

MANAGED CARE RESOURCE GUIDE

Department of Medical Assistance Services

15. Accessing Covered Services

**Guide to Accessing Medicaid Fee-For-Service,
Medallion II (Medicaid MCO), & FAMIS MCO**

A description of accessing covered services (Medallion II, FAMIS Plus, FAMIS, and FAMIS MOMS), including preventive services, service limitations, referral and prior authorization requirements. The following are not intended to be a comprehensive list of covered benefits. All covered service benefit limits should be verified through the appropriate DMAS Provider Manual.

More information on accessing covered services can be found at:
http://dmasva.dmas.virginia.gov/Content_pgs/mc-medallion2.aspx

Medicaid Fee-For-Service, Medallion II (Medicaid MCO), FAMIS MCO, & FAMIS MOMS Covered Services

Behavioral Health and Substance Abuse Services are Listed at the End of the Summary Table

Service	Fee-For-Service FFS (Medicaid, FAMIS Plus, & FAMIS)	Medallion II MCO (Medicaid, FAMIS Plus, & FAMIS MOMS)	FAMIS MCO	Medicaid Medallion II Comments	FAMIS MCO Comments
Abortions, induced	Covered ONLY in cases where there would be substantial danger to life of mother	Yes, services are paid through the Department within FFS coverage guidelines	Covered only if necessary to save the life of the mother.	The MCO shall not cover services for abortion. Requests for abortions that are referenced in Public Law 111-8 shall be reviewed to ensure compliance with State and federal law. The Commonwealth will be responsible for payment of abortion services meeting state and federal requirements under the fee-for-service program.	The MCO is not required to cover services for abortion.
Case Management Services for Members of Auxiliary Grants	Yes, services are covered by the Department (carved out service)	Yes, services are covered by the Department (carved out service)	No, not a covered benefit	The MCO is not required to cover this service. This service is covered and paid for by DMAS for FFS <u>and</u> MCO Medicaid and FAMIS Plus eligible members in accordance with DMAS guidelines.	The MCO is not required to cover this service.
Case Management Services for the Elderly	Yes, services are covered by the Department (carved out service)	Yes, services are covered by the Department (carved out service)	No, not a covered benefit	The MCO is not required to cover this service. This service is covered and paid for by DMAS for FFS <u>and</u> MCO Medicaid and FAMIS Plus eligible members in accordance with DMAS guidelines.	The MCO is not required to cover this service.
Case Management Services for High Risk Pregnant Women & Infants up to Age 2	Yes	Yes	No	See Section 12 Contact Information of this guide for High Risk Maternal Infant Program Services	See Section 12 Contact Information of this guide for High Risk Maternal Infant Program Services
Chiropractic Services	No, not a covered benefit	No, not a covered benefit	Yes – see comments	This service is not a Medicaid/FAMIS Plus covered service. The MCO is not required to cover this service.	The MCO shall provide \$500 per calendar year coverage of medically necessary spinal manipulation and outpatient chiropractic services rendered for the treatment of an illness or injury.
Christian Science Nurses and Christian Science Sanatoria	No, not a covered benefit	No, not a covered benefit	No, not a covered benefit	This service is not a Medicaid/FAMIS Plus covered service. The MCO is not required to cover this service.	The MCO is not required to cover this service.

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Clinic Services	Yes	Yes	Yes	The MCO is required to cover all clinic services that are defined as preventative, diagnostic, therapeutic, rehabilitative, or palliative services, including renal dialysis clinic visits.	The MCO shall cover clinic services that are defined as preventive, diagnostic, therapeutic, rehabilitative, or palliative services that are provided to outpatients and are provided by a facility that is not part of a hospital but is organized and operated to provide medical care to outpatients. With the exception of nurse-midwife services, clinic services are furnished under the direction of a physician. Renal dialysis clinic visits are also covered.
Colorectal Cancer Screening	Yes	Yes	No, not a covered benefit	The MCO shall cover colorectal cancer screening in accordance with the most recently published recommendations established by the American Cancer Society, for the ages, family histories and frequencies referenced in such recommendations.	The MCO is not required to cover this service.
Court Ordered Services	Yes	Yes	No – see comments	The MCO is required to cover all medically necessary court ordered Medallion II services.	The MCO is not required to cover this service unless the service is both medically necessary and is a FAMIS covered service.

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<p>Dental Services – <i>Routine dental care is covered under the Smiles For Children Dental Program for FFS and MCO enrollees.</i></p>	<p>Yes--see Comments</p>	<p>Yes – see comments.</p>	<p>Yes – see comments.</p>	<p>The Contractor is required to cover CPT codes billed by an MD as a result of an accident.</p> <p>The Contractor is required to cover medically necessary anesthesia and hospitalization services for certain members when determined such services are required to provide dental care. Services may require prior authorization.</p> <p>Coverage for adults is limited to medically necessary oral surgery and associated diagnostic services. See Article IIG of the Medallion II contract.</p> <p>Pediatric dental services (for eligible children up to age 21) are covered through the Smiles for Children Program through the Department's Dental Benefits Administrator (DBA). For more information regarding SFC dental benefits, call 1-888-912-3456.</p>	<p>The Contractor is required to cover CPT codes billed by an MD as a result of an accident.</p> <p>The Contractor is required to cover medically necessary anesthesia and hospitalization services for certain members when determined such services are required to provide dental care. See Article IIG of the FAMIS contract for specific requirement.</p> <p>Pediatric dental services (for eligible children up to age 21) are covered through the Smiles for Children Program through the Department's Dental Benefits Administrator (DBA). For more information regarding SFC dental benefits, call 1-888-912-3456.</p>
<p>Early and Periodic Screening, Diagnosis and Treatment (EPSDT)</p>	<p>Yes</p>	<p>Yes</p>	<p>No, not a covered benefit See “Well Baby and Well Child Care”</p>	<p>The MCO is required to cover EPSDT screenings and diagnostic services as well as any and all services identified as necessary to correct or ameliorate any identified defects or chronic conditions.</p> <p>The MCO is required to screen and assess all children.</p> <p>The MCO is required to cover immunizations.</p> <p>The MCO is required to educate providers regarding reimbursement of immunizations and to work with the Department to achieve its goal related to increased immunization rates.</p>	<p>The MCO is not required to cover this service. The MCO is required to cover well-baby and well child care services.</p>

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Early Intervention Services	Yes, services are covered by the Department (carved out service)	Yes, services are covered by the Department (carved out service)	Yes, services are covered by the Department (carved out service)	<p>The MCO is not required to provide coverage for early intervention (EI) services as described in 12 VAC 30-50-131. EI services for children who are enrolled in a contracted MCO are covered by the Department within the Department's coverage criteria and guidelines. EI billing codes and coverage criteria are described in the Department's Early Intervention Program Manual, on the DMAS website at http://websrvr.dmas.virginia.gov/ProviderManuals/Default.aspx.</p> <p>The MCO shall cover other medically necessary rehabilitative and developmental therapies, including for EI enrolled children where appropriate.</p>	<p>The MCO is not required to provide coverage for early intervention (EI) services as described in 12 VAC 30-50-131. EI services for children who are enrolled in a contracted MCO are covered by the Department within the Department's coverage criteria and guidelines. EI billing codes and coverage criteria are described in the Department's Early Intervention Program Manual, on the DMAS Website at http://websrvr.dmas.virginia.gov/ProviderManuals/Default.aspx.</p> <p>The MCO shall cover other medically necessary rehabilitative and developmental therapies for EI enrolled children where appropriate.</p>
Emergency Services	Yes	Yes	Yes	<p>The MCO is required to cover all emergency services without prior authorization. The MCO is also required to cover the services needed to ascertain whether an emergency exists. The MCO may not restrict an enrollee's choice of provider for emergency services.</p> <p>The MCO shall cover all emergency services provided by out-of-network providers. The MCO may not require prior authorization for emergency services. This applies to out-of-network as well as to in-network services that an enrollee seeks in an emergency.</p>	<p>The MCO shall provide for the reasonable reimbursement of services needed to ascertain whether an emergency exists in instances in which the clinical circumstances that existed at the time of the beneficiary's presentation to the emergency room indicate that an emergency may exist. The MCO shall ensure that all covered emergency services are available twenty-four (24) hours a day and seven (7) days a week.</p> <p>The MCO shall cover all emergency services provided by out-of-network providers. The MCO may not require prior authorization for emergency services. This applies to out-of-network as well as to in-network services that an enrollee seeks in an emergency.</p> <p>Enrollees who present to the emergency room shall pay the emergency room co-payment. If it is determined that the visit was a non-emergency, the hospital may bill the enrollee only for the difference between the emergency room and non-emergency co-payments, i.e. \$8.00 for <150% and \$20.00 for >150%. The hospital may not bill for additional charges.</p>

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Post-Stabilization Care following Emergency Services	Yes	Yes	Yes	The MCO must cover post-stabilization services subsequent to an emergency that a treating physician views as medically necessary AFTER an emergency medical condition has been stabilized.	The MCO must cover post-stabilization services subsequent to an emergency that a treating physician views as medically necessary AFTER an emergency medical condition has been stabilized regardless of whether the enrollee obtains the services within or outside the MCO's network.
Experimental and Investigational Procedures	No, not a covered benefit	No, not a covered benefit	No, not a covered benefit	This service is not a Medicaid/FAMIS Plus covered service.	The MCO is not required to cover this service. See MCO Contract for EPSDT related criteria.
Family Planning Services	Yes	Yes	Yes	<p>The MCO is required to cover all family planning services and supplies for members of child-bearing age which delay or prevent pregnancy, including drugs, supplies and devices.</p> <p>The MCO may not restrict an member's choice of provider or choice of method for family planning services or supplies, and the MCO is required to cover all family planning services and supplies provided to its enrollees by network providers and by out-of-network providers.</p>	<p>The MCO shall cover all family planning services, which includes services, drugs and devices for members of childbearing age which delay or prevent pregnancy, but does not include services to treat infertility or to promote fertility. FAMIS covered services include drugs, supplies and devices provided under the supervision of a physician.</p> <p>The MCO may not restrict an enrollee's choice of provider or choice of method for family planning services or supplies, and the MCO is required to cover all family planning services and supplies provided to its enrollees by network providers.</p> <p><i>Code of Virginia § 54.1-2969 (D)</i>, as amended, states that minors are deemed adults for the purpose of consenting to medical services required in case of birth control, pregnancy or family planning, except for purposes of sexual sterilization.</p>
HIV Testing and Treatment Counseling	Yes	Yes	No, not a covered benefit	The MCO is required to comply with the State requirements governing HIV testing and treatment counseling for pregnant women.	The MCO is not required to cover this service.

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Home Health Services	Yes	Yes	Yes	<p>The MCO is required to cover home health services, including nursing services, rehabilitation therapies, and home health aide services. At least 32 home health aide visits shall be allowed. Skilled home health visits are limited based upon medical necessity.</p> <p>The MCO must continue to manage the following service related conditions, where medically necessary and regardless of whether the need is long-term or short-term. This includes those instances where the member cannot perform the services; where there is no responsible party willing and able to perform the services, and where and the service cannot be performed in the PCP office/outpatient clinic, etc. The MCO may cover these services under home health or may choose to manage the related conditions using another safe and effective treatment option. The MCO shall not refer for skilled nursing under the home and community based waivers for these conditions.</p> <ul style="list-style-type: none"> ▪ B-12 shots ▪ Insulin injections ▪ Central line and porta cath flushes ▪ Blood draws, for example where the recipient is medically unstable or is morbidly obese and requires transportation via lab/MD office by ambulance ▪ Changing of indwelling catheter 	<p>The MCO shall cover home health services, including nursing and personal care services, home health aide services, PT, OT, speech, hearing and inhalation therapy up to 90 visits per calendar year. Personal care means assistance with walking, taking a bath, dressing; giving medicine; teaching self-help skills; and performing a few essential housekeeping tasks. The MCO is not required to cover the following home health services: medical social services, services that would not be paid for by FAMIS if provided to an inpatient of a hospital, community food service delivery arrangements, domestic or housekeeping services which are unrelated to patient care, custodial care which is patient care that primarily requires protective services rather than definitive medical and skilled nursing care services, and services related to cosmetic surgery.</p>

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Hospice Services	Yes, Services are covered through the Department within FFS coverage guidelines	No, hospice enrolled members are excluded from the Medallion II program.	Yes	The MCO is not required to cover this service. Members who elect Hospice Benefits will be excluded from the Medallion II MCO program. This service will continue to be covered through the Medicaid fee-for-service system.	The MCO shall cover hospice care services to include a program of home and inpatient care provided directly by or under the direction of a licensed hospice. Hospice care programs include palliative and supportive physician, psychological, psychosocial, and other health services to members utilizing a medically directed interdisciplinary team. Hospice care services must be prescribed by a Provider licensed to do so, furnished and billed by a licensed hospice, and medically necessary. Hospice care services are available if the enrollee is diagnosed with a terminal illness with a life expectancy of six months or fewer. DMAS shall reimburse the MCO for claims for this service.
Immunizations	Yes	Yes	Yes	The MCO is required to cover immunizations. The MCO is required to educate providers regarding reimbursement of immunizations and to work with the Department to achieve its goal related to increased immunization rates.	The MCO is required to cover immunizations. The MCO shall ensure that providers render immunizations, in accordance with the most current Advisory Committee on Immunization Practices (ACIP). The MCO shall allow for an annual flu vaccine without limitations to age and without the requirement of meeting the CDC at risk guidelines. FAMIS eligible enrollees shall not qualify for the free Vaccines for Children Program.
Inpatient Hospital Services	Yes	Yes	Yes	The MCO is required to cover inpatient stays in general acute care and rehabilitation hospitals for all enrollees. The MCO is required to comply with maternity length of stay requirements. MCO is required to comply with radical or modified radical mastectomy, total or partial mastectomy length of stay requirements. The MCO is required to cover an early discharge follow-up visit if the mother and newborn, or the newborn alone, are discharged earlier than 48 hours after the day of delivery.	The MCO is required to cover inpatient stays in general acute care and rehabilitation hospitals for all enrollees up to 365 days per confinement in a semi-private room or intensive care unit for the care of illness, injury, or pregnancy (includes medically necessary ancillary services). The MCO shall cover alternative treatment plan for a patient who would otherwise require more expensive services, including, but not limited to, long-term inpatient care. The MCO must approve in advance the alternative treatment plan.

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Laboratory and X-ray Services	Yes	Yes	Yes	The MCO is required to cover all laboratory and x-ray services directed and performed within the scope of the license of the practitioner.	The MCO is required to cover all laboratory and x-ray services ordered, prescribed and directed or performed within the scope of the license of a practitioner in appropriate settings, including physician office, hospital, independent and clinical reference labs. No co-pay shall be charged for laboratory or x-ray services that are performed as part of an encounter with a physician.
Lead Testing (Home)	Yes, services are covered by the Department (carved out service)	Yes, services are covered by the Department (carved out service)	Yes	The MCO is not required to cover this service. This service is carved-out of the MCO contract and is covered and paid for through the Medicaid fee-for-service system in accordance with DMAS guidelines.	The MCO is required to cover blood lead testing as part of well baby, well childcare.
Mammograms	Yes	Yes	Yes	MCO is required to cover low-dose screening mammograms for determining presence of occult breast cancer.	MCO is required to cover low-dose screening mammograms for determining presence of occult breast cancer.
Medical Supplies and Equipment	Yes	Yes	Yes	<p>The MCO is required to cover all medical supplies and equipment at least to the extent they are covered by Medicaid.</p> <p>The MCO is required to cover related supplies for children and nutritional supplements for adults over 21.</p> <p>The MCO is responsible for payment of any specially manufactured DME equipment that was prior authorized by the MCO.</p>	The MCO shall cover durable medical equipment and other medically related or remedial devices (such as prosthetic devices, implants, eyeglasses, hearing aids, dental devices, and adaptive devices). Durable medical equipment and prosthetic devices and eyeglasses are covered when medically necessary.
Nurse-Midwife Services	Yes	Yes	Yes	The MCO is required to cover nurse-midwife services as allowed under State licensure requirements and Federal law.	The MCO is required to cover nurse-midwife services as allowed under State licensure requirements and Federal law.

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Organ Transplantation	Yes	Yes	Yes	For the purposes of organ transplantation, all similarly situated members will be treated alike. Transplant services for kidneys, corneas, hearts, lungs, and livers (from living or cadaver donors) shall be covered for all eligible persons. High dose chemotherapy and bone marrow/stem cell transplantation shall be covered for all eligible persons with a diagnosis of lymphoma, breast cancer, leukemia, or myeloma when medically necessary. Contractor shall cover necessary procurement/donor related services. Transplant services for any other medically necessary transplantation procedures that are determined to not be experimental or investigational shall be limited to children (under 21 years of age). Standards for coverage of organ transplant services are in 12VAC30-50-540 through 12VAC30-50-580.	The MCO shall cover organ transplantation services as medically necessary for all eligible members, to include transplants of tissues, autologous, allogenic or syngenic bone marrow transplants or other forms of stem cell rescue for children with lymphoma and myeloma. The MCO shall cover kidney transplants for patients with dialysis dependent kidney failure, heart, liver, pancreas, and single lung transplants. The MCO is not required to cover transplant procedures determined to be experimental or investigational. Contractor shall cover necessary procurement/donor related services.
Outpatient Hospital Services	Yes	Yes	Yes	The MCO is required to cover preventive, diagnostic, therapeutic, rehabilitative or palliative outpatient services rendered by hospitals, rural health clinics, or federally qualified health centers. The MCO is required to cover limited oral surgery as defined under Medicare.	The MCO shall cover outpatient hospital services which are preventive, diagnostic, therapeutic, rehabilitative or palliative in nature that are furnished to outpatients, and are furnished by an institution that is licensed or formally approved as a hospital by an officially designated authority for State standard-setting. Observation bed services shall be covered when they are reasonable and necessary to evaluate a medical condition to determine appropriate level of treatment or non-routine observation for underlying medical complications. Outpatient services include emergency services, surgical services, and diagnostic and professional provider services. Facility charges are also covered.

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Pap Smears	Yes	Yes	Yes	MCO is required to cover annual pap smears.	The MCO is required to cover annual pap smears.
Physical Therapy, Occupational Therapy, Speech Pathology and Audiology Services	Yes	Yes	Yes	The MCO is required to cover physical therapy, occupational therapy, and speech pathology and audiology services that are provided as an inpatient or outpatient hospital service or home health service. The MCO's benefits shall include coverage for acute and non-acute conditions and shall be limited based upon medical necessity.	The MCO shall cover therapy services that are medically necessary to treat or promote recovery from an illness or injury, to include physical therapy, occupational therapy, speech therapy, inhalation therapy, intravenous therapy. The MCO shall not be required to cover those services rendered by a school-based clinic.
Physician Services	Yes	Yes	Yes	The MCO is required to cover all symptomatic visits to physicians or physician extenders and routine physicals for children up to age twenty-one under EPSDT.	The MCO shall cover all symptomatic visits provided by physicians or physician extenders within the scope of their licenses. Cosmetic services are not covered unless performed for medically necessary physiological reasons. Physician services include services while admitted in the hospital, outpatient hospital departments, in a clinic setting, or in a physician's office.
Podiatry	Yes	Yes	Yes, see comments	The MCO is required to cover podiatry services including diagnostic, medical or surgical treatment of disease, injury, or defects of the human foot.	The MCO is not required to cover services for the scraping or removing corns or calluses and the trimming of nails.

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Pregnancy-Related Services	Yes	Yes	Yes	<p>The MCO shall cover services for pregnant women. There is no co-pay for pregnancy related services.</p> <p>The Contractor is required to cover case management services for high risk pregnant women and children (up to age two).</p> <p>The Contractor is required to provide to qualified members expanded prenatal care services, including patient education; nutritional assessment, counseling and follow-up; homemaker services; and blood glucose meters. The Contractor is required to cover pregnancy-related and postpartum services for sixty (60) days after pregnancy ends.</p>	<p>The MCO shall cover services to pregnant women, including prenatal services for FAMIS and FAMIS MOMS. There is no co-pay for pregnancy related services. No cost sharing at all will be charged to members enrolled in FAMIS MOMS.</p>
Tobacco Dependence Treatment (i.e., Smoking Cessation) for Pregnant Women	Yes	Yes	Yes	<p>The MCO shall provide coverage for tobacco dependence treatment for pregnant women without cost sharing. Treatment includes counseling and pharmacotherapy.</p>	<p>The MCO shall provide coverage for tobacco dependence treatment for pregnant women without cost sharing. Treatment includes counseling and pharmacotherapy.</p>
Prenatal Services— Expanded	Yes	See Comment	No	<p>The MCO may choose to provide to qualified enrollees expanded prenatal care services, including member education; nutritional assessment, counseling and follow-up; homemaker services; and blood glucose meters. The MCO is required to cover pregnancy-related and post-partum services for sixty- (60) days after pregnancy ends</p>	<p>The MCO shall cover expanded prenatal services to pregnant women, enrolled in FAMIS MOMS. There is no co-pay for pregnancy related services. No cost sharing at all will be charged to members enrolled in FAMIS MOMS.</p>

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Private Duty Nursing	Not covered for Adults, Covered under the EPSDT benefit for children under age 21 within limitations.	Not covered for Adults, Covered under the EPSDT benefit for children under age 21 within limitations.	Yes	<p>The MCO is required to cover medically necessary private duty nursing services for children under age 21 consistent with the Department's criteria described in the EPSDT Nursing Supplement, and as required in accordance with EPSDT regulations described in 42 C.F.R. § 441.50, 42 C.F.R. § 440.80, and the Social Security Act §§1905(a) and 1905(r) I. Available on the DMAS website at: http://websrvr.dmas.virginia.gov/manuals/General/EPSDT_Nursing.pdf</p>	<p>The MCO shall cover private duty nursing services when medically necessary.</p> <p>Private duty nursing services must be authorized.</p>
Prescription Drugs	Yes	Yes	Yes	<p>The MCO is required to cover prescription drugs, including those prescribed by a provider during a physician visit or other visit covered by a third party payor including Mental Health visits.</p> <p>The MCO may establish a formulary, may require prior authorization on certain medications, and may implement a mandatory generic substitution program. However, the MCO shall have in place special authorization procedures to allow providers to access drugs outside of this formulary, if medically necessary.</p> <p>The MCO shall cover atypical antipsychotic medications developed for the treatment of schizophrenia. The MCO shall ensure appropriate access to the most effective means to treat, except where indicated for the safety of the member. The MCO shall not cover prescriptions for erectile dysfunction medication for enrollees</p>	<p>The MCO shall be responsible for covering all medically necessary drugs for its enrollees that by Federal or State law requires a prescription. The MCO shall cover all FAMIS covered prescription drugs prescribed by providers licensed and/or certified as having authority to prescribe the drug. The MCO is not required to cover Drug Efficacy Study Implementation (DESI) drugs or over the counter prescriptions.</p> <p>The MCO may establish a formulary, may require prior authorization on certain medications, and may implement a mandatory generic substitution program. However, the MCO shall have in place special authorization procedures to allow providers to access drugs outside of this formulary, if medically necessary.</p> <p>The MCO shall cover atypical antipsychotic medications developed for the treatment of schizophrenia. The MCO shall ensure appropriate access to the most effective means to treat, except where indicated for the safety of the member. The MCO shall not cover prescriptions for erectile dysfunction medication for enrollees</p>

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Prostate Specific Antigen (PSA) and digital rectal exams	Yes	Yes	No, not a covered benefit	The MCO is required to cover screening Prostate Specific Antigen (PSA) and the related digital rectal exams (DRE) for the screening of male enrollees for prostate cancer.	The MCO is not required to cover this service.
Prosthetics/ Orthotics	Yes	Yes	Yes	The MCO is required to cover prosthetics (arms and legs and their supportive attachments, breasts, eye prostheses) to the extent that they are covered under Medicaid. The MCO is required to cover medically necessary orthotics for children under age 21 and for adults and children when recommended as part of an approved intensive rehabilitation program as described in 12VAC30-60-120.	The MCO shall cover prosthetic services and devices (at minimum, artificial arms, legs and their necessary supportive attachments) for all enrollees. At a minimum, the MCO shall cover medically necessary orthotics (i.e., braces, splints, ankle, foot orthotics, etc.) for enrollees. The MCO shall cover medically necessary orthotics for enrollees when recommended as part of an approved intensive rehabilitation program.
Prostheses, Breast	Yes	Yes	Yes	The MCO is required to cover breast prostheses following medically necessary removal of a breast for any medical reason.	The MCO is required to cover breast prostheses following medically necessary removal of a breast for any medical reason.
Reconstructive Breast Surgery	Yes	Yes	Yes	MCO is required to cover reconstructive breast surgery.	MCO is required to cover reconstructive breast surgery.
Regular Assisted Living Services Provided to Residents of Assisted Living Facilities	Yes	Yes, Paid by DMAS	No, not a covered benefit	The MCO is not required to cover this service. When appropriate, the Department will reimburse the Assisted Living Facility. Reference the DMAS Assisted Living Manual for details.	The MCO is not required to cover this service.

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Service	Fee-For-Service FFS (Medicaid, FAMIS Plus, & FAMIS)	Medallion II MCO (Medicaid, FAMIS Plus, & FAMIS MOMS)	FAMIS MCO	Medicaid Medallion II Comments	FAMIS MCO Comments
School Health Services	Yes, services are covered by the Department (carved out service)	No, services are covered by the Department (carved out service) See comments	No, services are covered by the Department (carved out service) See comments	<p>All school health services that are rendered in a public school setting or on school property (including Head Start) and included on the child's IEP (except those below) will continue to be covered as a carve-out service through the Medicaid/FAMIS Plus fee-for-service system. The following services provided on school grounds shall be covered by the MCOs:</p> <ul style="list-style-type: none"> a) Services performed by an in-network clinic, FQHC, RHC, or medical facility housed on school grounds and providing covered medical and/or behavioral health services; b) Well-child screenings and/or immunizations performed by a registered nurse or nurse practitioner employed by the school system in DMAS-identified provider shortage areas; and, c) Services performed within a private school or day care setting except Early Intervention Services. <p>For more information, reference Article I <i>Definitions</i> section and Article II <i>Provision of Contract Services</i> section for more details. The Contractor shall not deny medically necessary outpatient or home setting therapies based on the fact that the child is also receiving therapies in a school</p>	<p>All school health services that are rendered in a public school setting or on school property (including Head Start) and included on the child's IEP (except those below) will continue to be covered as a carve-out service through the Medicaid/FAMIS Plus fee-for-service system. The following services provided on school grounds shall be covered by the MCOs:</p> <ul style="list-style-type: none"> a) Services performed by an in-network clinic, FQHC, RHC, or medical facility housed on school grounds and providing covered medical and/or behavioral health services; b) Well-child screenings and/or immunizations performed by a registered nurse or nurse practitioner employed by the school system in DMAS-identified provider shortage areas; and, c) Services performed within a private school or day care setting except Early Intervention Services. <p>For more information, reference Article I <i>Definitions</i> section and Article II <i>Provision of Contract Services</i> section for more details. The Contractor shall not deny medically necessary outpatient or home setting therapies based on the fact that the child is also receiving therapies in a school</p>

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Skilled Nursing Facility Care (SNF)	Yes, Services are covered through the Department within FFS coverage guidelines	No, services are covered through the Department within FFS coverage guidelines	Yes	The MCO is not required to cover skilled nursing facility care. This service will be covered through the Medicaid fee-for-service system. Institutionalized individuals will become excluded from Medallion II upon entry into the DMAS nursing facility authorization database. The Contractor may provide step down nursing care as an enhanced benefit to Medicaid members.	The MCO shall cover medically necessary services that are provided in a skilled nursing facility for up to 180 days per confinement.
Transportation	Yes	Yes	No	<p>The MCO is required to provide transportation to all Medicaid/FAMIS Plus covered services, including those Medicaid/FAMIS Plus services covered by a third party payor, and transportation to carved out services provided by subcontractors such as dental.</p> <p><i>EXCEPTION - Transportation to Home and Community Based Waiver Services is carved-out of the MCO Contract and covered by DMAS.</i></p>	<p>Transportation services are not provided for routine access to and from providers of covered medical services.</p> <p>Professional ambulance services when medically necessary are covered when used locally or from a covered facility or provider office. This includes ambulance services for transportation between local hospitals when medically necessary; if prearranged by the Primary Care Physician and authorized by the MCO if, because of the enrollee's medical condition, the enrollee cannot ride safely in a car when going to the provider's office or to the outpatient department of the hospital. Ambulance services will be covered if the enrollee's condition suddenly becomes worse and must go to a local hospital's emergency room. For coverage of ambulance services, the trip to the facility or office must be to the nearest one recognized by the MCO as having services adequate to treat the enrollee's condition; the services received in that facility or provider's office must be covered services; and if the MCO or the Department requests it, the attending provider must explain why the enrollee could not have been transported in a private car or by any other less expensive means.</p>

Medicaid Fee-For-Service, Medallion II (Medicaid MCO), FAMIS MCO, & FAMIS MOMS Covered Services

Behavioral Health and Substance Abuse Services are Listed at the End of the Summary Table

Service	Fee-For-Service FFS (Medicaid, FAMIS Plus, & FAMIS)	Medallion II MCO (Medicaid, FAMIS Plus, & FAMIS MOMS)	FAMIS MCO	Medicaid Medallion II Comments	FAMIS MCO Comments												
Vision Services	Yes	Yes	Yes	The MCO is required to cover vision services including diagnostic examination and optometric treatment procedures and services by ophthalmologists, optometrists and opticians. The MCO is also required to cover eyeglasses under age 21. The MCO's benefit limit for routine refractions shall not be less than once every twenty-four (24) months.	<p>The MCO shall cover vision services that are defined as diagnostic examination and optometric treatment procedures and services by ophthalmologists, optometrists, and opticians. Routine refractions shall be allowed at least once in twenty-four (24) months. Routine eye examinations, for all enrollees, shall not be limited to less than once every two-(2) years. The MCO shall cover eyeglasses (one pair of frames and one pair of lenses) or contact lenses prescribed as medically necessary by a physician skilled in diseases of the eye or by an optometrist for enrollees.</p> <p style="text-align: right;">Benefit:</p> <table style="margin-left: auto; margin-right: auto;"> <tr> <td style="padding-right: 10px;">Eyeglass Frames</td> <td>\$25</td> </tr> <tr> <td colspan="2">Eyeglass Lenses</td> </tr> <tr> <td style="padding-right: 10px;"> Single Vision</td> <td>\$35</td> </tr> <tr> <td style="padding-right: 10px;"> Bifocal</td> <td>\$50</td> </tr> <tr> <td style="padding-right: 10px;"> Trifocal</td> <td>\$88.50</td> </tr> <tr> <td style="padding-right: 10px;"> Contacts</td> <td>\$100</td> </tr> </table>	Eyeglass Frames	\$25	Eyeglass Lenses		Single Vision	\$35	Bifocal	\$50	Trifocal	\$88.50	Contacts	\$100
Eyeglass Frames	\$25																
Eyeglass Lenses																	
Single Vision	\$35																
Bifocal	\$50																
Trifocal	\$88.50																
Contacts	\$100																
Well Baby and Well Child Care	Yes	Yes	Yes	See Early and Periodic Screening Diagnosis and Treatment (EPSDT).	The MCO shall cover routine well baby and well childcare including routine office visits with health assessments and physical exams, as well as routine lab work and age appropriate immunizations as recommended by the American Academy of Pediatrics Advisory Board.												

Behavioral Health and Substance Abuse Health Services

Medicaid Fee-For-Service, Medallion II (Medicaid MCO), FAMIS MCO, & FAMIS MOMS Covered Services

BEHAVIORAL HEALTH

Service	Fee-For-Service FFS (Medicaid, FAMIS, & FAMIS Plus)	Medallion II MCO (Medicaid, FAMIS Plus, & FAMIS MOMS)	FAMIS MCO	Medicaid Medallion II Comments	FAMIS MCO Comments
Inpatient Mental Health Services					
Inpatient Mental Health Services Rendered in a Psychiatric Unit of a General Acute Care Hospital	Yes	Yes	Yes	Medically necessary inpatient psychiatric care rendered in a psychiatric unit of a general acute care hospital shall be covered for all enrollees, regardless of age, within the limits of coverage prescribed in 12 VAC 30-50-105.	<p>Inpatient mental health services are covered for up to 365 days per confinement,, including partial hospitalization treatment services. Inpatient hospital services may include room, meals, general-nursing services, prescribed drugs, and emergency room services leading directly to admission.</p> <p>The MCO is not required to cover any services rendered in freestanding psychiatric hospitals to enrollees up to nineteen (19) years of age. Medically necessary inpatient psychiatric services rendered in a psychiatric unit of a general acute care hospital shall be covered for all FAMIS enrollees within the limits of coverage prescribed in the FAMIS plan and State regulations. All inpatient mental health admissions for members of any age to general acute care hospitals shall be approved by the MCO using its own prior authorization criteria.</p>
Inpatient Mental Health Services Rendered in a State Psychiatric Hospital	Yes	No	No	<p>The MCO is not required to cover this service. Members who are admitted to a State Mental Hospital will be excluded from participating in Medallion II. Services rendered in State Mental Hospitals are covered through the Medicaid fee-for-service system in accordance with DMAS guidelines.</p> <p>For members aged 21 through 64, the MCO may authorize admission to a freestanding psychiatric hospital as an enhanced service to Medicaid enrollees in accordance with the MCO's overall mental health protocols, policies, and network requirements. If an member aged 21 through 64 is admitted to a freestanding psychiatric facility, and the admittance is not part of a pre-arranged admission by the MCO and reimbursed by the health plan as an enhanced service, that member will be excluded from managed care participation. The MCO will notify DMAS of all enrollee admissions to state mental hospitals.</p>	Not a FAMIS covered benefit.

Medicaid Fee-For-Service, Medallion II (Medicaid MCO), FAMIS MCO, & FAMIS MOMS Covered Services

BEHAVIORAL HEALTH

Service	Fee-For-Service FFS (Medicaid, FAMIS, & FAMIS Plus)	Medallion II MCO (Medicaid, FAMIS Plus, & FAMIS MOMS)	FAMIS MCO	Medicaid Medallion II Comments	FAMIS MCO Comments
Inpatient Mental Health Services Rendered in a Freestanding Psychiatric Hospital	Yes, for members over age sixty-four (64) or under age twenty-one (21).	Yes	No	The MCO is required to cover medically necessary inpatient psychiatric hospital stays for covered members over age sixty-four (64) or under age twenty-one (21). The MCO may authorize admission to a freestanding psychiatric hospital for ages 21-64 as an enhanced service to Medicaid enrollees	Not a FAMIS covered benefit.
Temporary Detention Orders (TDOs)	Yes	Yes	No	<p>The MCO shall provide, honor and be responsible for all requests for payment of services rendered as a result of a Temporary Detention Order (TDO) for Mental Health Services except if the member is age 21 through 64 and admitted to a freestanding facility. The MCO is responsible for all TDO admissions to an acute care facility regardless of age. The medical necessity of the TDO services is assumed by the Department to be established, and the MCO may not withhold or limit services specified in a TDO. Services such as an acute inpatient admission cannot be denied based on a diagnosis while the client is under TDO for Mental Health Services. For a minimum of twenty-four (24) hours with a maximum of 96 hours, a psychiatric evaluation for mental disorder or disease will occur. At the time of the hearing, based on the psychiatric evaluation and treatment while under the TDO for Mental Health Services, a legally appointed judge will make a determination. A TDO may be provided in a State facility certified by Department of Behavioral Health and Developmental Services. If the member remains in a state facility after the TDO he/she will be disenrolled from managed care.</p> <p>Members admitted to a freestanding psychiatric facility under a TDO will be handled as follows: (1) For members under the age 21, the MCO is responsible; (2) For members from age 21 through 64, the TDO will be paid through the TDO (non-Medicaid) program; (3) If the member is age 65 and over, the MCO is responsible.</p>	<p>The MCO is not required to cover this service.</p> <p>Coverage may be available through the State TDO program.</p>

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TREATMENT FOSTER CARE AND RESIDENTIAL TREATMENT SERVICES FOR CHILDREN					
Treatment Foster Care (TFC) Case Management for children under age 21 years.	Yes	No. Covered by the Department (carved out service)	No	The TFC provider must contact prior-authorization agent for authorization.	Not a FAMIS covered benefit.
Residential Treatment Facility Services (RTF) Level C for children under age 21 years	Yes	No. Covered by the Department**	No	**DMAS authorization into a Level C RTF program will result in disenrollment of the member from Medallion II. The RTF provider must contact the DMAS prior-authorization agent for authorization.	Not a FAMIS covered benefit.
OUTPATIENT MENTAL HEALTH SERVICES					
Outpatient Mental Health Services (Includes Private and Clinic Service Providers)	Yes	Yes	Yes	The MCO is responsible for covering outpatient mental health services. The benefit maximum for adults in the first year of treatment shall not be more than 52 visits and 26 visits per year following the first year of treatment. For children under age 21 the benefit maximum is based upon medical necessity. Covered services include: Psychiatric diagnostic examinations, member, group and family psychotherapy, electroconvulsive therapy, psychological / neuropsychological testing, and pharmacological management.	The MCO is responsible for covering medically necessary outpatient member, family, and group mental health and substance abuse clinic services. Inpatient and outpatient services may include diagnostic services; mental health services including: detoxification, member psychotherapy, group psychotherapy psychological testing, counseling with family members to assist in the member's treatment and electroconvulsive therapy.
Electroconvulsive Therapy	Yes	Yes	Yes	See the section above.	See the section above
Family Medical Psychotherapy	Yes	Yes	Yes	See the section above.	See the section above
Group Medical Psychotherapy	Yes	Yes	Yes	See the section above.	See the section above
Individual Medical Psychotherapy	Yes	Yes	Yes	See the section above.	See the section above
Psychiatric Diagnostic Exam	Yes	Yes	Yes	See the section above.	See the section above
Psychological/ Neuropsychological Testing	Yes	Yes	Yes	See the section above.	See the section above
Pharmacological Management	Yes	Yes	Yes	See the section above.	See the section above

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BEHAVIORAL HEALTH

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COMMUNITY MENTAL HEALTH REHABILITATIVE SERVICES – STATE PLAN OPTION MENTAL HEALTH REHABILITATION SERVICES					
Community Mental Health Rehabilitation Services—AS LISTED BELOW	Yes	No. Covered by the Department (carved out service)	Yes, but limited	The MCO must provide information and referrals as appropriate to assist members in accessing these services. The MCO is required to cover transportation to and from SPO services and prescription drugs prescribed by the outpatient mental health provider. See Carved Out Services Section. Also, refer to CMHRS manual	The MCO must provide information and referrals as appropriate to assist members in accessing these services. The MCO is required to cover medically necessary prescription drugs prescribed by the outpatient mental health provider. Transportation is not a FAMIS covered benefit. See Carved Out Services Section.
Intensive In-Home for Children and Adolescents (H2012 H0031-Assessment)	Yes	No. Covered by the Department (carved out service)	No. Covered by the Department (carved out service)	See the section above	See the section above
Mental Health Day Treatment (not hospital based) for Children and Adolescents (H0035, H0032-Assessment)	Yes	No. Covered by the Department (carved out service)	No. Covered by the Department (carved out service)	See the section above	See the section above
Mental Health Day Treatment/Partial Hospitalization Services for Adults (H0035, H0031-Assessment)	Yes	No. Covered by the Department (carved out service)	Only for Children	See the section above	Covered by MCO. See inpatient mental services.
Intensive Community Treatment (H0039, H0031-Assessment)	Yes, covered by the Department (carved out service)	No. Covered by the Department (carved out service)	No, not a covered benefit	See the section above	The DMAS Intensive Community Treatment service is not a FAMIS covered benefit.
Psychosocial Rehabilitation (H2017, H0032- Assessment)	Yes, covered by the Department (carved out service)	No. Covered by the Department (carved out service)	No, not a covered benefit	The MCO must provide information and referrals as appropriate to assist members in accessing these services. The MCO is required to cover transportation to and from SPO services and prescription drugs prescribed by the outpatient mental health provider. See Carved Out Services Section. Also, refer to CMHRS manual	The DMAS Psychosocial Rehabilitation service is not a FAMIS covered benefit.

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Mental Health Support (H0046, H0032-Assessment)	Yes, covered by the Department (carved out service)	No. Covered by the Department (carved out service)	No, not a covered benefit	See the section above	The DMAS Mental Health Support service is not a FAMIS covered benefit.
Mental Health Crisis Intervention (H0036)	Yes	No. Covered by the Department (carved out service)	No. Covered by the Department (carved out service)	See the section above	The MCO must provide information and referrals as appropriate to assist members in accessing these services. The MCO is required to cover medically necessary prescription drugs prescribed by the outpatient mental health provider. Transportation is not a FAMIS covered benefit. See Carved Out Services Section.
Mental Health Case Management (H0023)	Yes	No. Covered by the Department (carved out service)	No. Covered by the Department (carved out service)	See the section above	See the section above.
Mental Health Crisis Stabilization (H2019)	Yes	No. Covered by the Department (carved out service)	No, not a covered benefit	See the section above	The DMAS Mental Health Crisis Stabilization service is not a FAMIS covered benefit
Levels A (H2022) & B (H2020) Residential Treatment (Group Home)	Yes	No. Covered by the Department (carved out service)	No, not a covered benefit	See the section above	The DMAS Residential Treatment services are not a FAMIS covered benefits.
SUBSTANCE ABUSE TREATMENT SERVICES					
In-patient Substance Abuse Treatment	No	No	Yes	Inpatient substance abuse treatment is not covered.	The Mental Health Parity and Addiction Act of 2008 mandate coverage for mental health and substance abuse treatment services. Accordingly, inpatient substance abuse services in a substance abuse treatment facility are covered up to 365 days per confinement.

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Out-patient Substance Abuse Treatment	Yes	Yes	Yes	<p>The MCO is required to cover substance assessment and evaluation and outpatient services for substance abuse treatment for Medicaid/FAMIS Plus enrollees. The Department shall cover emergency services (crisis) (H0050), intensive outpatient (H2016), day treatment (H0047), and SA case management (H0006).</p> <p>Transportation and pharmacy services necessary for the treatment of substance abuse services including carved out services are the responsibility of the MCO.</p>	<p>The MCO is responsible for covering medically necessary outpatient member, family, and group mental health and substance abuse clinic services. Psychiatric and substance abuse services are limited to no more than a combined total of 50 medically necessary visits for treatment with a licensed mental health or substance abuse professional each calendar year. Inpatient and outpatient services may include diagnostic services; mental health services including: detoxification, member psychotherapy, group psychotherapy psychological testing, counseling with family members to assist in the member's treatment and electroconvulsive therapy.</p>
Substance abuse Opioid treatment (H0020)	Yes	No. Covered by the Department (carved out service)	Not a covered service	<p>If a member has been prescribed drugs for opioid treatment and the member obtains such drugs through an independent pharmacy, the drugs are the responsibility of the MCO. If the opioid treatment is administered by the Substance Abuse provider and the Substance Abuse provider obtains the drugs for the member, such drugs shall be considered carved-out of this contract and shall be covered by the Department</p> <p>Transportation and pharmacy services necessary for the treatment of substance abuse services including carved out services are the responsibility of the MCO.</p>	See the section above.
Substance Abuse Services – Crisis Intervention (H0050)	Yes	No. Covered by the Department (carved out service)	No. Covered by the Department (carved out service)	<p>The Department shall cover emergency services (crisis), intensive outpatient, day treatment and SA Case management. Transportation and pharmacy services necessary for the treatment of substance abuse services including carved out services are the responsibility of the MCO.</p>	<p>The MCO must provide information and referrals as appropriate to assist members in accessing this services. The MCO is required to cover medically necessary prescription drugs prescribed by the outpatient substance abuse treatment provider.</p> <p>Transportation is not a FAMIS covered benefit. See Carved Out Services Section.</p>

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Residential Treatment for Pregnant Women (H0018)	Yes , covered by the Department (carved out service)	No. Covered by the Department (carved out service)	No , See Comments	The MCO must provide information and referral as appropriate to assist members in accessing these services. The MCO is required to cover transportation to and from Community MH SPO services and prescription drugs prescribed by the mental health provider.	FAMIS MOMS receive the Medallion II benefit package.
Day Treatment for Pregnant Women (H0015)	Yes, covered by the Department (carved out service)	No. Covered by the Department (carved out service)	No, not a covered benefit. See Comments	See comment directly above.	See coverage for inpatient substance abuse services.