the first 90 days, preauthorization requirements for expansion members will be relaxed.</p> </td> <td data-bbox="970 410 1274 1433"> <p>CareNet Transition of Care Process - If a member is newly enrolled in CareNet, services will be reviewed to determine if transition of care applies. CareNet works with par and non-par providers for a 90-day period to be sure the member has no disruption in services and the medical needs are met. CareNet works with the member to assure the member's needs are understood and a plan is developed to assist with transition beyond the 90-day time frame. CareNet will review requests retroactively for 30 days for newly enrolled members. FSW Providers can begin calling CareNet on June 25, 2012 to request service authorizations.</p> </td> <td data-bbox="1274 410 1577 1433"> <p>Service auths from DMAS/KEPRO will be honored. We ask that you contact the health plan after July 1, 2012 to communicate the services that were rendered or to be rendered. Any new service requires a service auth. For the first 90 days MajestaCare will provide retro-auths as needed (i.e. Provider did not know patient had MajestaCare). All requests will be reviewed for medical necessity.</p> </td> <td data-bbox="1577 410 1881 1433"> <p>You may fax all authorizations to the department and please put the following information: Transition of Care (if you have received an authorization from KePro put that information on the request) if not then just put in the requests for service and these will be entered when the members become effective with the Plan. We will allow for Retro authorizations during the transition</p> </td> <td data-bbox="1881 410 2182 1433"> <p>Providers may call to request services starting 6/26/11. In addition, VPHP will allow retro authorizations for the first 7 days of July. (Ex. DOS 7/2, request on 7/3 – will review for Medical Necessity). Also, we will continue to review for retro within the first 90 days of the transition for any unusual circumstances.</p> </td> </tr> </tbody> </table>	Amerigroup	Anthem	Coventry/CareNet	MajestaCare	Optima	Virginia Premier	<p>In order to ensure that members are receiving care that they need, Amerigroup will be available to respond to requests for new members as of June 18th, 2012. During the ramp-up phase for our new service area, authorizations will be managed on a prospective and retrospective basis while adhering to predetermined clinical guidelines. Additionally an authorization waiver is in place during the transition period to ensure claims payment is not impacted.</p>	<p>Service auths from DMAS/KEPRO will be honored. For services starting on or after June 26, 2012, please contact Anthem for a service authorization. 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| 4 | Non-Formulary Transition, especially for ADHD children | <ol style="list-style-type: none"> 1. If we have members who have an established medication regime proven to be effective for the member, but where the ADHD drug needed is not on the MCOs formulary, will the plan continue reimbursing for the medication treatment without interruption? 2. What process do providers follow to request coverage through the member's MCO for ADHD drugs and/or other medications that are not available on the member's MCO's formulary? 3. What is the MCO's turn-around time for responding to requests for coverage of non-formulary medications? 4. Can the patient have an emergency supply of their meds while the pharmacy authorization requests are being considered? 5. If the member's physician disagrees with the MCO's decision regarding coverage/non-coverage for meds, what process is available to the physician to discuss with the MCO on the member's behalf? For example, is a peer to peer review an option? If yes, how do providers make this type of request? (Direct to the MCO or through the MCO's PBM?) |
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Amerigroup	Anthem	Coventry/CareNet	MajestaCare	Optima	Virginia Premier
https://providers.amerigroup.com/AGP%20Documents/PHARM_ALL%20Attention%20Deficit_Hyperactivity%20Disorder%20(ADHD)%20Medications.pdf 1. For continuity of care the plan will continue to reimburse for established medical treatment without interruption for the standard continuity of care grace period. Past continuity of care period, renewal or new requests will require submission of clinical for medical necessity determination. 2. Though most medications on the PDL are covered without Prior Authorization (PA), a few agents will require you to contact our	We can continue to allow for coverage without interruption if Anthem is advised of the medication profile prior to transition. Otherwise, a Prior Authorization request needs to be submitted to allow for continued coverage. Providers need to submit a prior authorization request for medications not available on the member's MCO formulary. 24 hours is the turnaround time for non-formulary medication coverage. The patient can have an emergency supply of medication while pharmacy authorization requests are considered.	If a member needs a drug that is not on the CareNet prescription drug list, we have a process for the member to get specific medically needed prescription drugs. CareNet must determine, after reasonable review and talking with the prescribing doctor that the drug on the prescription drug list does not work for the medical condition of the member. We will also allow a member to get specific medically needed prescription drugs not on the prescription drug list if the member has been getting the drug for at least six months before the change to the	The member will be approved for the first 30 days of the fill. 2 additional 30 days will be honored. During that time we ask the provider to submit all previous attempted medications so that an approval after 90 days can be obtained.	1. For a member on an established medication regimen, but where the ADHD drug needed is not on the MCOs formulary, the transition process allows for a temporary supply of non-formulary drugs in order to accommodate the immediate needs of an enrollee, as well as to allow the plan and/or the enrollee sufficient time to work with the prescriber to make an appropriate switch to a therapeutically equivalent medication, or in this specific instance, to allow the completion of an exception request to maintain coverage of an existing drug based on medical necessity	1. If the medication was PA while on DMAS, VPHP will honor the PA. If not, PA during FFS, VPHP will allow for a five day fill until drug is PA on VPHP. 2. Providers will contact Envision to request a prior auth. This can be done by phone call or fax. Information is found on www.virginiapremier.com 3. Within 48 hours. 4. Yes 5. A peer to peer can be requested with the Envision physician/pharmacy reviewer by calling Envision directly. If still not approved, the physician may appeal the decision to VPHP

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		<p>Pharmacy Department for authorization. You may reach our Pharmacy Department at 1-800-454-3730 between 8:00 a.m. and 7:00 p.m. Monday through Friday and from 10:00 a.m. to 2:00 p.m. on Saturday. The pharmacy fax number is 1-800-359-5781.</p> <p>3. The turn-around time is 24-72 business hours</p> <p>4. A three day emergency supply of medication is available to all members for all medications</p> <p>5. When a medication request is denied, the physician make take advantage of a "Reconsideration Period" of 5 days, and during that time may also submit additional clinical details or information to support the request. The reconsideration is done verbally by calling the Pharmacy department at 1-800-454-3730 and speaking with them directly. The</p>	<p>If the member's physician disagrees with the MCO's decision regarding coverage, then a peer to peer or reconsideration can be submitted by calling 1-866-312-4881.</p>	<p>prescription drug list. Also, the prescribing doctor must have decided that the drug on the prescription drug list does not work for the member and changing the drug presents a significant health risk to the member.</p> <p>To assure continuity of care for our members, we approve an emergency five-day supply of a non-formulary drug if necessary.</p> <p>We will act on the request within 1 working day.</p> <p>Members who want to request a drug that is not on the prescription drug list should have their doctor contact us at 1-800-378-7040 for review of the request. Either the member or the member's doctor may request an appeal of a previously denied request for a drug not on the prescription drug list.</p> <p>We do offer providers the opportunity to discuss an adverse</p>		<p>reasons. Please note that we recently added Vyvanse, generic Adderall XR and generic Concerta to our formulary, so the vast majority of individuals can be effectively treated with minimal interruption.</p> <p>2. Once the member obtains a non-formulary drug, the prescriber will be sent a fax explaining that the member has obtained a non-formulary drug. The fax will note formulary alternatives on the Preferred/ Standard list as well as the criteria for obtaining the non-formulary drug. Optima will make available prior authorization form upon request to prescribing physicians via a variety of mechanisms, including mail, fax, e mail and on plan web sites.</p> <p>3. We have a 24 hour turn-around time to respond to requests for coverage of non-formulary medications.</p>	<p>and it will be reviewed directly by VPHP Medical Director</p>
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“Reconsideration” decision takes approximately 48 business hours once all information has been submitted. If the reconsideration is upheld, then the physician may progress through the formal appeal process. Expedited appeals are answered within 72 hours of receipt, and standard appeals are answered within 30 calendar days of receipt. During the formal appeal process, the physician may request a “Peer-to-Peer” consultation with the Medical Director (or his designated associate Medical Director)

determination with a physician or pharmacist reviewer. We provide them a telephone number to call the health plan pharmacy call center to set up a peer-to-peer in the denial letter.

Per policy, all requests will be processed and a decision will be made within 24 hours of the receipt of the request.
 4. This should be covered by the transition policy. In addition, if a request is received after business hours or on the weekend and the drug is for an emergency medical condition (placing the health of the recipient in serious jeopardy) the After Hours staff will authorize a minimum of a 72 hour supply of the drug. In the case of the ADHD medications. Most of these are controlled substances, so if the member requests a 72 hour emergency supply, this will void the remainder of the prescription.
 5. Requests with additional information will be reviewed for reconsideration. If the additional information meets the established criteria, the request will be approved. If

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						<p>the Medical Director denies the request, a denial letter will be forwarded to the member and the provider, outlining the steps to be taken if the member wishes to initiate an appeal, or if the provider would like to request a peer to peer review</p>	
5	Virginia Vaccines for Children (VVFC)	<p>At the MAC meeting, providers were informed that for Medicaid they should continue to participate in VVFC. What is the correct way to submit the claim to the MCO for vaccines to Medicaid members? For example, do providers list the vaccine code at \$0.00 on the claim form along with the appropriate administration CPT code? Also describe how providers should submit claims for FAMIS members, (since FAMIS individuals are not eligible for VVFC).</p>					
		Amerigroup	Anthem	Coventry/CareNet	MajestaCare	Optima	Virginia Premier
		<p>A claim for a vaccine should be submitted with both the applicable serum and the administration codes. For VFC claims, the line should indicate the procedure code along with a \$0.00 charge. A subsequent line should be billed with the administration procedure code. For FAMIS members, both codes should be billed along with the applicable charges.</p>	<p>For HealthKeepers Plus, when the vaccine product is provided by <i>Virginia Vaccines for Children</i>: Immunization Administration: Do not use codes 90460 or 90461 to bill the administration & components of the vaccine serum(s) administered. Do use the appropriate <i>serum</i> codes 90476-90748 to bill for the administration of the vaccine products provided to you by the</p>	<p>Medicaid enrollees aged 0 through 18 are eligible for vaccines through the Virginia Vaccines for Children Program (VFC) that is administered by the Virginia Department of Health (VDH). Primary care physicians who administer childhood immunizations for Medicaid members must enroll in the Virginia Vaccines for Children Program. When a Medicaid member aged 0 through 18 needs immunizations, you may obtain these immunizations free</p>	<p>For Med II VFC services, the actual vaccine code should be billed with the admin charge, providers are reimbursed for the admin charge only. For FAMIS, vaccines for children should be billed with the vaccine code and admin code. They will be reimbursed for both.</p>	<p>Optima Family Care members are covered under the Virginia Vaccines for Children (VVFC) program. The VVFC program supplies vaccines to physicians at no charge. Optima Family Care providers should bill the <u>actual vaccine CPT code</u> not the administration code. For FAMIS members providers should be billed using the appropriate CPT code for the vaccine and the CPT code for the administration.</p>	<p>Providers should submit the vaccine claim for Medallion II members with the administration CPT code and amount as well as the vaccine code at \$0.00. FAMIS should be billed with the administration CPT code and the vaccine code with the billed amounts.</p>

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state for free under the *Virginia Vaccines for Children (VFC)* program.

Use of the modifier **SL** which denotes "state supplied vaccine" is optional, not required. Payment will be made for the *administration only* of the vaccine, but our system will record the actual vaccine product administered.

from VDH. You should only bill CareNet for administering this drug; bill the vaccine code at \$0.00 so we can capture the vaccine information. If you run out of VFC vaccinations, you may use your private stock for Medicaid members and ask the Department of Health to reimburse you. Enrollees in the FAMIS program and Medicaid members aged 19 and 20 are not eligible for VFC vaccines. For immunizations, you must use your own stock of vaccines. For reimbursement, you should bill us for the vaccine and for the administration of the vaccine.

6 Referrals to participating providers

At the MAC meeting, all of the MCOs stated that no referral is needed for their members to see an in-network provider. Please confirm that this is correct for your plan. Provide any additional clarification as necessary.

Amerigroup	Anthem	Coventry/CareNet	MajestaCare	Optima	Virginia Premier
Amerigroup does not require referrals for in-network providers.	Anthem HealthKeepers Plus is an Open Access Plan. As such, no referrals are required for participating/in-network providers.	No referrals are needed for in-network providers.	Referrals are not required for participating providers. A service authorization is required for services rendered by non participating providers.	No referrals required for an in-network physician; however, for certain services, authorizations may be required	NO referrals are needed for an in-network provider. Contact VPHP's medical management department for an authorization for out of

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							network providers.
7	Lab-work allowed in the physician's office	Please describe how your plan covers lab-work for members. What lab-work can be done in the provider's office versus the lab-work that must be done by a certain type of/lab provider?					
		<p>Amerigroup</p> <p>If a provider has a valid CLIA (Clinical Laboratory Improvement Amendments) certificate, they are entitled to render lab work within their office setting. Lab-work may also be done at any participating laboratory.</p>	<p>Anthem</p> <p>Laboratory Corporation of America (LabCorp) and its subsidiaries Dianon Systems, Inc. and Home Health Laboratory of America are the only participating laboratory providers for ALL HMO outpatient laboratory testing* except for those lab services included on the in-office laboratory list.</p> <p> LAB POL SPECIALIST LAB LIST- Revised 04</p> <p> LAB POL PCP LAB LIST - Revised 01FEB</p>	<p>Coventry/CareNet</p> <p>Laboratory services should be provided by a participating outpatient laboratory for lab services not provided in the provider's office. When a participating provider sends a lab to a vendor that Coventry Health Care has not contracted with to perform lab services, the provider is responsible for the charges. A provider may bill one handling charge, CPT Code 99000, per patient visit whenever the lab specimens are sent to a participating outpatient laboratory.</p>	<p>MajestaCare</p> <p>In network Providers may bill office based lab-work to MajestaCare. Out of network services require SA.</p>	<p>Optima</p> <p>We have an in-office lab list available on our website; www.optimahealth.com. All other labs must be sent out to a participating reference lab. LabCorp, Soltas, or Synergy</p>	<p>Virginia Premier</p> <p>Providers may perform specific CLIA waived lab tests for VPHP members in the office. A list of these specific CLIA waived lab tests is located under the Provider Notices section of the VPHP website. All other lab tests must be sent to LABCORP or Solstas Lab Partners.</p>
8	Licensed eligible behavioral health providers	<p>Does your plan reimburse for services rendered by qualified mental health professionals who are working towards getting licensed, meet the DBHDS qualifications of a QMHP or a QMHP- E, where the mental professional supervising them is licensed. FFS and some MCOs allow the individual being supervised to bill under the supervising entities NPI, within the DBHDS qualifications for QMHP-E. Some MCOs only allow this for CSB staff. DBHDS qualifications are described at: http://www.dbhds.virginia.gov/documents/OL-LicensingQMHP-QMRP-Qual.pdf</p>					

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	Amerigroup	Anthem	Coventry/CareNet	MajestaCare	Optima	Virginia Premier
	Yes; Amerigroup reimburses services rendered by licensed mental health providers aligned with DMAS's requirements. Our network contains providers of all applicable disciplines (i.e. Licensed Professional Counselors or LPC's, Masters in Social Work or MSW's, PhD Psychologists and MD Psychiatrists) and our contracts reflect this.	Anthem HealthKeepers Plus guidelines are modeled on DMAS' coverage guidelines for non-licensed behavioral health practitioners in supervision. The service is billed to using the supervising provider's provider number.	Our behavioral health partner, MHNet, has indicated that they follow the Medicaid regulations regarding this issue including the provider being supervised to bill under the supervising entities' NPI. The regulations allow non-licensed providers to treat Medicaid members when under direct supervision.	We follow DMAS billing guidelines for licensed eligible mental health professionals.	Optima allows only the community services boards or their contracted networks that are in underserved areas to submit for payment for licensed eligibles.	Yes, these services are reimbursed under the direct supervision of a licensed mental health professional. The service is billed under the supervising mental health professional.

9	Frequency of Well Child Exams/ Immunizations	Describe how your plan provides coverage for well child visits and immunizations. At the MAC meeting, MCOs responded that they follow the American Academy of Pediatrics and the Advisory Committee on Immunization Practice (ACIP) standards. Providers have questions regarding how the MCO's claim system calculates the frequency of visits/immunizations. For example, if the allowable is "annually" can the next visit/dose be given (reimbursed) at anytime in the member's annual treatment month or does it have to be delayed so that the next visit/immunization occurs at least 365 days from the last visit/immunization. Describe.					
		Amerigroup	Anthem	Coventry/CareNet	MajestaCare	Optima	Virginia Premier
		Amerigroup's claims payment system is configured to allow for payment within the calendar year rather than 365 days from the last date of treatment.	For Medallion II members, these fall under Early and Periodic Screening Diagnosis and Treatment (EPSDT): Newborn Less than 1 year 1-4 years 5-11 years 12-17 years 18-20 years	We follow the ACIP guidelines. An "annual" visit can be provided and reimbursed in the next calendar year. It does not need to be delayed so that it occurs 365 days from the last visit/immunization.	The frequency of visits/immunizations is annually and services can be provided as necessary during the benefit period. Services do not have to be at least 365 days from the last visit/immunization.	We do not do anything systematically to control the amount of time between visits or immunizations	We do not do anything systematically to control the amount of time between visits or immunizations

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For FAMIS members, the following services are rendered for the routine care of a well child: Laboratory services: blood lead testing, HGB, HCT or FEP (maximum of 2, any combination); Tuberculin test (maximum of 3 covered); Urinalysis (maximum of 2 covered); Pure tone audiogram for age 3 (Maximum of 1); Machine vision test (maximum of 1). Hearing services: all newborn infants will be given a hearing screening before discharge from the hospital after birth. Well child visits rendered at home, office and other outpatient provider locations are covered at:
 Birth
 1 month
 2 months
 4 months
 6 months
 9 months
 12 months

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		15 months 18 months 2 years 3 years 4 years 5 years 6-18 years annual visits				
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10 Pressure to take both commercial and Medicaid in order to serve Medicaid/FAMIS recipients. A small group of vision providers indicated that some of the MCO's vision subcontractors had language in their respective contracts that indicated that signing up with the vision subcontractor required the provider to serve as both a Medicaid and commercial provider. DMAS advised that the MCO contract prohibits the MCO or its subcontractor from requiring the provider who wants to serve only Medicaid/FAMIS to also serve the MCO's/subcontractor's commercial population. MCOs: Check with your Vision subcontractor's and advise.

Amerigroup	Anthem	Coventry/CareNet	MajestaCare	Optima	Virginia Premier
Amerigroup does not manage a commercial line of business; therefore this issue is not applicable.	It is not a Davis Vision practice to require providers to participate in the Davis Vision commercial network as a condition of participation in the Medicaid/FAMIS network. Further, none of the Davis Vision provider contracts contain language-requiring participation in the commercial network as a condition of participating in the Medicaid/FAMIS network.	We have reminded our subcontractors that participating in the commercial product cannot be a requirement for participation in the Medicaid product.	We have contacted March Vision to ensure that they are aware that they may not require a Provider who wants to serve only Medicaid/FAMIS members to also serve their commercial population.	According to EyeMed, the fact that a plan is Medicaid or Commercial is not part of the contract or dialogue with Providers. Providers are contracted based on an EyeMed Network. Since Optima Health Vision Plans use the Select Network, any provider that contracts for Select, can see your Health Plan Members.	We are working with our Vision Service Plan (VSP) to remove any language that would be problematic for the provider.

11 PACE Will PACE be included in the Medallion II Program?
No. Individuals who are enrolled in the DMAS PACE program will be exempt from the Medallion II MCO program.

12 Waivers Are the MCOs familiar with community based organizations like the Area Agencies on Aging and the role that these agencies plan to assist elderly and disabled individuals?

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		Amerigroup	Anthem	Coventry/CareNet	MajestaCare	Optima	Virginia Premier
		<p>Yes, our health plan receives and reviews the waiver reports on a monthly basis. Our case managers are provided with updated waiver logs to identify when members have waivers and are able, based on this information, to coordinate services for members as needed. Our case managers also consider member needs and barriers and include referrals to appropriate organizations such as Area Agencies on Aging to assist members in finding additional resources and obtaining assessments to determine if they are eligible for additional services/benefits and waivers. Our Case Management team currently works with many community based organizations (such as the Community Service Board and local health</p>	<p>Yes. We have established relationships with Area Agencies on Aging.</p>	<p>We are familiar with community-based organizations such as AAA and the services they offer. We maintain a community resource guide that is updated on a regular basis and is available to our health services and outreach staff and social workers.</p>	<p>Yes, MajestaCare establishes relationships with all community organizations and work together with them and the member's provider to provide the member with the necessary resources</p>	<p>Optima Family Care is familiar with the Community Resources. We work with the Area Agencies on Aging, Health Departments, Community Service Boards, CHIP and other organizations.</p>	<p>Yes, VPHP is very familiar with the resources for the elderly and disabled. Our case managers and outreach workers communicate frequently with these resources to coordinate care and other social services.</p>

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departments) to provide services to all members.

13 Billing and Coding Guidelines

Will the MCOs follow the same billing and coding guidelines as Virginia Medicaid?

General Rule - MCOs follow nationally recognized standards. Each plan may have different service authorization, referral, claim submission processes, and these may differ from Virginia Medicaid and may differ from the other participating MCOs in the region. Consult your contract with the MCO or your MCO provider representative regarding the MCOs billing and coding guidelines.

Amerigroup	Anthem	Coventry/CareNet	MajestaCare	Optima	Virginia Premier
Amerigroup's billing and coding guidelines are in adherence with the DMAS summary of benefits and nationally recognized standards as per Claim Check ® software and coding guidelines put forth from agencies such as CMS.	Per above	Per above	MajestaCare follows nationally recognized standards. Paper referrals are NOT required for MajestaCare members. Certain services require a service authorization. All inpatient services and all services rendered by non participating providers require service authorizations. Outpatient services are CPT/HCPC code specific. A provider can check the code on our provider portal (www.majestacare.com) or call the Service Authorization department 1-866-996-9140	Optima Family Care follows nationally recognized standards. You may also refer to our website: http://providers.optimahealth.com/Pages/default.aspx	Per above

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					Service authorizations are not required for emergency services.		
14	OB Visits – Global or separate?	I have read on the one of the MCO websites that OB visits will be paid separate and will not be considered part of the OB global package. Will OB visits be handled this way for all of the MCOs? Explain your MCOs billing process for OB visits.					
		Amerigroup	Anthem	Coventry/CareNet	MajestaCare	Optima	Virginia Premier
		Amerigroup manages obstetrical visits on a fee-for-service basis; or as specifically negotiated in the applicable provider contract.	Anthem HealthKeepers Plus reimburses maternity at a Global rate, which covers all prenatal care and delivery.	We use global billing for OB visits.	OB global and FFS billing is allowed. “Antepartum care, delivery, and postpartum care should be billed as an all-inclusive, single unit (global), except when the antepartum care and the delivery are provided by different physicians” If antepartum care, or delivery, or postpartum care services are provided by different physicians, the appropriate CPT codes that describe each individual service	We do reimburse global reimbursement for Medicaid; however, some services are considered FFS and are not part of the global. We have a document we can share with specific providers upon request.	Network Development / Contracting sets up all par providers as non-global so they can unbundle OB services, unless the provider requests otherwise. However, non-par providers are always setup as global and cannot unbundle OB services.

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					will be billed and paid the rate as provided in the DMAS fee schedule.		
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