Managed Care Resource Guide

Commonwealth of Virginia

Managed Care Helpline
800-643-2273
TDD 800-817-6608

DMAS.Virginia.Gov
ManagedCareHelp@DMAS.Virginia.Gov
VirginiaManagedCare.com

coverva.org

Department of Medical Assistance Services

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IMPORTANT: This is a reference guide only.
Information contained in this guide is subject to change without notice

MANAGED CARE RESOURCE GUIDE

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1. Overview of the Virginia Medicaid and FAMIS Program Delivery Systems

The Department of Medical Assistance Services (DMAS)

DMAS administers the Medicaid program, in accordance with Title XIX of the Social Security Act. DMAS also administers the Virginia Children's Health Insurance Program (CHIP), known as FAMIS (Family Access to Medical Insurance Security) under Title XXI of the Social Security Act. Medicaid and FAMIS programs are financed by Federal and State funds, administered by the State according to Federal and State guidelines, and are monitored closely by DMAS staff and the Centers for Medicare and Medicaid Services (CMS).

Medicaid Fee-For-Service and Managed Care Delivery Systems

DMAS provides Medicaid coverage to members primarily through two delivery systems: fee-for-service (FFS) and managed care. FFS benefits are administered by DMAS through participating providers within the traditional Medicaid program rules; in accordance with Federal and State regulations; and as described in the applicable DMAS provider manuals.
Provider Manuals are available on the DMAS website at: https://www.virginiamedicaid.dmas.virginia.gov/wps/portal.

DMAS operates one Medicaid mandatory managed care program, Medallion 3.0, in accordance with a CMS 1915(b) Managed Care Waiver, and in accordance with Federal and State Regulations. The Medallion 3.0 program is administered through DMAS' contracted managed care organizations (MCO).

FAMIS Programs and Delivery Systems

DMAS operates 2 FAMIS benefits programs: 1) the FAMIS program for children under age 19; and 2) FAMIS Select (a premium payment allowance for members eligible for employer offered benefits. Except for FAMIS Select, FAMIS benefits are administered through DMAS contracted MCOs or through FAMIS fee-for-service. Additional information on FAMIS programs is provided in Section 4 of this guide.

Fee-for-Service (FFS)	
Program Name	**Description**
Medicaid Fee-for-Service	Standard Medicaid Program under Title XIX.
FAMIS Fee-For-Service (Family Access to Medical Insurance Security Plan)	A Title XXI Children's Health Insurance Plan (CHIP).
Managed Care Organizations (MCOs)	
Program Name	**Description**
Medallion 3.0	A Title XIX Medicaid program, requiring mandatory participation for qualifying members, that utilizes contracted managed care organizations (MCOs).
FAMIS MCO (Family Access to Medical Insurance Security Plan)	Title XXI Children's Health Insurance Plan (CHIP).

2. Medallion 3.0 (Medicaid MCO Program)

The Medallion 3.0 program is a fully capitated, risk-based, mandatory managed care program for Medicaid members. Under Medallion 3.0, DMAS contracts with managed care organizations (MCOs) for the provision of most Medicaid covered services. The contracted MCO receives a capitated payment each month that covers a comprehensive set of services, regardless of how much care is used by the member. Claims for Medallion 3.0 services are paid by the MCO in accordance with Federal and State guidelines as well as the MCO/provider negotiated contracts. In most areas of the Commonwealth, qualified Medicaid members choose between at least two contracted MCOs *(see Medallion 3.0/FAMIS MCO Participation by Locality*). There are currently 6 DMAS contracted MCOs: Anthem HealthKeepers Plus, CoventryCares of Virginia, INTotal Health (Inova Health System Plan), Kaiser Permanente, Optima Family Care (Sentara Health System Plan), and Virginia Premier Health Plan (VCU Health System Plan). The Medallion 3.0 program is available state-wide.

Member Participation in Medallion 3.0

Not all Medicaid members residing in Virginia are eligible for enrollment in a MCO. Medallion 3.0 eligibles include non-institutionalized members in the following covered groups:

- Families and children-related groups; and,
- Persons aged, blind, or disabled

In order to see Medallion 3.0 members, providers must become part of the MCOs' networks and follow their rules and regulations.

Members will receive most services through their MCO, and must follow the rules of that MCO for referrals, appointments, and other administrative requirements. By contract, members do not have to get referrals from their PCP for the following services:

- Immunizations
- Family Planning/OB/GYN services
- School health services

Eligible members can enroll in an MCO or obtain additional information by calling the Managed Care HelpLine at:
1-800-643-2273 (TTY/TDD 1-800-817-6608)
8:30 am-6 pm, Monday through Friday

Detailed information is also provided at www.virginiamanagedcare.com.

Some members in these groups are not Medallion 3.0 eligible because they meet exclusionary criteria, as described on the next page of this guide.

The services listed below are "carved out" of the MCO contract and are covered and reimbursed by DMAS in accordance with DMAS program rules. Reference the chart in Section 13 of this guide for information on how to access carved out services.

- Community mental health rehabilitation services, intellectual disability case management and substance abuse treatment services as set forth in 12 VAC 30-50-226 (Mental Health), 12 VAC 30-50-440 (Intellectual Disability Case Management), and 12 VAC 30-50-228 (Substance Abuse).
- School Health Services (local education agencies/ public schools).
- Targeted Case Management - CM (except for high-risk maternity-infant targeted CM, i.e., Baby Care) and treatment foster care CM.
- Investigations by local health departments to determine the source of lead contamination for children diagnosed with elevated blood lead levels, as set forth in 12 VAC 30-50-227
- Abortions as set forth in 12 VAC 30-50-180 and 42 CFR 441.203 and 441.206
- Specialized infant formula available through VDH WIC clinics and medical supplements/foods for enrollees under age 21 *(enteral equipment and supplies are covered through the child's MCO)*
- Early and Periodic Screening Diagnosis and Treatment (EPSDT) Personal Care Services
- Early Intervention Services

Exclusion from Medallion 3.0

In accordance with 12VAC30-120-370, the following members shall be excluded from participating in Medallion 3.0. Members not meeting the exclusion criteria must participate in the Medallion 3.0 program.

1. Members who are inpatients in state mental hospitals.
2. Members who are approved by DMAS as inpatients in long-stay hospitals* (Article IID1.b. in the Medallion 3.0 Managed Care Contract), nursing facilities, or intermediate care facilities for the mentally retarded (MCO members who become enrolled in the Technology Assisted Waiver continue to be disenrolled from the MCO).
3. Members who are placed on spend-down.
4. Members who are participating in Plan First.
5. Members who are participating in the tech waiver or in federal waiver programs for home-based and community-based Medicaid coverage prior to managed care enrollment.
6. Members under age 21 who are approved for DMAS residential facility Level C programs as defined in 12VAC30-130-860.
7. Newly eligible members who are in the third trimester of pregnancy and who request exclusion within a department-specified timeframe of the effective date of their MCO enrollment. Exclusion may be granted only if the member's obstetrical provider (e.g., physician, hospital, and midwife) does not participate with the enrollee's assigned MCO. Exclusion requests made during the third trimester may be made by the member, MCO, or provider. DMAS shall determine if the request meets the criteria for exclusion. Following the end of the pregnancy, these members shall be required to enroll to the extent they remain eligible for Medicaid.
8. Members, other than students, who permanently live outside their area of residence for greater than 60 consecutive days except those members placed there for medically necessary services funded by the MCO.
9. Members who receive hospice services in accordance with DMAS criteria.
10. Members with other comprehensive group or member health insurance coverage, including Medicare, insurance provided to military dependents, and any other insurance purchased through the Health Insurance Premium Payment Program (HIPP).
11. Members requesting exclusion who are inpatients in hospitals, other than #1 and #2 above of this subsection, at the scheduled time of MCO enrollment or who are scheduled for inpatient hospital stay or surgery within 30 calendar days of the MCO enrollment effective date. The exclusion shall remain effective until the first day of the month following discharge. This exclusion reason shall not apply to members admitted to the hospital while already enrolled in a department-contracted MCO.
12. Members who request exclusion during assignment to an MCO or within a time set by DMAS from the effective date of their MCO enrollment who have been diagnosed with a terminal condition and who have a life expectancy of six months or less. The member's physician must certify the life expectancy.
13. Certain members between birth and age three certified by the Department of Behavioral Health and Developmental Services as eligible for services pursuant to Part C of the Members with Disabilities Education Act (20 USC § 1471 et seq.) who are granted an exception by DMAS to the mandatory Medallion 3.0 enrollment.
14. Members who have an eligibility period that is less than three months.
15. Members who are enrolled in the Commonwealth's Title XXI CHIP program (Known as FAMIS).
16. Members who have an eligibility period that is only retroactive.
17. Children enrolled in the Virginia Birth-Related Neurological Injury Compensation Program established pursuant to Chapter 50 (§ 38.2-5000 et seq.) of Title 38.2 of the Code of Virginia.

Members enrolled with a MCO who subsequently meet one or more of the aforementioned criteria during MCO enrollment shall be excluded from MCO participation as determined by DMAS, with the exception of those who subsequently become members in the federal long-term care waiver programs, as otherwise defined elsewhere in the contract for home-based and community-based Medicaid coverage (IFDDS, ID, EDCD, Day Support, or Alzheimer's, or as may be amended from time to time). These members shall receive acute and primary medical services via the MCO and shall receive waiver services and related transportation to waiver services via the fee-for-service program.

Members excluded from mandatory managed care enrollment shall receive Medicaid services under the current fee-for-service system. When enrollees no longer meet the criteria for exclusion, they shall be required to enroll in the appropriate managed care program.

3. Family Access to Medical Security Insurance (FAMIS) Program

FAMIS

FAMIS benefits are administered through DMAS contracted MCOs or through FAMIS fee-for-service (through DMAS). Like Medallion 3.0, the FAMIS MCO program also operates under a risk-based capitated payment contract. DMAS contracted MCOs for FAMIS are the same as those contracted with DMAS for Medallion 3.0.

In all areas of the Commonwealth, FAMIS enrollees have the choice between 2 or more MCOs. When a child is first enrolled in FAMIS, he or she is able to access health care through the FAMIS fee-for-service program. Within 1 or 2 months after FAMIS enrollment, the child will be enrolled with a FAMIS MCO.

FAMIS benefits are slightly different from the benefits under Medicaid (i.e., through Medallion 3.0 and Medicaid FFS). (Reference the covered services grid in Section 13 of this guide for a detailed listing of covered services). There are benefit limitations and small co-payments much like those associated with commercial group health insurance.

The following services (while covered under Medicaid) are **NOT** covered under FAMIS:

- EPSDT services – Early and Period Screening Diagnosis and Treatment services are not a covered service for FAMIS MCO members; however, is covered for FAMIS FFS members because they receive the Medicaid benefit package. Many of the services that are covered as EPSDT services by Medicaid are covered under FAMIS MCO's well child and immunization benefits.
- Psychiatric Treatment in free standing facilities is not covered (but is covered when provided in a psychiatric unit of an acute hospital)
- Routine transportation to and from medical appointments is not covered. (Exception: Children enrolled in FAMIS FFS may receive non-emergency transportation services.) Emergency transportation is covered for both FAMIS FFS and FAMIS MCO members.
- Temporary Detention Orders (TDOs) are not covered. Coverage may be available thru the State TDO program.
- Community mental health rehabilitation services other than: Intensive in-home, therapeutic day treatment, mental health crisis intervention, and case management for children at risk of or experiencing a serious emotional disturbance.

Children Born to FAMIS Enrolled Mother

Children born to teen mothers enrolled in FAMIS are deemed to be eligible for coverage under Medicaid for their first year and are automatically enrolled in coverage upon report of the birth. The DMAS-213 form has been revised to include reporting information for children born to FAMIS enrolled mothers. This allows hospitals and MCOs serving the FAMIS population the ability to notify the entity that handles FAMIS enrollment of the child's birth using the DMAS-213 form, so that the child is enrolled under the appropriate coverage (Medicaid or FAMIS).

FAMIS Select

FAMIS *Select* is a program that gives parents of FAMIS enrolled children the freedom to choose between covering their children with the FAMIS health insurance plan or with a private or employer's health plan. FAMIS *Select* gives parents the choice to purchase private or employer sponsored health insurance with up to $100 per child per month to help pay the child's part of the premium. In some cases, a private or employer plan may give a family more choice of providers. For some families, the FAMIS *Select* payment will be enough to make health coverage affordable for the entire family.

FAMIS Cost Sharing

Under FAMIS there are no enrollment fees or monthly premiums. Most services rendered to FAMIS children in MCOs except well-child, preventive care, and immunization services, requires co-payments from the enrollee. FAMIS co-payments are typically $2 or $5 depending on income for most services. The table below provides more detail on copayments by type of service. Cost sharing cannot exceed $180 per family per calendar year if a family's gross income is less than 150 percent of the federal poverty level and $350 per family per calendar year if gross income is more than 150% of the federal poverty level. No cost sharing is charged to American Indian and Alaska Native children.

Copayment By Type of Service		
Type of Service	**<150%**	**>150%**
Chiropractic (Coverage is limited to 500 per calendar year)	$2	$5
Dental Services	$0	$0
Early Intervention (Coverage through DMAS Fee-For-Service)	$0	$0
ER Physician Charges (Emergent per Prudent Layperson)	$2	$5
Hospice	$0	$0
Home Health and Private Duty Nursing	$2	$5
Hospital ER (Emergent per Prudent Layperson)	$2	$5
Inpatient Services (Per Confinement) --Acute, Rehab, Psychiatric, Substance Abuse	$15	$25
Non-Emergency use of ER	$10	$25
Organ Transplants Facility Out Patient *Donor identification Services - limited to $25,000 per member)*	 $15 $2	 $25 $5
Outpatient Services (Medical, Mental Health, and Substance Abuse Treatment Services)	$2	$5
Physician (Primary, Specialty, Maternity) *Pap Smears require no co-pay* *Physician Inpatient requires no co-pay*	$2 No copayments for maternity	$5 No copayments for maternity
Pregnancy or Family Planning Services/Supplies/Drugs	$0	$0
Prescription Drugs Retail, up to 34 day supply Retail 35 – 90 day supply Mail service up to 90 day supply	 $2 $4 $4	 $5 $10 $10
*(If a generic is available, enrollee pays co-payment **plus** 100% of the difference between the allowable of the generic drug and the brand drug.)*		
Second Opinions	$2	$5
Skilled Nursing Facility	$15	$25
Therapy (PT, OT, Speech)	$2	$5
Vision Services-- Routine eye exam (one per 24 months)	$2	$5
Well Child Care, Immunizations, Lead Testing	$0	$0
Other Services (Emergency Transportation, Hearing Aids, Lab and X-ray, Durable Medical Equipment*, Prosthetics/ Orthotics). **Supplies require no copayment*	$2	$5
Annual Co-Payment Limit	**<150%**	**>150%**
Calendar Year Limit / Per Family	**$180 per family**	**$350 per family**
Plan pays 100% of allowable charge once limit is met for covered services.		

For the most up-to-date information on FAMIS, visit the Cover Virginia website at: wwwcoverva.org.

4. Verifying Eligibility and Enrollment (MCO or FFS)

All providers of services must verify program coverage at each visit. Medicaid and FAMIS eligibility and/or MCO enrollment can change. Relying on the FFS plastic ID card or the MCO ID card does not guarantee eligibility or reimbursement. Providers should verify the payer (FFS/MCO) before services are rendered.

VIRGINIA MEDICAID WEB PORTAL

DMAS offers a web-based Internet option to access information regarding Medicaid or FAMIS member eligibility, MCO enrollment, claims status, checks status, service limits, service authorizations, and electronic copies of remittance advices. Providers must register through the Virginia Medicaid Web Portal in order to access this information. The Virginia Medicaid Web Portal can be accessed by going to: www.virginiamedicaid.dmas.virginia.gov. If you have any questions regarding the Virginia Medicaid Web Portal, please contact the ACS Web Portal Support Helpdesk; toll free, at 1-866-352-0496 from 8:00 a.m. to 5:00 p.m. Monday through Friday, except holidays. The MediCall audio response system provides similar information and can be accessed by calling 1-800-884-9730 or 1-800-772-9996. Both options are available at no cost to the provider. Providers may also access fee-for-service (FFS) service authorization information including status via KePRO's Provider Portal at http://dmas.kepro.org/.

ELIGIBILITY VENDORS

DMAS has contracts with the following eligibility verification vendors offering internet real-time, batch and/or integrated platforms. Eligibility details such as eligibility status, third party liability, and service limits for many service types and procedures are available. Contact information for each of the vendors is listed below.

Passport Health Communications, Inc. www.passporthealth.com sales@passporthealth.com Telephone: 1 (888) 661-5657	SIEMENS Medical Solutions – Health Services Foundation Enterprise Systems/HDX www.hdx.com Telephone: 1 (610) 219-2322	Emdeon www.emdeon.com Telephone: 1 (877) 363-3666

"HELPLINE"

The "HELPLINE" is available to answer questions Monday through Friday from 8:00 a.m. to 5:00 p.m., except on holidays. The "HELPLINE" numbers are:

1-804-786-6273	Richmond area and out-of-state long distance
1-800-552-8627	All other areas (in-state, toll-free long distance)

Please remember that the "HELPLINE" is for provider use only. Please have your Medicaid Provider Identification Number available when you call.

MediCall

Providers call MediCall at **800-884-9730 or 800-772-9996** to verify eligibility. The MediCall line will give member eligibility, special indicator codes, Managed Care Program assignment (including coverage dates), and MCO name.

MediCall is operational 24 hours a day 365 days a year. Although MediCall is designed to be accessed by touch-tone phone, dial phone may be used. A live operator is available 8:30 a.m. to 4:30 p.m.

Information required to use MediCall includes your National Provider Identifier (NPI) number or your atypical Provider Identification (API) number, the Member Medicaid ID number OR the Social Security Number and date of birth, and the From and Through date(s) of service--a single date or dates spanning not more than 31 days. Providers also may check reimbursement, check status inquiry, and claims status inquiry from the most recent three remittances.

5. Medicaid Managed Care Helpline (Medallion 3.0 Members)

The Medicaid Managed Care Helpline (MC Helpline) is a toll-free telephone helpline #1-800-643-2273 and TDD# 1-800-817-6608 customer service call center, available to Medallion 3.0 *eligible or enrolled* members. The MC Helpline provides detailed information about enrollment choices primarily to assist members in making an informed decision about the most appropriate MCO to meet their health care needs. The MC Helpline operates from 8:30 AM to 6:00 PM, Monday through Friday except on State holidays.

The functions of the Managed Care Helpline include, but are not limited to:

- Enrolling members into an MCO, initially or as a change.
- Educating members about managed care health plans in their locality.
- Assisting members with questions, referring members to appropriate resources for resolution of health care issues and billing related issues, tracking member complaints, and providing complaint information to DMAS.
- Triaging of telephone calls to participating health plans, member services departments, local Department of Social Services (DSS) agencies or the Department's member and provider HelpLines.
- Completing Health Status Assessments (HSA) on MCO members and forwarding information to the participating MCO that the member has selected.

Functions excluded from the Managed Care Helpline include, but are not limited to:

- Entering or modifying member eligibility information such as name, address, telephone number, date of birth, FIPS code, Aid Category, TPL, etc. **This is a function of the local DSS.**
- Verification of eligibility requests: DMAS has mechanisms for providers to verify member eligibility including the Audio Voice Response System (AVRS), formerly called the REVS line, and the DMAS web based system. The MCOs also provide assistance to verify their member eligibility.
- Issuance of any ID cards.

Information on Managed Care, including details on how to enroll, open enrollment, MCOs available by locality, etc., is also available on the Managed Care Helpline website at www.virginiamanagedcare.com.

Cover Virginia

http://www.coverva.org/

Cover Virginia http://www.coverva.org/ provides general program information and accepts applications over the phone at **1-855-242-8282** for Medicaid and FAMIS programs. Members may also apply for benefits on-line at: www.commonhelp.virginia.gov. Most FAMIS members choose their MCO when they apply. For those that did not choose an MCO plan at the time of application, they may call Cover Virginia at 1-855-242-8282 to enroll in an MCO. Seven MCOs administer FAMIS coverage in Virginia. Different MCOs serve different parts of Virginia. Members may call Cover Virginia to find out which MCOs are offered in their area, for general questions, or to request change to another plan. There are no open enrollment periods for FAMIS. If the member is within the first 90 days of enrollment with a particular MCO and wishes to change to another MCO in the area, they may contact Cover Virginia to request the change. After 90 days, the member will remain with that MCO until their annual renewal. When the member's FAMIS coverage is renewed each year, they will have a chance to choose another MCO (if available in their locality) or remain with the current health plan. If they do not want to make a change, the member will remain with the current MCO. Members, who have questions or concerns about receiving services, may contact member services with the MCO (see Section 12 for contact information).

Health Status Survey Questionnaire

This questionnaire is completed by the Managed Care Helpline for most Medallion 3.0 members that call the Helpline to select or change their MCO plan.

I would like to ask you some questions about your health and the health of any other MCO members in your house. The information you give me will go to the MCO. It's helpful for the MCO to know something about their new members so they can begin planning for your care. Do you have a minute to answer these questions?

Some of these questions are personal, and your answers will be confidential and private—only the MCO will get this information.

Please answer for yourself and everyone in your house who is a member of the MCO.

Case Head:	Case Head SSN:		Case Head Language:
Last Name	First Name		Medicaid ID#
Address	City	State/Zip	Ph#

1.	Gender	☐ Male ☐Female
2.	Date of Birth	
3.	What MCO are you choosing?	Name:
4.	Do you have a doctor you want to be your Primary Care Provider?	Name:
5.	If you have a regular doctor now, what is the doctor's name?	Names:
6.	Are you seeing any specialists (doctors who specialize in a particular field of medicine, such as a cardiologist)? [If yes] What are the names?	☐ Yes ☐No List:
7.	Are you taking medicines that a doctor has prescribed? [If yes, ask what they are and what they're for.]	☐ Yes ☐No List:
8.	Are you using any durable medical equipment; such as, a hospital bed, oxygen, a wheelchair, a breathing machine—anything like that? If yes, did a doctor prescribe it?	☐ Yes ☐No What: ☐ Yes ☐No
9.	Are you pregnant? [If yes], ▪ When is the baby due? ▪ Does the doctor have any special concerns about this pregnancy?	☐ Yes ☐No Date:
Now I'm going to read a list of health problems, and you tell me if you or anyone in the family has that problem.		
10.	Do you have surgery planned for the future? If yes, what is the date of surgery?	☐ Yes ☐No Date:
11.	Are you getting home care or home hospice care? If yes, please explain.	☐ Yes ☐No Explanation:
12.	Are you on an organ transplant list? If yes, please explain.	☐ Yes ☐No Explanation:
13.	Are you getting physical therapy, or occupational therapy, or speech therapy?	☐ Yes ☐No
14.	Do you have a heart condition— such as congestive heart failure?	☐ Yes ☐No

Health Status Survey Questionnaire (Continued)

15.	Do you have a lung disorder; such as, asthma or COPD?	☐ Yes ☐No
16.	Are you being treated by a psychiatrist or psychologist?	☐ Yes ☐No
17.	Do you have diabetes?	☐ Yes ☐No
18.	High blood pressure?	☐ Yes ☐No
19.	Do you have kidney disease or are you on dialysis?	☐ Yes ☐No
20.	Do you have cancer?	☐ Yes ☐No
21.	Do you smoke?	☐ Yes ☐No
22.	Are you living with HIV or AIDS?	☐ Yes ☐No
23.	Do you have a blood disease, such as sickle cell anemia or Hepatitis?	☐ Yes ☐No
24.	Do you have tuberculosis (TB)?	☐ Yes ☐No
25.	Is there a child in the house in ▪ Part C services, care coordination for children ▪ Any health department program, or does any child receive Case Manager or Care Coordinator services?	☐ Yes ☐No List program and/or care coordinator:
26.	Can you think of any other special medical or mental health needs that the MCO might want to know about?	☐ Yes ☐No List:
27.	Have you been in the hospital in the last 12 months? [If yes] Why were you admitted?	☐ Yes ☐No Reason:
28.	What is your height?	feet _____ inches_____
29.	What is your weight?	Pounds

Thank you for taking the time to answer these questions. I'll give this information to your new MCO, and they will be in touch with you soon.

If you have any questions or need assistance, please call the Managed Care Helpline at 1-800-MGD-CARE or 1-800-643-2273

6. Medallion 3.0 Open Enrollment Effective Dates

*****NOTE: THESE OPEN ENROLLMENT PERIODS DO NOT APPLY TO FAMIS*****

CENTRAL VIRGINIA REGION					
LETTERS MAIL LATE JANUARY. MEMBERS CALL FEBRUARY AND MARCH. CHANGES EFFECTIVE APRIL 1.					
001	ACCOMACK	081	GREENSVILLE	133	NORTHUMBERLAND
007	AMELIA	085	HANOVER	135	NOTTOWAY
025	BRUNSWICK	087	HENRICO	730	PETERSBURG
033	CAROLINE	670	HOPEWELL	145	POWHATAN
036	CHARLES CITY	097	KING AND QUEEN	147	PRINCE EDWARD
041	CHESTERFIELD	099	KING GEORGE	149	PRINCE GEORGE
570	COLONIAL HEIGHTS	101	KING WILLIAM	760	RICHMOND CITY
049	CUMBERLAND	103	LANCASTER	159	RICHMOND CO.
053	DINWIDDIE	111	LUNENBURG	175	SOUTHAMPTON
595	EMPORIA	115	MATHEWS	177	SPOTSYLVANIA
057	ESSEX	117	MECKLENBURG	179	STAFFORD
620	FRANKLIN CITY	119	MIDDLESEX	181	SURRY
630	FREDERICKSBURG	127	NEW KENT	183	SUSSEX
075	GOOCHLAND	131	NORTHAMPTON	193	WESTMORELAND
TIDEWATER REGION					
LETTERS MAIL LATE APRIL. MEMBERS CALL MAY AND JUNE. CHANGES EFFECTIVE JULY 1.					
550	CHESAPEAKE	700	NEWPORT NEWS	800	SUFFOLK
073	GLOUCESTER	710	NORFOLK	810	VIRGINIA BEACH
650	HAMPTON	735	POQUOSON	830	WILLIAMSBURG
093	ISLE OF WIGHT	740	PORTSMOUTH	199	YORK
095	JAMES CITY CO.				
NORTHERN AND WINCHESTER REGION					
LETTERS MAIL LATE JUNE. RECPIENTS CALL JULY AND AUGUST. CHANGES EFFECTIVE SEPTEMBER 1.					
510	ALEXANDRIA	610	FALLS CHURCH	139	PAGE
013	ARLINGTON	061	FAUQUIER	153	PRINCE WILLIAM
043	CLARKE	069	FREDERICK	157	RAPPAHANNOCK
047	CULPEPER	107	LOUDOUN	171	SHENANDOAH
600	FAIRFAX CITY	683	MANASSAS CITY	187	WARREN
059	FAIRFAX CO.	685	MANASSAS PARK	840	WINCHESTER
WESTERN REGION					
LETTERS MAIL LATE AUGUST. MEMBERS CALL SEPTEMBER AND OCTOBER. CHANGES EFFECTIVE NOVEMBER 1.					
003	ALBEMARLE	590	DANVILLE	125	NELSON
009	AMHERST	065	FLUVANNA	137	ORANGE
011	APPOMATTOX	079	GREENE	143	PITTSYLVANIA
015	AUGUSTA	083	HALIFAX	165	ROCKINGHAM
029	BUCKINGHAM	660	HARRISONBURG	790	STAUNTON
031	CAMPBELL	109	LOUISA	820	WAYNESBORO
037	CHARLOTTE	680	LYNCHBURG		
540	CHARLOTTESVILLE	113	MADISON		

Medallion 3.0 Open Enrollment Effective Dates (continued)

ROANOKE/ALLEGHANY REGION LETTERS MAIL LATE NOVEMBER. MEMBERS CALL DECEMBER AND JANUARY. CHANGES EFFECTIVE FEBRUARY 1.					
005	ALLEGHANY	063	FLOYD	141	PATRICK
017	BATH	067	FRANKLIN CO.	155	PULASKI
515	BEDFORD CITY	071	GILES	750	RADFORD
019	BEDFORD CO.	089	HENRY	770	ROANOKE CITY
023	BOTETOURT	091	HIGHLAND	161	ROANOKE CO.
530	BUENA VISTA	678	LEXINGTON	163	ROCKBRIDGE
580	COVINGTON	690	MARTINSVILLE	775	SALEM
045	CRAIG	121	MONTGOMERY	197	WYTHE
SOUTHWEST REGION **LETTERS MAIL LATE APRIL. RECIPIENTS CALL MAY AND JUNE. CHANGES EFFECTIVE JULY 1.**					
021	BLAND	640	GALAX	169	SCOTT
520	BRISTOL	077	GRAYSON	173	SMYTH
027	BUCHANAN	105	LEE	185	TAZEWELL
035	CARROLL	720	NORTON	191	WASHINGTON
051	DICKENSON	167	RUSSELL	195	WISE

Updated April 1, 2014

COUNTIES	FIPS	INTotal Health	Anthem Health Keepers Plus	CoventryCares of Virginia	Optima Family Care	Virginia Premier	Kaiser Permanente
ACCOMACK	001		X		X	X	
ALBEMARLE	003		X		X	X	
ALLEGHANY	005	X	X	X	X	X	
AMELIA	007		X	X	X	X	
AMHERST	009		X	X	X	X	
APPOMATTOX	011		X	X	X	X	
ARLINGTON	013	X	X				X
AUGUSTA	015		X		X	X	
BATH	017	X	X	X	X	X	
BEDFORD COUNTY	019	X	X	X	X	X	
BLAND	021	X	X	X	X	X	
BOTETOURT	023	X	X	X	X	X	
BRUNSWICK	025		X		X	X	
BUCHANAN	027	X	X	X	X	X	
BUCKINGHAM	029		X		X	X	
CAMPBELL	031		X	X	X	X	
CAROLINE	033		X	X	X		
CARROLL	035	X	X	X	X	X	
CHARLES CITY	036		X	X	X	X	
CHARLOTTE	037		X		X	X	
CHESTERFIELD	041		X	X	X	X	
CLARKE	043	X	X			X	
CRAIG	045	X	X	X	X	X	
CULPEPER	047	X	X				
CUMBERLAND	049		X	X	X	X	
DICKENSON	051	X	X	X	X	X	
DINWIDDIE	053		X	X	X	X	
ESSEX	057		X	X	X		
FAIRFAX COUNTY	059	X	X				X
FAUQUIER	061	X	X				
FLOYD	063	X	X	X	X	X	
FLUVANNA	065		X		X	X	
FRANKLIN COUNTY	067	X	X	X	X	X	
FREDERICK	069	X	X			X	
GILES	071	X	X	X	X	X	
GLOUCESTER	073		X		X		
GOOCHLAND	075		X	X	X	X	
GRAYSON	077	X	X	X	X	X	
GREENE	079		X		X	X	
GREENSVILLE	081		X		X	X	
HALIFAX	083		X		X	X	
HANOVER	085		X	X	X	X	

HENRICO	087		X	X	X	X
HENRY	089	X	X	X	X	X
HIGHLAND	091	X	X	X	X	X
ISLE OF WIGHT	093		X		X	X
JAMES CITY	095		X		X	
KING & QUEEN	097		X	X	X	
KING GEORGE	099		X			X
KING WILLIAM	101		X	X	X	X

COUNTIES	FIPS	INTotal Health	Anthem Health Keepers Plus	CoventryCares of Virginia	Optima Family Care	Virginia Premier	Kaiser Permanente
LANCASTER	103		X	X	X		
LEE	105	X	X	X	X	X	
MIDDLESEX	119		X	X	X		
MONTGOMERY	121	X	X	X	X	X	
LOUDOUN	107	X	X				X
LOUISA	109		X		X	X	
LUNENBURG	111		X	X	X	X	
MADISON	113	X	X		X		
MATHEWS	115		X	X	X		
MECKLENBURG	117		X	X	X	X	
NELSON	125		X		X	X	
NEW KENT	127		X	X	X	X	
NORTHAMPTON	131		X		X	X	
NORTHUMBERL	133		X	X	X		
NOTTOWAY	135		X	X	X	X	
ORANGE	137	X	X		X		
PAGE	139	X	X		X	X	
PATRICK	141	X	X	X	X	X	
PITTSYLVANIA	143		X		X	X	
POWHATAN	145		X	X	X	X	
PRINCE EDWARD	147		X		X	X	
PRINCE GEORGE	149		X	X	X	X	
PRINCE WILLIAM	153	X	X				X
PULASKI	155	X	X	X	X	X	
RAPPAHANNOCK	157	X	X				
RICHMOND	159		X	X	X		
ROANOKE	161	X	X	X	X	X	
ROCKBRIDGE	163	X	X	X	X	X	
ROCKINGHAM	165		X		X	X	
RUSSELL	167	X	X	X	X	X	
SCOTT	169	X	X	X	X	X	
SHENANDOAH	171	X	X			X	
SMYTH	173	X	X	X	X	X	
SOUTHAMPTON	175		X		X	X	
SPOTSYLVANIA	177		X			X	
STAFFORD	179		X			X	
SURRY	181		X	X	X	X	
SUSSEX	183		X	X	X	X	
TAZEWELL	185	X	X	X	X	X	
WARREN	187	X	X				
WASHINGTON	191	X	X	X	X	X	

WESTMORELAN	193		X	X	X	X
WISE	195	X	X	X	X	X
WYTHE	197	X	X	X	X	X
YORK	199		X		X	

Cities are listed on next page

COUNTIES	FIPS	INTotal Health	Anthem Health Keepers Plus	CoventryCares of Virginia	Optima Family Care	Virginia Premier	Kaiser Permanente
ALEXANDRIA	510	X	X				X
BEDFORD CITY	515	X	X	X	X	X	
BRISTOL	520	X	X	X	X	X	
BUENA VISTA	530	X	X	X	X	X	
CHARLOTTESVILLE	540		X		X	X	
CHESAPEAKE	550		X		X	X	
COLONIAL HEIGHTS	570		X	X	X	X	
COVINGTON	580	X	X	X	X	X	
DANVILLE	590		X		X	X	
EMPORIA	595		X		X	X	
FAIRFAX CITY	600	X	X				X
FALLS CHURCH	610	X	X				X
FRANKLIN CITY	620		X		X	X	
FREDERICKSBURG	630		X			X	
GALAX	640	X	X	X	X	X	
HAMPTON	650		X		X	X	
HARRISONBURG	660		X		X	X	
HOPEWELL	670		X	X	X	X	
LEXINGTON	678	X	X	X	X	X	
LYNCHBURG	680		X	X	X	X	
MANASSAS CITY	683	X	X				X
MANASSAS PARK	685	X	X				X
MARTINSVILLE	690	X	X	X	X	X	
NEWPORT NEWS	700		X		X	X	
NORFOLK	710		X		X	X	
NORTON	720	X	X	X	X	X	
PETERSBURG	730		X	X	X	X	
POQUOSON	735		X		X		
PORTSMOUTH	740		X		X	X	
RADFORD	750	X	X	X	X	X	
RICHMOND CITY	760		X	X	X	X	
ROANOKE CITY	770	X	X	X	X	X	
SALEM	775	X	X	X	X	X	
STAUNTON	790		X		X	X	
SUFFOLK	800		X		X	X	
VIRGINIA BEACH	810		X		X	X	
WAYNESBORO	820		X		X	X	
WILLIAMSBURG	830		X		X		
WINCHESTER	840	X	X			X	

8. Hospitalized at Time of MCO Enrollment

MEDICAID

Medicaid recipients who are hospitalized under fee-for-service at the time of initial enrollment in the Medallion 3.0 (Medicaid MCO) program are disenrolled from the MCO upon notification to DMAS by the admitting hospital or the MCO. These individuals are covered by DMAS fee-for-service until they are discharged from the hospital; providers are required to follow DMAS coverage criteria and reimbursement guidelines. Generally, these individuals will be enrolled in the MCO on the first day of the next month after discharge. In order for DMAS to handle MCO disenrollment's timely, **hospitals must notify the DMAS Managed Care Unit monthly of any Medicaid individuals who are hospitalized overnight on the last day of each month by sending the "Report of Overnight Medicaid or MCO/Medicaid Patients on Last Day of the Month" form by fax to 804-786-5799.** Questions can be sent to managedcarehelp@dmas.virginia.gov. Please do not send protected health information via unencrypted email.

For Medicaid recipients who are enrolled with a DMAS contracted MCO at the time of admission, where the MCO contracts with the hospital on a DRG basis, the MCO is responsible for the full DRG (admission to discharge) – in accordance with the MCO coverage criteria and reimbursement guidelines. Where the MCO and hospital have a per-diem based reimbursement contract, the MCO covers the hospitalization for the dates in which the individual is enrolled with the MCO.

FAMIS

FAMIS recipients who are hospitalized under FAMIS fee-for-service at the time of initial enrollment into a FAMIS MCO are **NOT** disenrolled from the MCO. For acute care hospital admissions (medical/surgical services), for FAMIS fee-for-service members, DMAS will cover the full DRG from admission to discharge. For inpatient rehabilitation and inpatient psychiatric admissions for individuals who are in FAMIS fee-for-service at the time of admission, DMAS covers the hospitalization from the date of admission until the effective date in the MCO. Where the MCO and hospital have a per-diem based reimbursement contract, the MCO covers the hospitalization for the dates in which the individual is enrolled with the MCO. For fee-for-service coverage, providers are required to follow DMAS coverage criteria and reimbursement guidelines. Similarly, coverage through the MCO follows MCO established criteria/guidelines.

Questions may be sent to managedcarehelp@dmas.virginia.gov. Please do not send protected health information via unencrypted email.

For FAMIS recipients who are enrolled with a DMAS contracted MCO at the time of admission, where the MCO contracts with the hospital on a DRG basis, the MCO is responsible for the full DRG (admission to discharge) – in accordance with the MCO coverage criteria and reimbursement guidelines. Where the MCO and hospital have a per-diem based reimbursement contract, the MCO covers the hospitalization for the dates in which the individual is enrolled with the MCO.

REPORT OF OVERNIGHT MEDICAID OR MCO/MEDICAID PATIENTS

ON LAST DAY OF THE MONTH

Send To Attention Of:	**FROM:**
DMAS Health Care Services	Hospital:
Systems and Reporting Unit	Contact Person:
Attention: Carolyn Peete	Telephone #
Phone:804-786-3378	Fax #
FAX: 804-786-5799	

*Fax this report on the first day of each month for Medicaid recipients who are hospitalized overnight on the last day of the month. FAMIS recipients who are hospitalized at the time of initial enrollment into a FAMIS MCO are **NOT** disenrolled from the MCO.*

Member Last/First Name (Please Print Clearly)	Admission Date	Discharge Date (If Known)	Date of Birth	Medicaid I.D. #:	MCO (If Known)

Revised April 1, 2014

CARE FOR KIDS

9. Early and Periodic Screening, Diagnosis, and Treatment Service

What is EPSDT?

Early and Periodic Screening, Diagnosis, and Treatment Services (EPSDT) is a comprehensive and preventive child health program for members under the age of 21 that is required by the federal government to be a part of every state's Medicaid package.

Under the Social Security Act Section 1905(r)(5), states are required to provide any medically necessary health care services listed at Section 1905 (a) of the Social Security Act to correct and/or ameliorate physical and mental conditions discovered during screening services even if the service is not included under the state's Medicaid plan. This includes periodic screening, vision, dental and hearing services.

Virginia's EPSDT program goals are to keep children as healthy as possible by:

- Assuring that health concerns are diagnosed as early as possible,
- Assuring that treatment is provided before problems become complex, and
- Assuring that medically justified services are provided to treat or correct identified problems

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Who is eligible for EPSDT Services?

- Children under the age of 21 who receive Medicaid through Medicaid fee-for-service or a MCO.
- FAMIS children who are enrolled in fee-for-service. MCO enrolled FAMIS children are not eligible for the full scope of EPSDT services.

EPSDT screenings are conducted by physicians, physician assistants or certified nurse practitioners and can occur during the following:

- Initial Screening – This is a checkup provided when the child enters Medicaid.
- Periodic Screening – Check up that should occur at regular intervals. Virginia uses the American Academy of Pediatrics and Bright Futures guidelines to develop the Virginia EPSDT periodicity schedule.
- Inter-periodic Screening – unscheduled check-up or problem focused assessment that can happen at any time because of illness or a change in condition. Any caregiver or professional who interacts with the member may request the screening.

What are the required components in EPSDT screenings?

- Comprehensive unclothed physical exam
- Patient and family medical history including identifying risk factors for health and mental health status
- Developmental, Vision and Hearing Screening
- Preventive laboratory services including
    - *Mandatory Lead testing at 12 months and 24 months*
- Age appropriate Immunizations
- Referral to a dentist at age 1
- Age appropriate anticipatory guidance/health counseling
- Referrals for medically necessary health and mental health treatment

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All requests for EPSDT treatment services must:

- Be deemed medically necessary to correct or ameliorate a health or mental health condition; and,
- Have the need for specialist referral or treatment documented during an EPSDT screening.

Services that are considered experimental or investigational are not covered.

EPSDT Specialized Services are medically necessary treatment services that are not a routinely covered service through Virginia Medicaid. All EPSDT "specialized services" must be a service that is allowed by the Centers for Medicare and Medicaid Services (CMS). The allowable treatment services are defined in the United States Code in 42 U.S.C. sec 1396d (r) (5).

The most frequently provided EPSDT specialized services are:

- Hearing Aids
- Assistive Technology
- Personal Care
- Private Duty Nursing
- Behavioral Therapy
- Medical Formula and Medical Nutritional Supplements
- Specialized Residential Behavioral Therapy and Residential Treatment
- Substance Abuse Residential Treatment Services

DMAS Contact: EPSDT@dmas.virginia.gov or 804-786-6134

EPSDT Screening Procedure Codes

DESCRIPTION	Age	CPT Code
INITIAL SCREENINGS		
Newborn Care (outpatient)	Normal newborn care	99432
New Member	less than 1 year of age	99381*
New Member	1-4 years of age	99382*++
New Member	5-11 years of age	99383*
New Member	12-17 years of age	99384*
New Member	18-20 years of age	99385*
PERIODIC SCREENINGS		
Established Member	less than 1 year of age	99391*
Established Member	1-4 years of age	99392*++
Established Member	5-11 years of age	99393*
Established Member	12-17 years of age	99394*
Established Member	18-20 years of age	99395*
DEVELOPMENTAL TESTING (Interpretation/Report)		
Extended	0-20 years of age	96111
LEAD TESTING (Mandatory12 mos. and 24 mos. of age)		
Venous Sample	0-20 years of age	36415
Capillary Sample	0-20 years of age	36416
Specimen Handling	0-20 years of age	99000
VISION SCREENING		
Vision	3-20 years of age	99173
HEARING SCREENING		
Hearing	0-20 years of age	92551

**Use appropriate Immunization Codes for scheduled immunizations*
++ Lead Testing required at 12 and 24 months

10. Virginia Vaccines For Children (VVFC) Program

Virginia Vaccines For Children provides federally purchased vaccine, at no cost to health care providers, for administration to eligible children. Most Medallion 3.0 PCPs participate in Virginia Vaccines for Children.

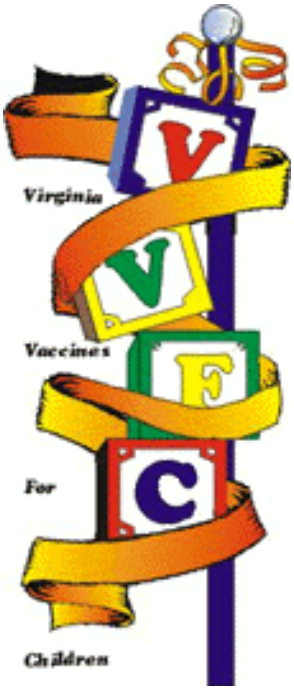
Medicaid:

Age 0-18----eligible for VVFC

- DMAS will not reimburse the acquisition cost for vaccines under VVFC.
- DMAS will reimburse an appropriate office visit or preventive medicine fee.
- DMAS will reimburse the provider an administration fee ($11.00) for each vaccine.

Age 19-20---not eligible for VVFC

- DMAS will reimburse the provider the acquisition cost.
- DMAS will reimburse an appropriate office visit or preventive medicine fee.
- DMAS will **not** reimburse an administration fee.



FAMIS:

Age 0-18---not eligible for VVFC

Children enrolled in FAMIS **are not eligible** for VFC. They are not Medicaid. Depending on where the child is enrolled, DMAS fee-for-service or the MCO will reimburse the provider for the following:

- the acquisition cost
- an appropriate office visit fee.
- an administration fee ($11.00).

To ensure proper reimbursement by DMAS for fee-for-service members:

- Use the Evaluation and Management CPT code for the appropriate office visit or Preventive Medicine Service (EPSDT Screening Procedure Code).
- Always bill your usual and customary fee.
- Use the CPT code for the immunization. Bill the usual and customary cost plus $11.00.
- Complete 11d appropriately.
- The DMAS claims system will read the member/FAMIS enrollee file and pay accordingly.

Medallion 3.0 and FAMIS MCO:

Medicaid and FAMIS members enrolled in a Virginia Medicaid contracted MCO:
Member eligibility for Virginia Vaccines For Children is the same as above.
Providers participating in Medallion 3.0 should contact their MCO for billing instructions.

Virginia Vaccines For Children:

VVFC covers children who are less than 19 years of age and meet one of the following criteria:

- Medicaid enrolled
- Uninsured (no health insurance)
- American Indian or Alaskan Native
- Under insured (commercial insurance coverage does not include vaccines). *These children must go to a Federally Qualified Health Center, Rural Health Center or local Health Department.*

For more information on VVFC call 800-568-1929 or 804-864-8055

11. MCO Reimbursement for "BabyCare" Services

	DMAS BabyCare	New Baby, New Life℠	CoventryCares of Virginia Baby Matters	INTotal Health Starring: Baby and Me	Kaiser Permanente Healthy Mom Healthy Baby	Optima Partners in Pregnancy	Virginia Premier Healthy Heartbeats
Contact Information	**Ashley Harrell** **Tabitha Taylor** **DMAS** **Maternal and Child Health Division** 600 East Broad Street Suite 1300 Richmond, VA 23219 804-786-6134 Fax: 804-612-0043 BabyCare@dmas.virginia.gov	1-800-901-0200 **Future Moms Program** 1-855-254-3853 **Authorization of Anthem Benefits & Services** 1-800-901-0200 **Anthem Member/ Provider Services** 1-800-901-0200	Evette M. Ashby RN, BSN OB/NICU Case Manager 1-800-975-1213 Extension 223-2476 FAX 1-855-736-5304 Preauthorization Department 9881 Mayland Drive Richmond, VA 23233 1-800-234-2206 Fax: 800-586-7015	**Jane Fletcher, RN** OB Case Manager 703-286-3984 Jane. Fletch@inova.org **Katina Waller** Newborn Coordinator or questions 703-286-3987 Fax: 1-888-393-8978 Katina.Waller@inova.org Gifty Sey, RN OB Case Manager 703-286-3976 Gifty.Sey@inova.org	**(866)223-2347**	1-866-239-0618	1-800-727-7536
Reimburse for case management (G9002)?	Yes	Covered on a case by case basis	Yes	No	Yes	Refer to FFS provider case by case basis	Yes
Require service auth? (SA)	Yes	Yes	No	N/A	No	Yes	No
Reimburse for patient education classes (S9442 and S9446)?	Yes	Covered on a case by case basis	Yes	Yes	Yes	Use S9446	Yes
Require SA?	No	Yes	No	Yes, for non-par provider only	No	No	No

MCO Reimbursement for "BabyCare" Services (continued)

	DMAS BabyCare	Anthem Future Moms	CoventryCares of Virginia Baby Matters	INTotal Health Starring: Baby and Me	Kaiser Permanente Healthy Mom Healthy Baby	Optima Partners in Pregnancy	Virginia Premier Healthy Heartbeats
Reimburse for Behavioral Health Risk Screen (99420)?	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Accept DMAS-16 (P)rovider and (S)elf-questionnaire?	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Require SA?	No	Yes, for non-par provider only	No	Yes, for non-par provider only	No	No	No
Reimburse for case management assessment (G9001)?	Yes	Reviewed for coverage on a case by case basis	Yes	Yes	Yes	Yes	Yes
Accept DMAS-50 (M)aternal and (I)nfant?	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Require SA?	No	No	No	Yes, for non-par provider only	No	No	No
Reimburse for nutritional assessment (97802)?	Yes	Yes, Office and Outpatient facility setting covered	Yes	Yes	Yes	Yes	Yes
Require SA?	No	No (if in office setting) Yes (if outpatient facility setting)	No	Yes, for non-par provider only	No	Yes	No
Reimburse for nutritional counseling and follow up visit (97803)?	Yes	Yes, Office and Outpatient facility setting covered	Yes	Yes	Yes	Yes	Yes
Require SA?	No	No (if in office setting) Yes (if outpatient facility setting)	No	Yes, for non-par provider only	No	Yes	No

12. Midwife Services

The MCOs are required to cover services provided by a participating Certified Nurse Midwife (CNM) should a Medicaid, FAMIS, or FAMIS MOMs member choose to receive pregnancy and delivery services from a midwife.

The MCOs are NOT required to cover services provided by a Certified Professional Midwife (CPM). However, the MCOs may provide coverage of participating CPMs as a value added benefit. A member should call the MCO to find out what they cover.

Pregnant Medicaid and FAMIS MOMs individuals who are new to managed care and have chosen to receive services from a non-participating midwife must request an exemption from managed care. FAMIS enrollees can NOT be exempted for this reason.

- These requests may be made by either the expectant mother or the midwife provider and should be submitted to DMAS as soon as possible. The request form must be signed by the member requesting exemption.
- Requests may be made by faxing the attached form to 804-786-5799, or by calling the Managed Care Helpline at 1-800-643-2273.
- Exemption is granted only during the first 90 days of the initial managed care enrollment.
- A response to the exemption request is provided by DMAS to the expectant mother in writing and it is the expectant mother's responsibility to provide a copy of that response to the midwife providing services.
- Members who become pregnant or who find out they are pregnant after they have been MCO-enrolled for more than 90 days must use a MCO participating provider (midwife or OB).
- The midwife should verify eligibility for each individual prior to providing each service to determine if the individual continues to be eligible.
- Following the end of the pregnancy, member shall be required to enroll (in an MCO) to the extent she remains eligible for Medicaid.

Managed Care Exemption Request Form

Date: _____

I hereby request continued coverage through fee-for-service Medicaid to be able to receive prenatal and delivery services through a Midwife.

Midwife name: _____

If you have questions or concerns, you may contact me at_____.
You may also contact my midwife_____at_____.

Name (printed) _____ Signature _____

Medicaid ID#: _____

My estimated delivery date (EDD) is _____

Please fax this form to: 804-786-5799, Attn: Managed Care Exemptions

MANAGED CARE RESOURCE GUIDE

Department of Medical Assistance Services

13. Referral and Prior Authorization Requirements

Medical Services Referral and Prior Authorization (PA) Requirements

MCO	PCP REFERRAL REQUIRED	PRIOR AUTHORIZATION REQUIREMENTS
Anthem HealthKeepers Plus	No referral needed for an in-network specialist.	All inpatient hospital services, some outpatient hospital services, out of network/out of area services, DME (rentals), some high dollar purchase, fixed wing transportation, pain management, transplant services, prosthetics and orthotics, private duty nursing, sleep studies, outpatient radiology. For complete information on services requiring prior authorization/ precertification, providers should log in from the Point of Care secured login and select VA Medicaid to access the precertification look up tool. Anthem HealthKeepers Plus prior authorization - 1-800-901-0020.
CoventryCares of Virginia	No referral needed for an in-network specialist.	Cardiac rehabilitation, clinical trials, DME, home health care or services, hospital observation stays, inpatient hospital care, MRI, MRA and PET Scans, outpatient surgery, pain management services/programs, polysomnograms, services performed by a non- participating provider, physical, occupational and speech therapy, and all inpatient and outpatient mental health and substance abuse services, AICD, bi-ventricular pacemaker, dental treatment for accidents, injectable drugs and neuropsychological testing, insulin pump and supplies, pulmonary rehabilitation, CT Scans, Genetic Testing, Hyperbaric Oxygen, Intensity-modulated Radiation Therapy, Non-Implanted Prosthetic Devices, Nuclear radiology, Nutritional Formulas and Supplements, OB ultrasounds(beginning with 3rd ultrasound), Oral Surgery, Orthotics, Stress Echocardiograms, Transplant Consultations, evaluations, and testing/transplant procedures. Biofeedback Therapy,
INTotal Health	No referral needed for an in-network specialist.	Inpatient admission and services, skilled nursing services, chemotherapy, cardiac rehab, Non-routine diagnostic testing (CAT, MRA,MRI, PET scans, nuclear cardiology), genetic testing, DME, home healthcare, hospice, pain management, selected pharmacy, podiatry, non-par/out of area services, chiropractic, dermatology, ENT, gastroenterology, neurology, ophthalmology, oromaxillofacial plastic/cosmetic services, and inpatient and outpatient mental health and substance abuse services. INTotal Health does not require preauthorization for PT/OT/Speech therapy unless out of network.
Kaiser Permanente	A referral is required except for self-referrals such as Behavioral Health, Routine Well Women's Care, and Routine Vision with participating providers	The following services require prior authorization from Kaiser Permanente for non-KP physicians: Home Health Services, hospice services, inpatient hospital services for non-emergency stays, organ transplants, private duty nursing, skilled nursing facility care, therapy services, and certain prescription drugs. To check if a service, procedure or prescription drug is covered, call Member Services toll-free at 855-249-5025 or 866-513-0008 TTY/TDD.

Medical Services Referral and Prior Authorization (PA) Requirements

Optima Family Care	No referral needed for an in-network specialist.	Non-formulary drugs, inpatient care, outpatient and surgery services including some diagnostic testing, inpatient mental health and substance abuse, DME (including hearing aids), early intervention, home health, hospice care, orthopedic and prosthetic appliances, physical therapy, occupational therapy and speech therapy, private duty and skilled nursing.
Virginia Premier Health Plan	No referral needed for an in-network specialist.	All inpatient hospital services, some outpatient hospital services, out of network services, DME, home health, PT/OT/ST, prosthetics and orthotics, skilled nursing. Visit our web site at www.virginiapremier.com, Providers, Medical Management, Utilization Management to review our General Rules for our authorization requirements. This site includes the authorization requirements for all CPT, Revenue and HCPCS codes.
DMAS Fee-for-Service		The Department of Medical Assistance Services (DMAS) contracts with Keystone Peer Review Organization (KePRO) to handle the service authorization process for most medical services for the Medicaid and FAMIS clients in the fee-for-service programs. Additional information regarding service authorization, including for services handled outside of the KePRO contract, is available on the DMAS website at http://dmasva.dmas.virginia.gov. Check the DMAS website on a regular basis for new program information, changes, or updates. Questions regarding service authorizations can be sent via e-mail to providerissues@kepro.com or PAUR06@dmas.virginia.gov. For Atrezzo Connect Portal issues, send inquiries to atrezzoissues@kepro.com.

Authorization Process for PT, OT and Speech Therapies

MCO	PCP REFERRAL REQUIRED	PRIOR AUTHORIZATION REQUIRED	UTILIZATION REVIEW PROCESS
Anthem HealthKeepers Plus	No	For non-participating providers, authorization is required. Providers may access the precertification loop up tool from the Point of Care secured login. Select VA Medicaid for specific code authorization requirements.	Please call 1-800-901-0020 for information on utilization review. Please fax requests to 1-800-964-3627.
CoventryCares of Virginia	No	Yes – for all services after the initial evaluation	Therapist submits plan of care for authorization of services. Utilization review frequently for continued authorization of visits.
INTotal Health	No	INTotal Health does not require preauthorization for PT/OT/Speech therapy unless out of network.	Out of network providers may call (855)-323-5588
Kaiser Permanente	Yes. Required for therapies ordered by non-KP physicians	Rehabilitative Services (PT, OT, SPT) require referral for non-KP physicians	Referrals are entered into the referral system directly or faxed to UMOC via 1-800-660-2019 Toll Free number for UMOC: 1-800-810-4766 follow prompts.
Optima Family Care	No	Yes – for all services after initial evaluation.	Therapist submits plan of care for authorization of services. Utilization review frequently for continued authorization of visits.
Virginia Premier Health Plan, Inc.	No	Yes	**Physician or therapist must request prior authorization for evaluation. Additional visits will require utilization review.**
DMAS Fee For Service	Yes	Yes – for all services after the 5 visit limit per fiscal year (July 1 – June 30th)	Send preauthorization requests to the DMAS Preauthorization Contractor (KePRO). Submit requests via Atrezzo Connect http://dmas.kepro.com/ or call 804-622-8900 or 1-888-827-2884 Or FAX – 1-877-652-9329

Revised 11/1/2013

Medicaid/FAMIS MCO Behavioral Health Authorization and Referral Requirements *All MCOs require prior authorization for inpatient admissions; no PCP referral is required*	
Health Plan/Contact Information	**Outpatient Authorization/Referral Required?**
Anthem HealthKeepers Plus Providers call: 1-800-901-0020	No prior authorization required for participating providers; services from non-participating providers require prior authorization. Neuropsychological testing, electroconvulsive therapy, and transcranial magnetic stimulation and psychological testing require authorization. Prior authorization is also required for partial hospitalization.
CoventryCares of Virginia Providers call MHNet: 800-975-8919 www.mhnet.com	No prior authorization required for participating providers for members 21 and younger; services from non-participating providers require prior authorization. Psychological/neuropsychological testing and electroconvulsive therapy require authorization.
INTotal Health Providers call: 1-855-323-5588	No prior authorization required for participating providers for most services; services from non-participating providers require prior authorization. Psychological/neuropsychological testing and electroconvulsive therapy require authorization.
Kaiser Permanente Behavioral Health Unit: 1-301-897-2434 Select Prompt # 6 for non-urgent inquiries Select Prompt #9 for Emergency Services	Initial visit to a participating specialist is not required. Authorization & referral is required for services after initial consult
Optima Family Care / Optima Behavioral Health Providers call: 757-552-7174 or 800-648-8420 Pre-authorization fax: 757-552-7176 or 888-576-9675	No prior authorization required for participating providers; services from non-participating providers require prior authorization. Electroconvulsive therapy requires preauthorization.
Virginia Premier Health Plan *Contacts:* *Tidewater: 800-828-7989* *Richmond/Central/Western: 800-727-7536* *Roanoke/Alleghany, Danville/Lynchburg* *Southwest: 888-338-4579* *www.vapremier.com* *Preauthorization-* *800-727-7536 ext. 66710 or Fax- 800-827-7192*	No prior authorization is required for the first 26 visits; services from non-participating providers require prior authorization. No authorization required for up to 8 hours of psychological testing by participating provider. Authorization required after initial 8 hours or for non-participating providers Neuropsychological testing and electroconvulsive therapy require authorization.

MCOs Honoring Prior Authorizations

- Contracts require the MCO to honor all services previously authorized by DMAS, its contractor, or another MCO.

- If a member was receiving home health visits, for example, this service should continue without interruption. This may allow the MCO to review the service for medical necessity within the utilization review process to determine continued needs and to determine if the criteria for medical necessity are being met.

- MCOs may also change the provider to one of their own contracted providers on a timely basis so as not to delay or stop the continuity of care being provided.

- Children covered by a MCO under Medallion 3.0 who have services prior authorized for coverage under the Medallion 3.0 MCO, but then become covered by that same plan under FAMIS, can receive the authorized service, as long as the service is covered by FAMIS.

- The MCO is not required to cover transplant procedures determined to be experimental or investigational. However, scheduled transplantations authorized by DMAS must be honored by the MCO, as with all authorizations, until such time that DMAS can disenroll the member from the MCO, if applicable, if the transplant is scheduled concurrent with the member's enrollment with the MCO.

MANAGED CARE RESOURCE GUIDE

Department of Medical Assistance Services

14. Contact Information

Provider Services Contact Information

Plan Name	Provider Services Phone Number
Anthem HealthKeepers Plus	1-800-901-0020 www.anthem.com
CoventryCares of Virginia	1-800-449-1944 www.directprovider.com
INTotal Health	1-855-323-5588 www.intotalhealth.org
Kaiser Permanente	1-800-810-4766 (claims status, referral /authorizations, member eligibility) 1-877-806-7470 (provider contract or participating status) http://providers.kp.org
Optima Family Care	1-757-552-7474 or 1-800-229-8822 www.optimahealth.co m
Virginia Premier Health Plan, Inc.	Tidewater - 1-800-828-7989 Richmond/Central/Western - 1-800-727-7536 Roanoke/Danville/Lynchburg - 1-888-338-4579 Southwest – 1-888-285-8963 www.vapremier.com
Fee-for-Service *DMAS Provider Helpline* Monday through Friday from 8:30 a.m. to 4:30 p.m.	1-804- 786-6273 Richmond area and out-of-state long-distance 1-800-552-8627 All other areas (in-state long-distance, toll-free) http://www.dmas.virginia.gov/

Member Services Contact Information

Plan Name	Member Services Phone Number
Anthem HealthKeepers Plus	1-800-901-0020 24/7 Nurse Line – 1-800-901-0020 www.anthem.com/vamedicaid
CoventryCares of Virginia	1-800-279-1878 TTY/TDD 711 24/7 Nurse Advice Line – 1-877-878-8940 www.CoventryCaresVA.com
INTotal Health	1-855-323-5588 24/7 Nurse Advice Line - 1-855-323-5588 TTY English: 1.800.855.2880 - TTY Spanish: 1.800.855.2884 www.intotalhealth.org
Kaiser Permanente	(855) 249-5025 TTY/TDD - (866) 513-0008 Medical Advice Line - (800) 777-7904, (800) 700-4901 TTY/TDD* kp.org/medicaid/va
Optima Family Care	1-757-552-8975 or 1-800-881-2166 TTY/TDD - 757-552-7120 or 1-800-225-7784 Nurse Advice Line – 1-800-394-2237 or 1-757-552-7250 www.optimahealth.com
Virginia Premier Health Plan, Inc.	Tidewater – 757-461-0064 or 800-828-7989 Richmond/Central/Western Members - 804-819-5151 or 800-727-7536 Roanoke/Danville/Lynchburg Members - 540-344-8838 or 888-338-4579 Southwest - 800-727-7536 TTY (text) - 800-828-1120 - TDD (voice) - 800-828-1140 Nurse Advice Line – 800-256-1982 www.vapremier.com
FAMIS *Cover Virginia*	1-855-242-8282 TDD: 1-888-221-1590 www.coverva.org
Fee-For-Service *DMAS Member Helpline*	Eligibility - Call your local Department of Social Services Covered Services - Call DMAS Member Helpline: 1-804-786-6145 or TDD 800-343-0634 http://www.dmas.virginia.gov

Medicaid/FAMIS Behavioral Health Contacts

Plan Name	Provider Services Phone Number
Anthem HealthKeepers Plus	Providers call: 1-800-901-0020
CoventryCares of Virginia	Providers call MHNet: 800-975-8919 www.mhnet.com
INTotal Health	Providers call: 1-855-323-5588
Kaiser Permanente	1-800-810-4766 (claims status, referral /authorizations, member eligibility) 1-877-806-7470 (provider contract or participating status) http://providers.kp.org
Optima Family Care / Optima Behavioral Health	Providers call: 757-552-7174 or 800-648-8420 Pre-authorization fax: 757-552-7176 or 888-576-9675
Virginia Premier Health Plan	Tidewater - 1/757-461-0064 or 800-828-7989 Richmond/Central/Western - 804-819-5151 or 800-727-7536 Roanoke/Danville/Lynchburg – 1-540-344-8838 or 888-338-4579 www.vapremier.com

High Risk Maternal Infant Program Services and Contact Information

Plan and Infant Program	Services		
Anthem HealthKeepers Plus ***New Baby, New Life ℠*** 1-800-901-0020 Child with Special Health Care Needs 1- 800-901-0020	▪ Prenatal High Risk screening and risk assessment ▪ Identification and comprehensive case management for high risk pregnancies ▪ Postpartum assessment	▪ 24/7 toll free access to an RN ▪ Prenatal, Postpartum and newborn educational materials ▪ Prenatal, postpartum and well child incentive rewards	▪ Coordination of Community Resources ▪ Tobacco/Smoking cessation ▪ Breastfeeding support and assistance ▪ You and Your Baby in the NICU educational program and support
CoventryCares of Virginia **Baby Matters** 1-800-424-0077 Child with Special Health Care Needs 1-800-424-0077, ext. 2981149	▪ Patient Education ▪ Nutrition counseling ▪ Homemaker services ▪ Coordination of community resources ▪ Prenatal incentive Rewards	▪ Post-partum educational materials ▪ Telephone follow up to screen for depression ▪ Follow-up monitoring ▪ Guidance and support ▪ Telephone/mailing contacts	▪ Makena ▪ Identification and intensive RN Case Management for high-risk pregnancies ▪ Case Management program for NICU babies
INTotal Health **Starring: Baby and Me** 1-855-323-5588 Child with Special Health Care Needs 1-855-323-5588	▪ Outreach Welcome Call with OB Risk Screening and resource referral and assistance ▪ Comprehensive OB and NICU Case Management Services with Health Assessments and referrals ▪ Ongoing member health and needs assessments	▪ Welcome Prenatal and Post Partum packets with education information and incentive Gift Card awards for prenatal and post partum visits ▪ Ongoing member educational support ▪ Physician collaboration in care ▪ Utilization management and Concurrent Review for hospitalized moms and NICU babies	▪ Provision of SafeLink phones and services to select members ▪ Text4Baby national partner ▪ Assistance with Smoking Cessation resources ▪ Assistance with Breastfeeding referrals and services ▪ 24 hour Nurse helpline
Kaiser Permanente **Healthy Mom Healthy Baby** (866) 223-2347	▪ 24-hour advice nurse available by phone ▪ Interactive web site for tracking pregnancy each week ▪ Healthy Living prenatal classes to help members know what to expect during pregnancy, prepare for childbirth and care of new baby ▪ Podcasts, videos and other materials about pregnancy and how to care for Mom and baby	▪ Special care from RN case manager for moms experiencing a high risk pregnancy ▪ Nutrition and exercise advice ▪ Depression screening ▪ Assistance with smoking cessation ▪ Breast-feeding support from International Board Certified Lactation Consultants (IBCLCs)	▪ On-line videos that show how to feed, bathe and soothe baby ▪ Secure messaging so members can email their doctor and baby's doctor with a question or concern ▪ Case managers for babies with special needs ▪ Coordination with community resources ▪ Printed education materials
Optima Family Care **Partners in Pregnancy** 1-866-239-0618 Child with Special Health Care Needs 1-800-229-5522 Fax 1-877-800-2839	▪ Monthly telephone calls/serial screening for risk factors ▪ Continual assessment and follow up with MD when appropriate	▪ RN OB case manager follows high-risk cases and refers to community resources as available and appropriate ▪ Home visitation through CHIP or Sentara Home care Services according to risk evaluation	▪ Regular educational and support material mailings ▪ 24-hour toll-free access to RNs, Nutrition counseling, Homemaker services, Smoking cessation, Breastfeeding referrals and resources, Postpartum assessment and screening for depression
Virginia Premier Health Plan, Inc. **Healthy Heartbeats** 1-800-727-7536 Child with Special Health Care Needs 1-800-727-7536	▪ Initial contact by Medical Outreach Rep with Intake Assessment ▪ Follow-up visits frequency depends on risk (minimum of once per trimester) ▪ Educational Baby Showers	▪ Postpartum home visit ▪ Incentive gifts with enrollment into program and gift bag with baby items postpartum ▪ Printed educational materials ▪ OB classes (CBE; breast feeding; baby care)	▪ RN case management if high risk ▪ Text 4 Baby ▪ Assistance with smoking cessation resources ▪ Home visiting outreach ▪ Breast pumps
DMAS MCH Division **BabyCare*** 804-786-6134 Fax: 804-612-0043 Email: BabyCare@dmas.virginia.gov	▪ Case management for pregnant women and infants up to age two who are identified as high-risk	▪ Expanded prenatal services for pregnant women including patient education classes, tobacco cessation, nutritional services, homemaker services and Substance Abuse Treatment Services.	

Medical and Disease Management Services Contact Information

Plan Name	Case Management Information
Anthem HealthKeepers Plus	Medical Management - 1-800-901-0020 Case Management Referral Line - 1-800-901-0020 Disease Management (ConditionCare) - 1-800-901-0020
CoventryCares of Virginia	Case Management/Disease Management Department 1-800-424-0077
INTotal Health	Case Management Department 1-855-323-5588 Disease Management 1-855-323-5588
Kaiser Permanente	Case Management Self-Referral 1-866-223-2347 Disease Management 1-703-536-1465
Optima Family Care	Pre-authorization Team phone 1-800-229-5522 Fax 1-877-800-2839 Health Care Services Team 1-866-503-5828
Virginia Premier Health Plan, Inc.	Medical Management 1-800-727-1536 Disease Management 1-866-243-0937 Referrals/Preauthorization 1-888-251-3063

Pharmacy Services Contact Information

Plan	Formulary	Prior Authorization
Anthem HealthKeepers Plus	Closed formulary	Providers should FAX forms to 1-888-642-4016 Retail Pharmacy Services help desk 1-800-824-0898 Prior Authorization 1-866-310-3666
CoventryCares of Virginia	Closed Formulary	Pharmacy Services Help Desk 1-800-378-7040 Formulary Exception Requests Pharmacy Call Center Phone 1-877-215-4100 FAX 1-855-799-2553
INTotal Health	Closed Formulary	INTotal Health Pharmacy Department Provider phone: 1-855-323-5588 Provider fax: 1-855-762-5205
Kaiser Permanente	Closed Formulary	Pharmacy Service Help Desk 1-800-788-2949 Pharmacy service authorization requests should be faxed to: 1-866-331-2104
Optima Family Care	Closed Formulary	Catamaran Help Desk 1-866-244-9113 Optima Pharmacy Department 1-800-229-5522 Optima Pharmacy Department Fax - 1-757-552-7516 or 1-800-750-9692
Virginia Premier Health Plan, Inc.	Formulary	EnvisionRxOptions ENVISION's Member/Pharmacy/Medical toll-free helpline: 855-872-0005 Physician PA fax line: 877-503-7231
Fee-For-Service	Formulary	Affiliated Computer Services (ACS) 1-800-932-6648 Fax: 1-800-932-6651 www.virginiamedicaidpharmacyservices.com

Transportation Services Scheduling and Contact

Plan	Scheduling Instructions	Special Instructions
Anthem HealthKeepers Plus Reservations -1-877-892-3988 Stretcher/Ambulance - 1-877-892-3988 Ride Assist – 1-877-892-3988	Members are advised to call 5 days before the scheduled appointment. To allow time to mail bus tickets, 7 days is recommended. Member will be picked up by the transportation provider 1 hour before the scheduled appointment.	Special arrangements can be made for wheelchair transportation. Bus tickets are provided by mail. Urgent, non-emergent transportation requests are available 24/7. Complaints call ride assist line.
CoventryCares of Virginia Reservations - 800-734-0430 Stretcher/Ambulance–804-968-7206 Ride Assist – 800-734-0430	Members are advised to call 3 business days before the scheduled appointment. The transportation provider will pick up member about 1 hour before the scheduled appointment.	Bus tickets and bus passes are available and will be mailed to members. There are also other available modes of transportation available for those members with special needs. Complaints call ride assist line.
INTotal Health Reservations - 800-894-8139 Fax - 866-679-6329 Stretcher/Ambulance under 19 – 800-894-8139 Stretcher/Ambulance 19 and over – 855-323-5588 option 6 Ride Assist - 800-894-8396	Members are advised to call **72** hours before the scheduled appointment. Members are advised to be ready 1 hour before the scheduled appointment unless otherwise indicated. Special arrangements are made for wheelchair transportation.	Operators will be available 24 hours a day, 7 days a week for immediate response to urgent requests for transportation services. If proper notice is given, bus tickets and passes will be mailed to members when requested. Gas reimbursement may be available to a friend, neighbor or relative to transport members to medical appointments. Complaints call ride assist line.
Kaiser Permanente Reservations – 866-823-8349 – all areas, ages, and levels of service Ride Assist – 866-823-8350	Members are advised to call 72 hours before the scheduled appointment. Members can make reservations up to 30 days in advance	Standard hours of operation for routine/non urgent reservations are Monday – Friday 8:30 a.m. – 5:00 p.m. EST. Calls for ride assistance and hospital discharges are available 24/7/365. Calls for urgent and same day reservation are available 24/7/365. Complaints call ride assist line.
Optima Family Care Reservations 877-892-3986 Stretcher/Ambulance 800-881-2166 Ride Assist - 866-660-4371	Members are advised to call 48 hours before scheduled appointments and 5 days before routine physical appointments preferred. Member will be picked up by the transportation provider 1 hour before the scheduled appointment.	Special arrangements may be made for wheelchair and ambulance transportation. Bus tickets and bus passes are available and will be mailed to members. Discharge planners at the hospital work with case manager at the MCO for discharge transport arrangement. Complaints call ride assist line.
VA Premier Health Plan, Inc. Reservations - 800-727-7536, Option 2 then Option 1 Ride Assist – 800-727-7536 Option 2 then Option 3	Members are advised to call at least 72 hours before the scheduled appointment. Member needs to be ready 1 hour prior to pickup time.	Bus tickets are available by mail or an outreach worker can hand deliver to client's home. VA Premier Health Plan operates their own transportation Vans. Special arrangements can be made for wheelchair transportation. Complaints call 800-727-7536.
Fee-For-Service - LogistiCare Reservations – 1-866-386-8331 – all regions, ages, and levels of service. Ride Assistance – 866-246-9979	Request trips at least 5 days in advance unless it is an urgent trip. If you become ill and your doctor can see you in less than five days, call the broker and request an Urgent Trip. If you will have at least three trips per week at the same time and to and from the same destination, you can request a Standing Order.	All complaints from members and facilities should go to the "Ride Assist" number 866-246-9979.

Global Medicaid Transportation Coverage Guidelines

Emergency Ambulance Services

Emergency ambulance is a covered service. Coverage is not available for emergency ambulance transportation to treat minor abrasions, lacerations, bruises, fever, normal labor pains and other similar non-life-threatening conditions.

Non-Emergency Transportation Services

Covered non-emergency services include the following modes of transportation:

- Ambulance
- Wheelchair van
- Common carrier bus services
- Commercial taxicab services
- Stretcher Vans
- Mileage Reimbursement
- Bus Tickets/Passes

Please contact LogistiCare for bus tickets or gas reimbursement forms prior to making the trip(s).

Transportation is Covered When:

No other means of transportation is available to the member to receive services which are covered by Medicaid.

Transportation is NOT Covered for:

- Routine physicals and immunizations except to receive Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services.
- Picking up prescription drugs at the pharmacy when the prescription can be delivered or mailed. If such a service is not available, transportation may be covered.
- Picking up Women, Infants and Children (WIC) Supplemental Food Program vouchers or for certification or recertification to the WIC Program.
- Any other non-covered service, services not medically necessary, free services-services provided free to the general public, etc.

NOTE:
One escort is allowed to accompany a member or group of members who are blind, deaf, mentally ill, mentally retarded or under 21 years of age. No charge is to be made for the escort.

Vision Services Contact Information

MCO Name and Administrator	Customer Service Contact
Anthem HealthKeepers Plus Administered by Davis Vision	1-800-901-0020
CoventryCares of Virginia Administered by Vision Service Plan (VSP)	1-800-279-1878
INTotal Health Administered by Block Vision, Inc.	Members - 1-800-428-8789 Providers - 1-866-819-4298
Kaiser Permanente	1-800-777-7904
Optima Family Care Administered by EyeMed Vision Care	1-800-610-2268
Virginia Premier Health Plan Administered by Vision Service Plan	800-828-7989 – Tidewater 800-727-7536 - Richmond/Central/Western/ Southwest 888-338-4579 – Roanoke/Danville/Lynchburg
Fee For Service	Providers – Provider Helpline 1-804- 786-6273 Richmond area and out-of-state long-distance 1-800-552-8627 All other areas (in-state long-distance, toll-free) http://www.dmas.virginia.gov/ http://websrvr.dmas.virginia.gov/ProviderManuals/Default.aspx

MCO Contact Information -- Quick Guide

Transportation *	Member Services	Provider Services	Network Relations
Anthem HealthKeepers Plus Reservations -1-877-892-3988 Stretcher/Ambulance - 800-901-0020 Ride Assist – 877-892-3988	Behavioral Health Member Services 1-800-901- Nurse Advice Line (24/7 Nurse Line) 1-800-901- www.anthem.com	Behavioral Health Provider Services 1-800-901-0020 www.anthem.com	Network Relations- Questions about provider contracts Central Region- 1-804-354-4126 Eastern Region- 1-757-326-5158 Northern/Western Region- 1-804-354-2338 Ancillary Providers- 1-804-354-2338 Provider Services 1-800-901-0020
CoventryCares of Virginia Reservations - 800-734-0430 Stretcher/Ambulance–804-968-7206 Ride Assist – 800-734-0430	1-800-279-1878 TTY/TDD 711 Nurse Advice Line 1-877-878-8940 www.CoventryCaresVA.com	Behavioral Health Provider Services 800-975-8919 www.mhnet.com Provider Services 1-800-449-1944 www.directprovider.com	Rafael Pinero Provider Network Rep, MHNet 1-855-995-4086 ext. 3074724
INTotal Health Reservations - 800-894-8139 Fax - 866-679-6329 Stretcher/Ambulance under 19 – 800-894-8139 Stretcher/Ambulance 19 and over – 855-323-5588 option 6 Ride Assist - 800-894-8396	1-855-323-5588 TTY 1-800-855-2880 www.intotalhealth.org	1-855-323-5588 www.intotalhealth.org	Janine Woldt Chief Administrative Officer 800-231-8076
Kaiser Permanente Reservations – 866-823-8349 – all areas, ages, and levels of service Ride Assist – 866-823-8350	(855) 249-5025, (866) 513-0008 TTY/TDD Medical Advice Line (800) 777-7904, (800) 700-4901 TTY/TDD kp.org/medicaid/va	1-877-806-7470 1-800-810-4766 (claims status, referral /authorizations, member eligibility)	Kenya Onley Provider Relations Kenya.C.Onley@kp.orgMCO Contact
Optima Family Care Ride Assist – 866-823-8350	1-800-394-2237 1-757-552-7250 www.optimahealth.com	1-866-996-9140 www.optimahealth.com	After hours ambulance – 540-345-7628 Ride Assist 877-564-0576
VA Premier Health Plan, Inc. **Reservations - 800-727-7536, Option 2 then** **Ride Assist – 800-727-7536 Option 2 then Option** **VA Premier Health Plan, Inc.**	Tidewater 757-461-0064 or 800-828-7989 Richmond/Central/Western/ Far Southwest Members 804-819-5151 or 800-727-7536 Roanoke/Danville/Lynchburg Members 540-344-8838 or 888-338-4579 Nurse Advice Line 800-256-1982 www.vapremier.com	Tidewater 1-800-828-7989 Richmond/Central/Western 1-800-727-7536 Roanoke/Danville/Lynchburg 1-888-338-4579 www.vapremier.com	Tidewater 757-461-0064 or 800-828-7989 Richmond/Central/Western/Southwest Members 804-819-5151 or 800-727-7536 Roanoke/Danville/Lynchburg Members 540-344-8838 or 888-338-4579 Nurse Advice Line 800-256-1982 www.vapremier.com

* Transportation should be arranged 3-5 days in advance if possible; however, transport can be arranged in shorter windows when necessary and upon request. If issues are encountered with transportation please call the appropriate MCO member services contact (above) for assistance

MANAGED CARE RESOURCE GUIDE

Department of Medical Assistance Services

15. Accessing Covered Services

Guide to Accessing Medicaid Fee-For-Service,
Medallion 3.0 (Medicaid MCO), & FAMIS MCO

A description of accessing covered services (Medallion 3.0, 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 3.0 (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)**	**Medallion 3.0 MCO (Medicaid &**	**FAMIS MCO**	**Medicaid Medallion 3.0 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 and MCO Medicaid 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 and MCO Medicaid 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 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 covered service. The MCO is not required to cover this service.	The MCO is not required to cover this service.

Medicaid Fee-For-Service, Medallion 3.0 (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)**	**Medallion 3.0 MCO (Medicaid &**	**FAMIS MCO**	**Medicaid Medallion 3.0 Comments**	**FAMIS MCO Comments**
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 3.0 services.	The MCO is not required to cover this service unless the service is both medically necessary and is a FAMIS covered service.
Dental Services – *Routine dental care is covered under the Smiles For Children Dental Program for FFS and MCO enrollees.*	Yes--see Comments	Yes – see comments.	Yes – see comments.	The Contractor is required to cover CPT codes billed by an MD as a result of an accident. 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. Coverage for adults is limited to medically necessary oral surgery and associated diagnostic services. See Article IIG of the Medallion 3.0 contract. 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.	The Contractor is required to cover CPT codes billed by an MD as a result of an accident. 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. 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.

Medicaid Fee-For-Service, Medallion 3.0 (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)**	**Medallion 3.0 MCO (Medicaid &**	**FAMIS MCO**	**Medicaid Medallion 3.0 Comments**	**FAMIS MCO Comments**
Early and Periodic Screening, Diagnosis and Treatment (EPSDT)	Yes	Yes	No, not a covered benefit See "Well Baby and Well Child Care"	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. The MCO is required to screen and assess all children. 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 not required to cover this service. The MCO is required to cover well-baby and well child care services.
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)	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/Provider Manuals/Default.aspx. The MCO shall cover other medically necessary rehabilitative and developmental therapies, including for EI enrolled children where appropriate.	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/Provider Manuals/Default.aspx. The MCO shall cover other medically necessary rehabilitative and developmental therapies for EI enrolled children where appropriate.

Medicaid Fee-For-Service, Medallion 3.0 (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)**	**Medallion 3.0 MCO (Medicaid &**	**FAMIS MCO**	**Medicaid Medallion 3.0 Comments**	**FAMIS MCO Comments**
Emergency Services	Yes	Yes	Yes	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. 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.	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. 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. 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.
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 covered service.	The MCO is not required to cover this service. See MCO Contract for EPSDT related criteria.

Medicaid Fee-For-Service, Medallion 3.0 (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)**	**Medallion 3.0 MCO (Medicaid &**	**FAMIS MCO**	**Medicaid Medallion 3.0 Comments**	**FAMIS MCO Comments**
Family Planning Services	Yes	Yes	Yes	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. The MCO may not restrict a 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.	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. 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. *Code of Virginia* § 54.1-2969 (D), 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.
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.

Medicaid Fee-For-Service, Medallion 3.0 (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)**	**Medallion 3.0 MCO (Medicaid &**	**FAMIS MCO**	**Medicaid Medallion 3.0 Comments**	**FAMIS MCO Comments**
Home Health Services	Yes	Yes	Yes	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. 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. ▪ 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	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.

Medicaid Fee-For-Service, Medallion 3.0 (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)**	**Medallion 3.0 MCO (Medicaid &**	**FAMIS MCO**	**Medicaid Medallion 3.0 Comments**	**FAMIS MCO Comments**
Hospice Services	Yes, Services are covered through the Department within FFS coverage guidelines	No, hospice enrolled members are excluded from the Medallion 3.0 program.	Yes	**The MCO is not required to cover this service.** Members who elect Hospice Benefits will be excluded from the Medallion 3.0 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.

Medicaid Fee-For-Service, Medallion 3.0 (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)**	**Medallion 3.0 MCO (Medicaid &**	**FAMIS MCO**	**Medicaid Medallion 3.0 Comments**	**FAMIS MCO Comments**
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	The MCO is required to cover all medical supplies and equipment at least to the extent they are covered by Medicaid. The MCO is required to cover related supplies for children and nutritional supplements for adults over 21. The MCO is responsible for payment of any specially manufactured DME equipment that was prior authorized by the MCO.	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.

Medicaid Fee-For-Service, Medallion 3.0 (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)**	**Medallion 3.0 MCO (Medicaid &**	**FAMIS MCO**	**Medicaid Medallion 3.0 Comments**	**FAMIS MCO Comments**
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 synegenic 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.
Pap Smears	Yes	Yes	Yes	MCO is required to cover annual pap smears.	The MCO is required to cover annual pap smears.

Medicaid Fee-For-Service, Medallion 3.0 (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)**	**Medallion 3.0 MCO (Medicaid &**	**FAMIS MCO**	**Medicaid Medallion 3.0 Comments**	**FAMIS MCO Comments**
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.
Pregnancy-Related Services	Yes	Yes	Yes	The MCO shall cover services for pregnant women. There is no co-pay for pregnancy related services. The Contractor is required to cover case management services for high risk pregnant women and children (up to age two). 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.	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.

Medicaid Fee-For-Service, Medallion 3.0 (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)**	**Medallion 3.0 MCO (Medicaid &**	**FAMIS MCO**	**Medicaid Medallion 3.0 Comments**	**FAMIS MCO Comments**
Tobacco Dependence Treatment (i.e., Smoking Cessation) for Pregnant Women	Yes	Yes	Yes	The MCO shall provide coverage for tobacco dependence treatment for pregnant women without cost sharing. Treatment includes counseling and pharmacotherapy.	The MCO shall provide coverage for tobacco dependence treatment for pregnant women without cost sharing. Treatment includes counseling and pharmacotherapy.
Prenatal Services—Expanded	Yes	See Comment	No	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	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.
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	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	The MCO shall cover private duty nursing services when medically necessary. Private duty nursing services must be authorized.

Medicaid Fee-For-Service, Medallion 3.0 (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)**	**Medallion 3.0 MCO (Medicaid &**	**FAMIS MCO**	**Medicaid Medallion 3.0 Comments**	**FAMIS MCO Comments**
Prescription Drugs	Yes	Yes	Yes	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. 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. 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	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. 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. 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
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.

Medicaid Fee-For-Service, Medallion 3.0 (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)**	**Medallion 3.0 MCO (Medicaid &**	**FAMIS MCO**	**Medicaid Medallion 3.0 Comments**	**FAMIS MCO Comments**
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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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	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 fee-for-service system. The following services provided on school grounds shall be covered by the MCOs: 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. For more information, reference Article I *Definitions* section and Article II *Provision of Contract Services* 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	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 fee-for-service system. The following services provided on school grounds shall be covered by the MCOs: 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. For more information, reference Article I *Definitions* section and Article II *Provision of Contract Services* 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

Medicaid Fee-For-Service, Medallion 3.0 (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)**	**Medallion 3.0 MCO (Medicaid &**	**FAMIS MCO**	**Medicaid Medallion 3.0 Comments**	**FAMIS MCO Comments**
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 3.0 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	The MCO is required to provide transportation to all Medicaid covered services, including those Medicaid services covered by a third party payor, and transportation to carved out services provided by subcontractors such as dental. *EXCEPTION - Transportation to Home and Community Based Waiver Services is carved-out of the MCO Contract and covered by DMAS.*	Transportation services are not provided for routine access to and from providers of covered medical services. 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.

Medicaid Fee-For-Service, Medallion 3.0 (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)**	**Medallion 3.0 MCO (Medicaid &**	**FAMIS MCO**	**Medicaid Medallion 3.0 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.	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. Benefit: 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 3.0 (Medicaid MCO), FAMIS MCO, & FAMIS MOMS Covered Services

Behavioral Health

Service	Fee-For-Service FFS (Medicaid, FAMIS)	Medallion 3.0 MCO (Medicaid,	FAMIS MCO	Medicaid Medallion 3.0 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.	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. 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.
Inpatient Mental Health Services Rendered in a State Psychiatric Hospital	Yes	No	No	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 3.0. Services rendered in State Mental Hospitals are covered through the Medicaid fee- for-service system in accordance with DMAS guidelines. 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.	Not a FAMIS covered benefit.

Medicaid Fee-For-Service, Medallion 3.0 (Medicaid MCO), FAMIS MCO, & FAMIS MOMS Covered Services Behavioral Health					
Service	**Fee-For-Service FFS (Medicaid, FAMIS)**	**Medallion 3.0 MCO (Medicaid,**	**FAMIS MCO**	**Medicaid Medallion 3.0 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	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. 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.	The MCO is not required to cover this service. Coverage may be available through the State TDO program.

Medicaid Fee-For-Service, Medallion 3.0 (Medicaid MCO), FAMIS MCO, & FAMIS MOMS Covered Services Behavioral Health					
Service	**Fee-For-Service FFS (Medicaid, FAMIS)**	**Medallion 3.0 MCO (Medicaid,**	**FAMIS MCO**	**Medicaid Medallion 3.0 Comments**	**FAMIS MCO Comments**
TREATMENT FOSTER CARE AND RESIDENTAL 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 3.0. 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	Yes	Yes	Yes	See the section above.	See the section above

Medicaid Fee-For-Service, Medallion 3.0 (Medicaid MCO), FAMIS MCO, & FAMIS MOMS Covered Services Behavioral Health					
Service	**Fee-For-Service FFS (Medicaid, FAMIS)**	**Medallion 3.0 MCO (Medicaid,**	**FAMIS MCO**	**Medicaid Medallion 3.0 Comments**	**FAMIS MCO Comments**
Diagnostic Exam					
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
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.

Medicaid Fee-For-Service, Medallion 3.0 (Medicaid MCO), FAMIS MCO, & FAMIS MOMS Covered Services Behavioral Health					
Service	**Fee-For-Service FFS (Medicaid, FAMIS)**	**Medallion 3.0 MCO (Medicaid,**	**FAMIS MCO**	**Medicaid Medallion 3.0 Comments**	**FAMIS MCO Comments**
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 Réhabilitation (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.
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	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.

Medicaid Fee-For-Service, Medallion 3.0 (Medicaid MCO), FAMIS MCO, & FAMIS MOMS Covered Services Behavioral Health					
Service	**Fee-For-Service FFS (Medicaid, FAMIS)**	**Medallion 3.0 MCO (Medicaid,**	**FAMIS MCO**	**Medicaid Medallion 3.0 Comments**	**FAMIS MCO Comments**
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.
Out-patient Substance Abuse Treatment	Yes	Yes	Yes	The MCO is required to cover substance assessment and evaluation and outpatient services for substance abuse treatment for Medicaid enrollees. The Department shall cover emergency services (crisis) (H0050), intensive outpatient (H2016), day treatment (H0047), and SA case management (H0006). Transportation and pharmacy services necessary for the treatment of substance abuse services including carved out services are the responsibility of the MCO.	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.
Substance abuse Opioid treatment (H0020)	Yes	No. Covered by the Department (carved out service)	Not a covered service	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 Transportation and pharmacy services necessary for the treatment of substance abuse services including carved out services are the responsibility of the MCO.	See the section above.

Medicaid Fee-For-Service, Medallion 3.0 (Medicaid MCO), FAMIS MCO, & FAMIS MOMS Covered Services Behavioral Health					
Service	**Fee-For-Service FFS (Medicaid, FAMIS)**	**Medallion 3.0 MCO (Medicaid,**	**FAMIS MCO**	**Medicaid Medallion 3.0 Comments**	**FAMIS MCO Comments**
Substance Abuse Services – Crisis Intervention (H0050)	Yes	No. Covered by the Department (carved out service)	No. Covered by the Department (carved out service)	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.	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 substance abuse treatment provider. Transportation is not a FAMIS covered benefit. See Carved Out Services Section.
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 3.0 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.

MANAGED CARE RESOURCE GUIDE

Department of Medical Assistance Services

16. Accessing Carved-Out Services

Guide to Accessing Medicaid Fee-For-Service,
Medallion 3.0 (Medicaid MCO) & FAMIS
Carved Out Services

A description of accessing carved out services (Medallion 3.0 and FAMIS), including preventive services, service limitations, referral and prior authorization requirements. The following are not intended to be a comprehensive list of carved-out services. All carved-out services 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/mcmedallion2.aspx

Medallion 3.0 (Medicaid MCO) Carved Out Services		
Carved-Out Service	**Comments**	**Contact**
Abortion Services	**The MCO shall not cover services for abortion except in those cases where there would be substantial danger to life of mother.** 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.	Direct requests for these procedures to: Medical Director, DMAS Medical Support Services, 600 East Broad Street, Suite 1300, Richmond, Virginia 23219; Phone: 804-786-8056; Fax - 804-786-0414.
Case Management Services for members of auxiliary grants in adult care residences		Local Department of Social Services (DSS)
Community Mental Health Rehabilitation and Substance Abuse Treatment Services and Case Management For Members Receiving Community Mental Health and Mental Retardation Services. See http://websrvr.dmas.virginia.gov/ProviderManuals/Default.aspx. See Page 63 in this guide for a listing of services.	MCOs must cover transportation to community mental health rehabilitation and smoking cessation services. See Page 61 in this guide.	Local Community Service Board (CSB). Contact the Department's prior authorization contractor for behavioral health services for services requiring pre-authorization.
Dental Services - *Smiles For Children* is the dental program for children enrolled in Medicaid or FAMIS. Limited medically necessary diagnostic and oral surgery services are covered for adults. http://dmasva.dmas.virginia.gov/Content_pgs/dnt-home.aspx	Children under the age of 21: Comprehensive dental benefits. Adults 21 and over: Limited medically necessary diagnostic/oral surgery services.	1-888-912-3456 (Providers or Members) **Website:** http://dmasva.dmas.virginia.gov/Content_pgs/dnt-home.aspx Links to: Enrollee Information, Dental Provider Information, Smiles for Children Contract, and Locate a Dentist.
Early Intervention Services	EI services for fee-for-service children and for children who are enrolled in a contracted MCO are covered by DMAS within DMAS coverage criteria and guidelines. Early intervention billing codes and coverage criteria are described in the DMAS Early Intervention Program Manual, on the DMAS website at https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual	For information on EI Provider Certification – Contact the Infant & Toddler Connection at 804-786-3710 or visit: http://www.infantva.org/ For information on EI service referrals, visit: http://www.infantva.org/documents/pr-Referral Guide. PDF For information on enrolling as a DMAS EI Provider – Contact DMAS Provider Enrollment at 1-888-829-5373 or visit: http://www.dmas.virginia.gov/search.asp?Userid=2&type=8
Environmental Investigations to determine sources of lead contamination. The MCO must cover blood lead testing as part of EPSDT screening.	Child must have elevated blood lead level	Local Health Department
Personal Care Services (EPSDT)	Medicaid will pay under EPSDT if medically necessary.	Medicaid EPSDT Coordinator Brian Campbell 804-786-0342
School Health Services for Special Education Students	School health services are defined as any service rendered on property of a local education agency or public school including but not necessarily limited to physical therapy, occupational therapy, speech language therapy, psychological and psychiatric services, skilled nursing services, medical assessments, audiology services, personal care services, and medical evaluation services. Services must be included in an individualized education program (IEP). School health services also include transportation on specially adapted school buses on days the student is receiving a DMAS covered service on the child's IEP. All services rendered in a school setting or on school property are **carved out** and are reimbursed directly by DMAS.	For a complete list of School Health services, see the Department's School Division Provider Manual available on the DMAS website at http://websrvr.dmas.virginia.gov/ProviderManuals/ManualChapters/sd/chapterIV_sd.pdf
Specialized Infant Formula for children under age 21. *Note: Enteral supplies* and equipment are paid through the MCO.	Available through VDH WIC clinics and FFS DME vendors	Local Department of Health, FFS DME vendors. See DME Provider Manual for criteria and coverage requirements.
Targeted Case Management for elderly (age 60 and over) needing assistance in 2 or more activities of daily living such as bathing, dressing, toileting, transferring, continence, or eating.		Local Area Agency on Aging

FAMIS Carved Out Services		
Carved-Out Service	**Comments**	**Contact**
Community Mental Health Rehabilitation, Mental Retardation, and Substance Abuse Treatment Services and Case Management For Members Receiving Community Mental Health and Mental Retardation Services See http://websrvr.dmas.virginia.gov/ProviderManuals/Default.aspx See Page 63 in this guide for a listing of services.	The MCO is not required to cover community mental health rehabilitation services (CMHRS). Different than under Medicaid, for FAMIS MCO members, not all CMHRS services are covered by the Department as carved-out services. CMHRS services that are covered by the Department include: Intensive in-home services, assessment for intensive in home, therapeutic day treatment, mental health crisis intervention, and case management for children at risk of (or with) serious emotional disturbance. The remaining CMHRS are not covered by either fee-for-service or managed care for FAMIS MCO members. Also, the MCO shall cover therapeutic drugs even when they are prescribed as a result of carved-out services.	Local Community Service Board (CSB) For a complete list of CMHRS services, see the Department's Community Mental Health Rehabilitation Services Provider Manual available on the DMAS website at http://websrvr.dmas.virginia.gov/ProviderManuals/ManualChapters/CMHS/Chapter4_cmhrs.pdf Contact the Department's prior authorization contractor for behavioral health services for services requiring pre-authorization.
Dental Services	The MCO is not required to cover dental services. Once the child has been determined eligible for Medicaid or FAMIS, they are automatically enrolled in the ***Smiles For Children*** dental program. The ***Smiles For Children*** program provides coverage for diagnostic, preventive, restorative/surgical procedures, as well as orthodontia services for Medicaid and FAMIS children. The program also provides coverage for limited medically necessary oral surgery services for adults (age 21 and older). DentaQuest is the single dental benefits administrator that will coordinate the delivery of all ***Smiles For Children*** dental services.	The Department's Dental Benefits Administrator, DentaQuest, will reimburse dental services. For a complete list of Dental services, see the Department's Dental Provider Manual available on the DMAS website at http://websrvr.dmas.virginia.gov/ProviderManuals/Default.aspx For more information, contact DentaQuest's Systems Operations Department at 888-560-8135 or via email to operations@dentaquest.com.
Specialized Infant Formula Enteral nutrition/medical foods	Coverage of enteral nutrition and total parenteral nutrition shall not include the provision of routine infant formula. Enteral nutrition/medical foods for enrollees under 21 are **carved out**. The MCO shall cover supplies and equipment necessary to administer enteral nutrition.	For a complete list of Durable Medical Equipment services, see the Department's Durable Medical Equipment & Supplies Services Provider Manual available on the DMAS website at http://websrvr.dmas.virginia.gov/ProviderManuals/ManualChapters/DME/chapterIV_dme.pdf
School Health Services for Special Education Students	School health services are defined as any service rendered on property of a local education agency or public school including but not necessarily limited to physical therapy, occupational therapy, speech language therapy, psychological and psychiatric services, skilled nursing services, medical assessments, audiology services, personal care services, and medical evaluation services. Services must be included in an individualized education program (IEP). School health services also include transportation on specially adapted school buses on days the student is receiving a DMAS covered service on the child's IEP. All services rendered in a school setting or on school property are **carved out** and are reimbursed directly by DMAS.	For a complete list of School Health services, see the Department's School Division Provider Manual available on the DMAS website at http://websrvr.dmas.virginia.gov/ProviderManuals/ManualChapters/sd/chapterIV_sd.pdf

Community Mental Health Rehabilitation Services (CMHRS)

Coverage Through DMAS for Medallion II MCO Enrollees (Medicaid, FAMIS Plus and FAMIS MOMS)

1. Intensive In-home Services for Children and Adolescents
2. Therapeutic Day Treatment (non-hospital based) for Children and Adolescents
3. Mental Health and Substance Abuse Crisis Intervention
4. Case Management for Children at Risk of Serious Emotional Disturbance, Children with Serious Emotional Disturbance, and for Adults with Serious Mental Illness
5. Mental Health Day Treatment Services for Adults
6. Psychosocial Rehabilitation
7. Mental Health and Substance Abuse Crisis Intervention
8. Intensive Community Treatment
9. Mental Health Crisis Stabilization
10. Mental Health Support
11. Substance Abuse Intensive Outpatient Treatment
12. Substance Abuse Day Treatment
13. Opioid Treatment
14. Residential Substance Abuse Treatment for Pregnant and Post Partum Women
15. Substance Abuse Day Treatment for Pregnant and Post Partum Women
16. Substance Abuse Case Management
17. Levels A & B Residential Treatment for Children and Adolescents Under 21 (Group Homes)*

**Level C is also covered by DMAS and causes the member to come out of the MCO.*

Coverage through DMAS for FAMIS MCO enrollees*

1. Intensive In-home Services for Children and Adolescents
2. Therapeutic Day Treatment (non-hospital based) for Children and Adolescents
3. Mental Health Crisis Intervention
4. Case Management for Children at Risk of Serious Emotional Disturbance, Children with Serious Emotional Disturbance.

CMHRS other than those listed above are not covered for FAMIS MCO enrollees*

For more information, see the DMAS CMHRS Manual available on the DMAS website at http://websrvr.dmas.virginia.gov/ProviderManuals/ManualChapters/CMHS/Chapter4_cmhrs.pdf

**FAMIS MOMS receive Medallion II MCO Benefits*

MCOs provide coverage for outpatient mental health and substance abuse treatment services and medications for their Medicaid and FAMIS Members. Transportation services are also covered for Medicaid/FAMIS Plus and FAMIS MOMS MCO members including transportation to services carved-out of the MCO contracts. Transportation *is not covered* for FAMIS MCO members. Smoking cessation counseling and medications are covered for pregnant women in MCOs.

MANAGED CARE RESOURCE GUIDE

Department of Medical Assistance Services

17. Sample ID Cards

Guide to Accessing Medicaid Fee-For-Service,
Medallion 3.0 (Medicaid MCO) & FAMIS ID Cards

A description of accessing carved out services (Medallion 3.0 and FAMIS), including preventive services, service limitations, referral and prior authorization requirements. The following are not intended to be a comprehensive list of carved-out services. All carved-out services 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/mcmedallion2.aspx

Virginia Medicaid Permanent Plastic ID Card
SAMPLE

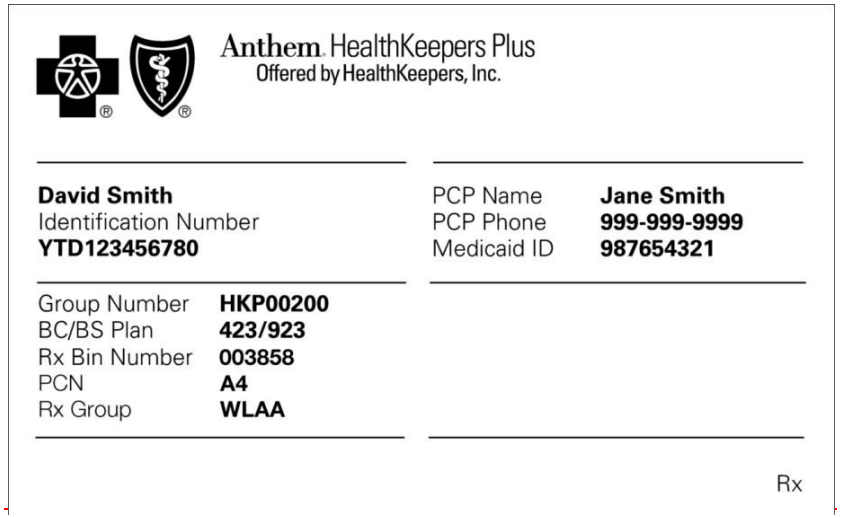
FRONT

BACK

Medallion 3.0 MCO ID Cards

Anthem HealthKeepers *PLUS* Medallion 3.0 ID Card

FRONT


Anthem HealthKeepers Plus
Offered by HealthKeepers, Inc.

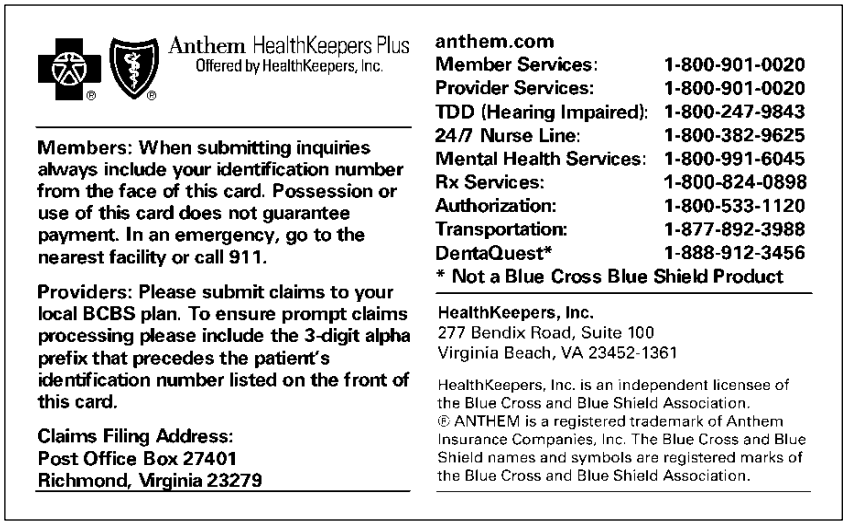
David Smith
Identification Number
YTD123456780

PCP Name **Jane Smith**
PCP Phone **999-999-9999**
Medicaid ID **987654321**

Group Number **HKP00200**
BC/BS Plan **423/923**
Rx Bin Number **003858**
PCN **A4**
Rx Group **WLAA**

Rx

BACK


Anthem HealthKeepers Plus
Offered by HealthKeepers, Inc.

Members: When submitting inquiries always include your identification number from the face of this card. Possession or use of this card does not guarantee payment. In an emergency, go to the nearest facility or call 911.

Providers: Please submit claims to your local BCBS plan. To ensure prompt claims processing please include the 3-digit alpha prefix that precedes the patient's identification number listed on the front of this card.

Claims Filing Address:
Post Office Box 27401
Richmond, Virginia 23279

anthem.com

Member Services:	**1-800-901-0020**
Provider Services:	**1-800-901-0020**
TDD (Hearing Impaired):	**1-800-247-9843**
24/7 Nurse Line:	**1-800-382-9625**
Mental Health Services:	**1-800-991-6045**
Rx Services:	**1-800-824-0898**
Authorization:	**1-800-533-1120**
Transportation:	**1-877-892-3988**
DentaQuest*	**1-888-912-3456**

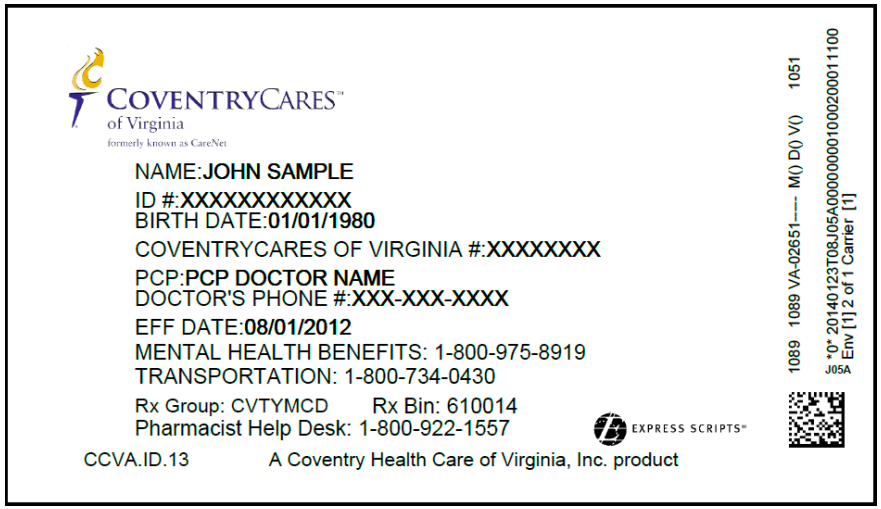
*** Not a Blue Cross Blue Shield Product**

HealthKeepers, Inc.
277 Bendix Road, Suite 100
Virginia Beach, VA 23452-1361

HealthKeepers, Inc. is an independent licensee of the Blue Cross and Blue Shield Association.
® ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association.

CoventryCares of Virginia Medallion 3.0 ID Card

FRONT



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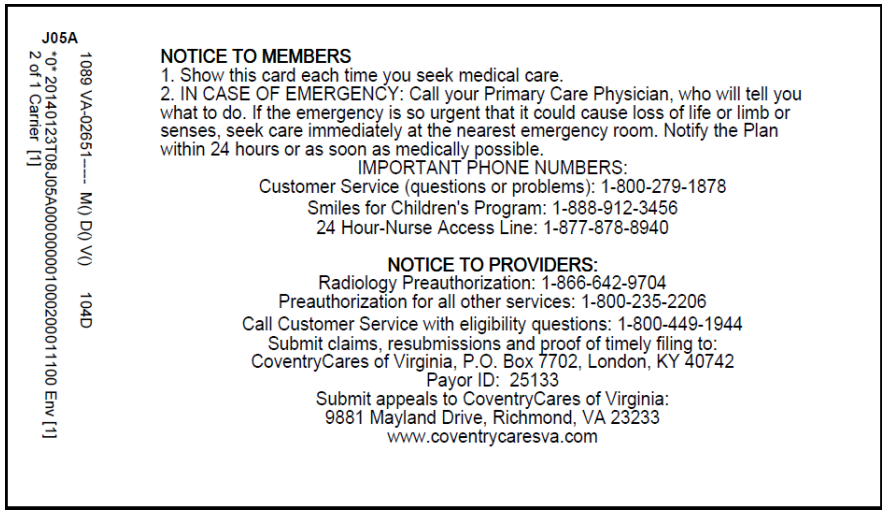
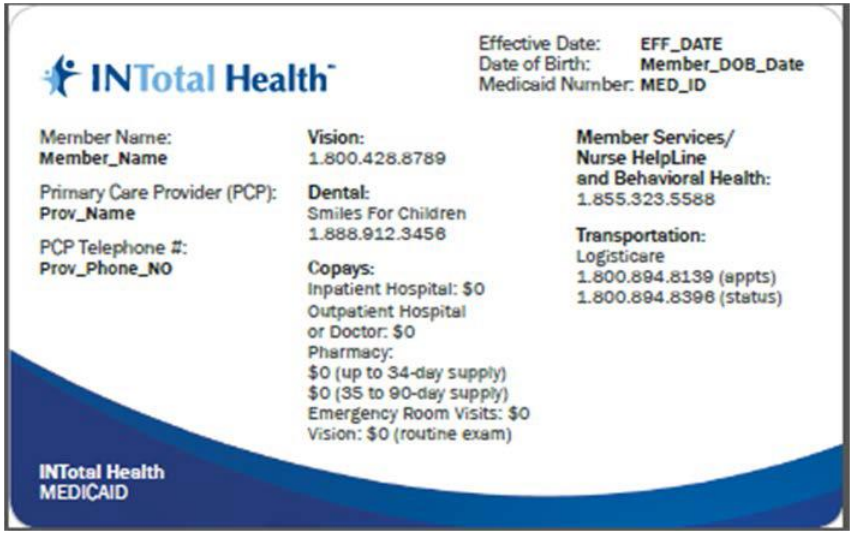


INTotal Health ID Medallion 3.0 ID Card

FRONT



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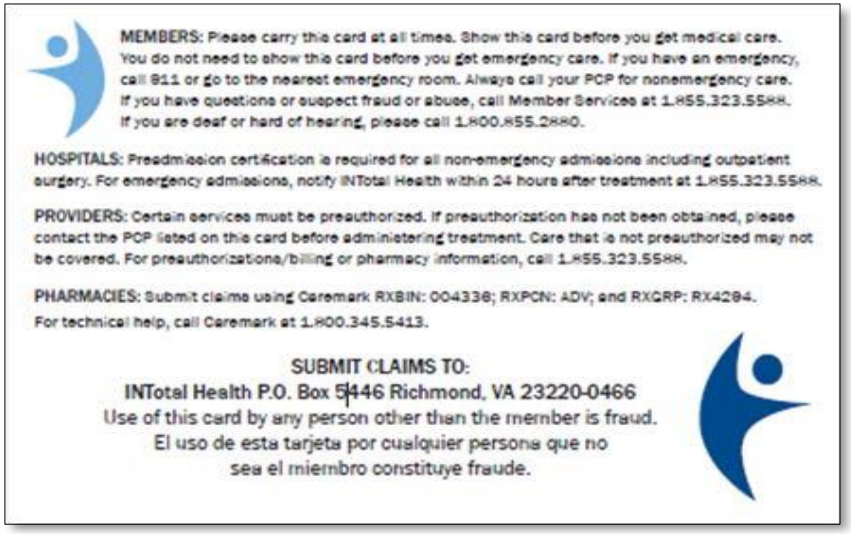


MEMBERS: Please carry this card at all times. Show this card before you get medical care. You do not need to show this card before you get emergency care. If you have an emergency, call 911 or go to the nearest emergency room. Always call your PCP for nonemergency care. If you have questions or suspect fraud or abuse, call Member Services at 1.855.323.5588. If you are deaf or hard of hearing, please call 1.800.855.2880.

HOSPITALS: Preadmission certification is required for all non-emergency admissions including outpatient surgery. For emergency admissions, notify INTotal Health within 24 hours after treatment at 1.855.323.5588.

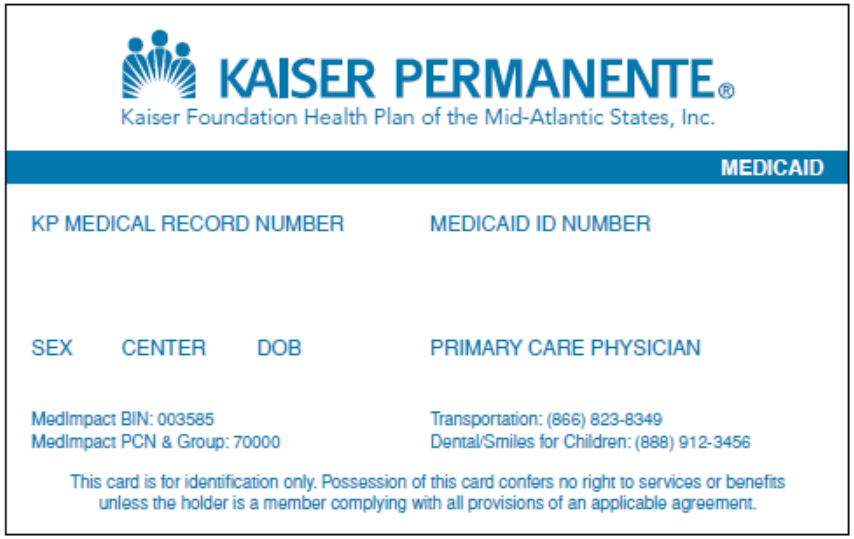
PROVIDERS: Certain services must be preauthorized. If preauthorization has not been obtained, please contact the PCP listed on this card before administering treatment. Care that is not preauthorized may not be covered. For preauthorizations/billing or pharmacy information, call 1.855.323.5588.

PHARMACIES: Submit claims using Caremark RXBIN: 004336; RXPCN: ADV; and RXGRP: RX4204. For technical help, call Caremark at 1.800.345.5413.

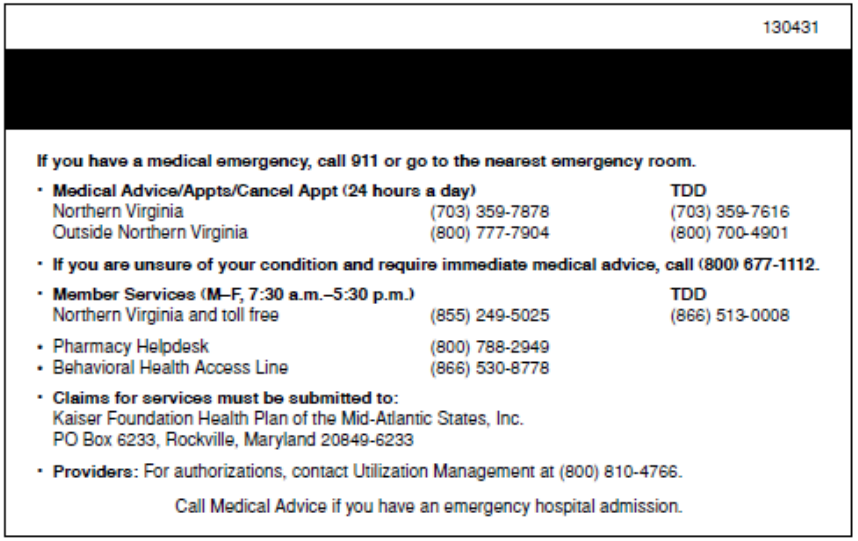
SUBMIT CLAIMS TO:
INTotal Health P.O. Box 5446 Richmond, VA 23220-0466
Use of this card by any person other than the member is fraud.
El uso de esta tarjeta por cualquier persona que no sea el miembro constituye fraude.

Kaiser Permanente Medallion 3.0 ID Card

FRONT



BACK



130431

If you have a medical emergency, call 911 or go to the nearest emergency room.

- **Medical Advice/Appts/Cancel Appt (24 hours a day)** — TDD
  Northern Virginia (703) 359-7878 (703) 359-7616
  Outside Northern Virginia (800) 777-7904 (800) 700-4901
- **If you are unsure of your condition and require immediate medical advice, call (800) 677-1112.**
- **Member Services (M–F, 7:30 a.m.–5:30 p.m.)** — TDD
  Northern Virginia and toll free (855) 249-5025 (866) 513-0008
- Pharmacy Helpdesk (800) 788-2949
- Behavioral Health Access Line (866) 530-8778
- **Claims for services must be submitted to:**
  Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.
  PO Box 6233, Rockville, Maryland 20849-6233
- **Providers:** For authorizations, contact Utilization Management at (800) 810-4766.

Call Medical Advice if you have an emergency hospital admission.

Optima Family Care Medallion 3.0 ID Card

FRONT

OptimaHealth

FAMILY CARE

Member Name: John Doe
Member Number: 9999999*99
Group Number: 999999
Member Effective Date: 99-99-99
PCP Name: 99999999999999999999999
PCP Phone: 999-9999

OV: $0
ED: $0
RX: $0

Medicaid #: 999999999999 DOB: 99-99-9999

Detailed benefit information is available at optimahealth.com

BACK

Preauthorization may be required for: hospitalization, outpatient surgery and therapies, advanced imaging, DME, home health, skilled nursing, acute rehab, or prosthetics.

IN CASE OF AN EMERGENCY: Call 911 or go to the nearest emergency room. Always call your Primary Care Physician for non-emergent care.

PHARMACY INFORMATION:

BIN# 610011 PROCESSOR CONTROL# OHPMCAID

Catamaran Pharmacy Help desk: 1-866-244-9113

Member Services:	757-999-9999 OR 9-999-999-9999
Provider Relations:	757-552-7474 OR 1-800-229-8822
Medical/Pharmacy Pre Authorization:	757-552-7540 OR 1-800-229-5522
Behavioral Health Pre Authorization:	757-552-7174 OR 1-800-648-8420
After Hours Nurse Advice:	757-552-7250 OR 1-800-394-2237
Smiles for Children:	1-888-912-3456
Transportation:	1-877-892-3986

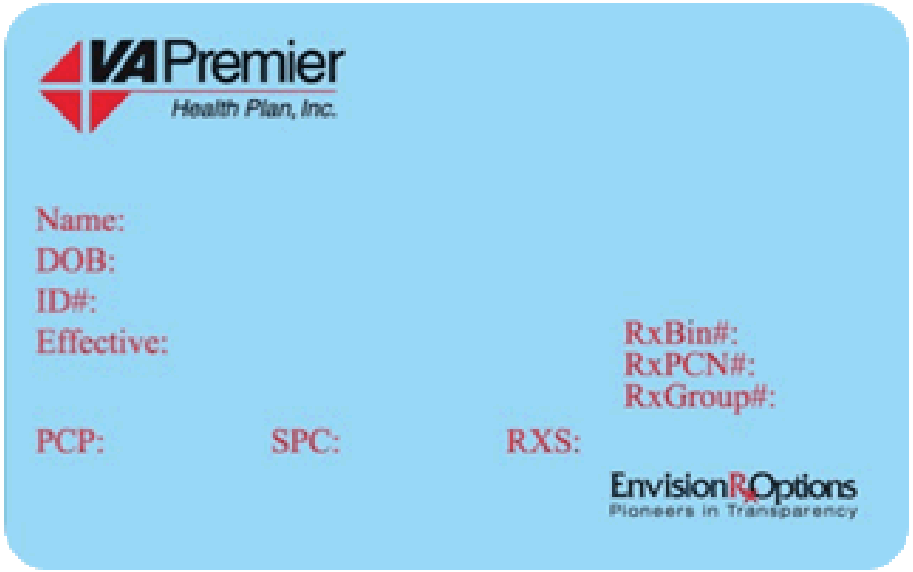
MEDICAL CLAIMS
P.O. Box 5028
Troy, MI 48007-5028

BEHAVIORAL HEALTH CLAIMS
P.O. Box 1440
Troy, MI 48099-1440

Offered by Optima Health Plan

VA Premier Medallion 3.0 ID Card

FRONT



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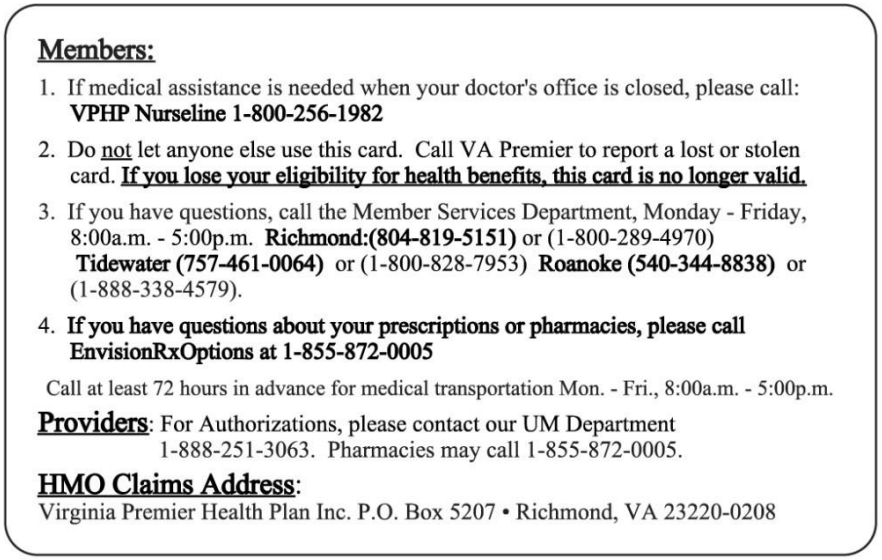

Members:

1. If medical assistance is needed when your doctor's office is closed, please call: **VPHP Nurseline 1-800-256-1982**
2. Do not let anyone else use this card. Call VA Premier to report a lost or stolen card. **If you lose your eligibility for health benefits, this card is no longer valid.**
3. If you have questions, call the Member Services Department, Monday - Friday, 8:00a.m. - 5:00p.m. **Richmond:(804-819-5151)** or (1-800-289-4970) **Tidewater (757-461-0064)** or (1-800-828-7953) **Roanoke (540-344-8838)** or (1-888-338-4579).
4. **If you have questions about your prescriptions or pharmacies, please call EnvisionRxOptions at 1-855-872-0005**

Call at least 72 hours in advance for medical transportation Mon. - Fri., 8:00a.m. - 5:00p.m.

Providers: For Authorizations, please contact our UM Department 1-888-251-3063. Pharmacies may call 1-855-872-0005.

HMO Claims Address:
Virginia Premier Health Plan Inc. P.O. Box 5207 • Richmond, VA 23220-0208

FAMIS MCO Identification Cards

Anthem HealthKeepers PLUS FAMIS ID Card
$2 Co-pay

FRONT

Anthem HealthKeepers Plus
Offered by HealthKeepers, Inc.

FAMIS

Identification Number

PCP Name
PCP Phone
Medicaid ID

Group Number	HKP00200
BC/BS Plan	923
Rx Bin Number	610575

PCP/Specialist	$2/$2	
Outpatient	$2	
Inpatient	$15	
Emergency	$2	
Rx	$2	(up to a 34-day supply)
	$4	(35 to 90-day supply)

BACK

Anthem HealthKeepers Plus
Offered by HealthKeepers, Inc.

Members: When submitting inquiries always include your identification number from the face of this card. Possesion or use of this card does not guarantee payment. In an emergency, go to the nearest facility or call 911.

Providers: Please submit claims to your local BCBS plan. To ensure proper claims processing, please include the 3-digit alpha prefix that precedes the patient's identification number listed on the front of this card.

Claims Filing Address:
Post Office Box 27401
Richmond, Virginia 23279
VA23 11/13

www.anthem.com/vamedicaid

Member Services:	**1-800-901-0020**
Provider Services:	**1-800-901-0020**
TDD (Hearing Impaired):	**1-800-855-2880**
24/7 Nurse Line:	**1-800-901-0020**
Mental Health Services:	**1-800-901-0020**
Rx Services:	**1-800-824-0898**
Authorization:	**1-800-901-0020**
Smiles for Children*	**1-888-912-3456**

*Contracts directly with group

HealthKeepers, Inc.
P.O. Box 27401
Mail Drop VA2002-N500
Richmond, VA 23279

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Anthem is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association.

Anthem HealthKeepers PLUS FAMIS ID Card
$5 Co-pay

FRONT

Anthem HealthKeepers Plus
Offered by HealthKeepers, Inc.

FAMIS

Identification Number

PCP Name
PCP Phone
Medicaid ID

Group Number	HKP00200	PCP/Specialist	$5/$5
BC/BS Plan	923	Outpatient	$5
Rx Bin Number	610575	Inpatient	$25
		Emergency	$5
		Rx	$5 (up to a 34-day supply)
			$10 (35 to 90-day supply)

BACK

Anthem HealthKeepers Plus
Offered by HealthKeepers, Inc.

Members: When submitting inquiries always include your identification number from the face of this card. Possesion or use of this card does not guarantee payment. In an emergency, go to the nearest facility or call 911.

Providers: Please submit claims to your local BCBS plan. To ensure proper claims processing, please include the 3-digit alpha prefix that precedes the patient's identification number listed on the front of this card.

Claims Filing Address:
Post Office Box 27401
Richmond, Virginia 23279
VA24 11/13

www.anthem.com/vamedicaid

Member Services:	**1-800-901-0020**
Provider Services:	**1-800-901-0020**
TDD (Hearing Impaired):	**1-800-855-2880**
24/7 Nurse Line:	**1-800-901-0020**
Mental Health Services:	**1-800-901-0020**
Rx Services:	**1-800-824-0898**
Authorization:	**1-800-901-0020**
Smiles for Children*	**1-888-912-3456**

*Contracts directly with group

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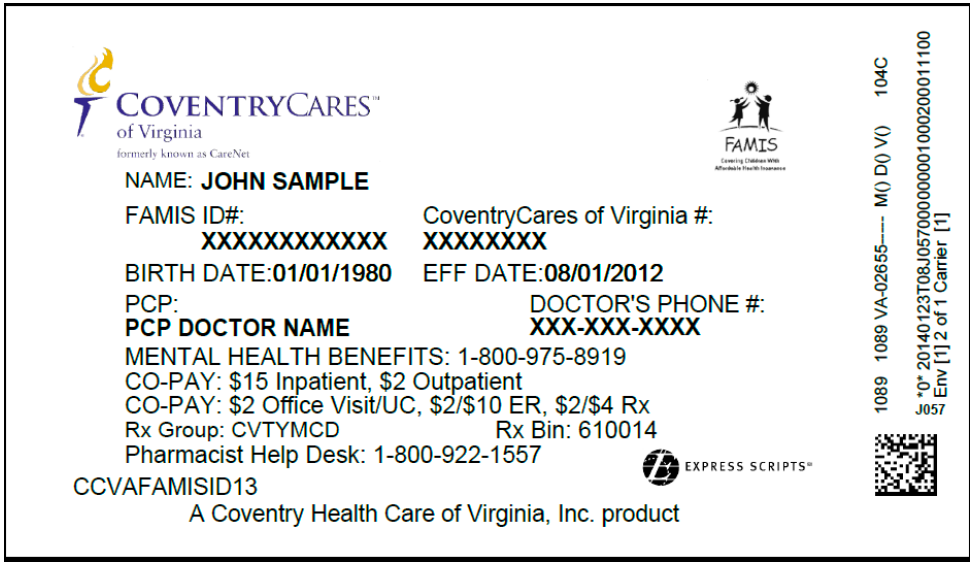
CoventryCares of Virginia FAMIS ID Card
$2 Co-pay

FRONT



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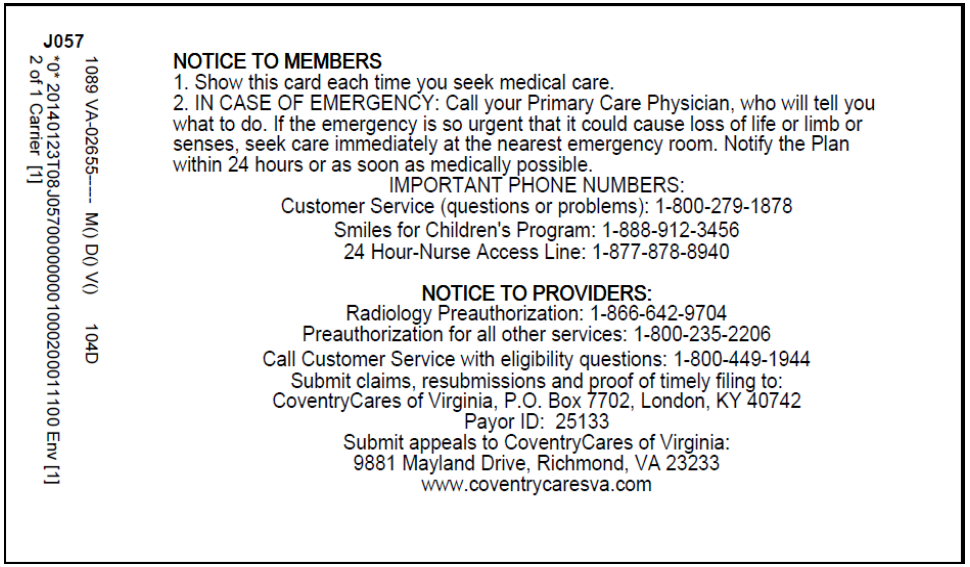
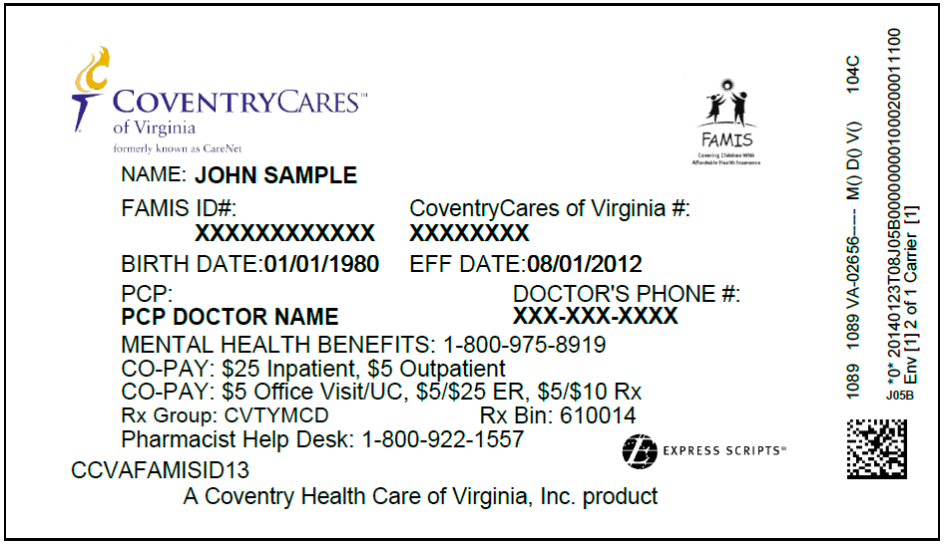


CoventryCares of Virginia FAMIS ID Card
$5 Co-pay

FRONT



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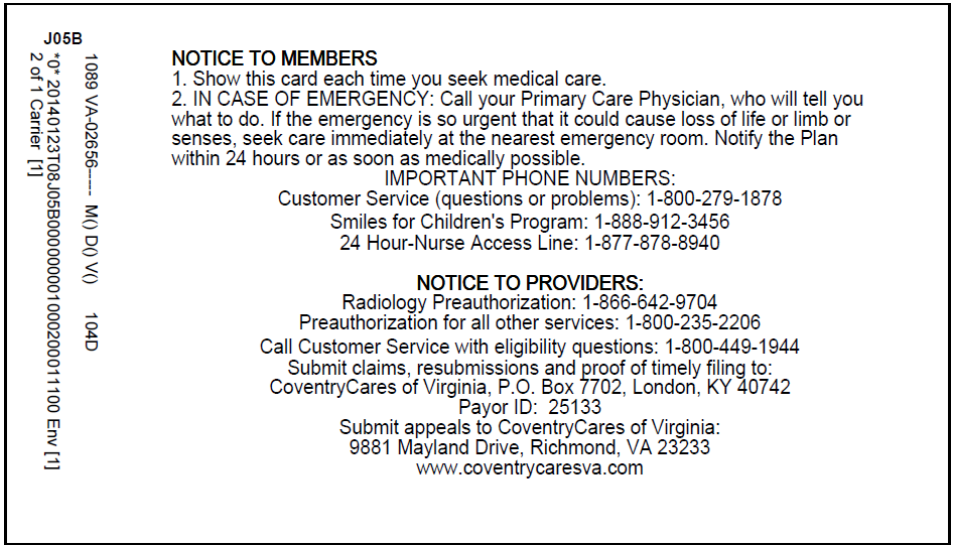
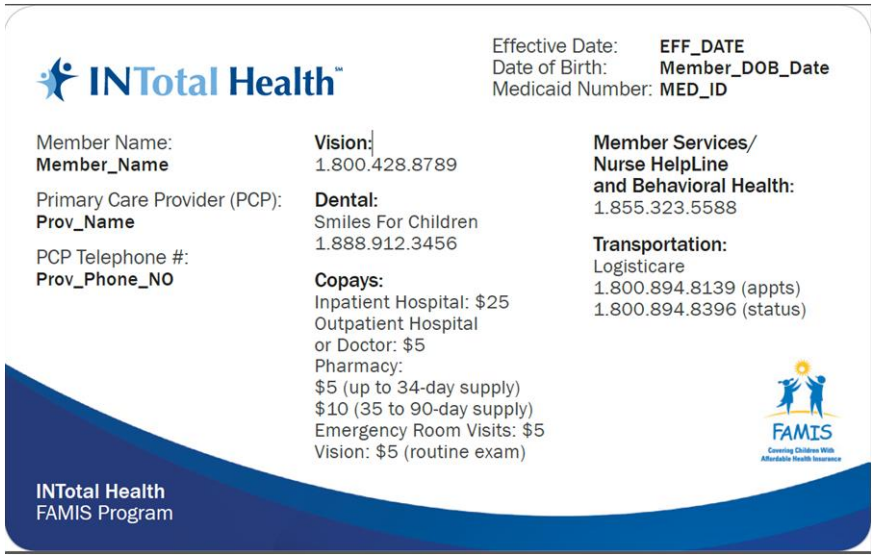


INTotal Health FAMIS ID Card
$5 Co-pay

FRONT



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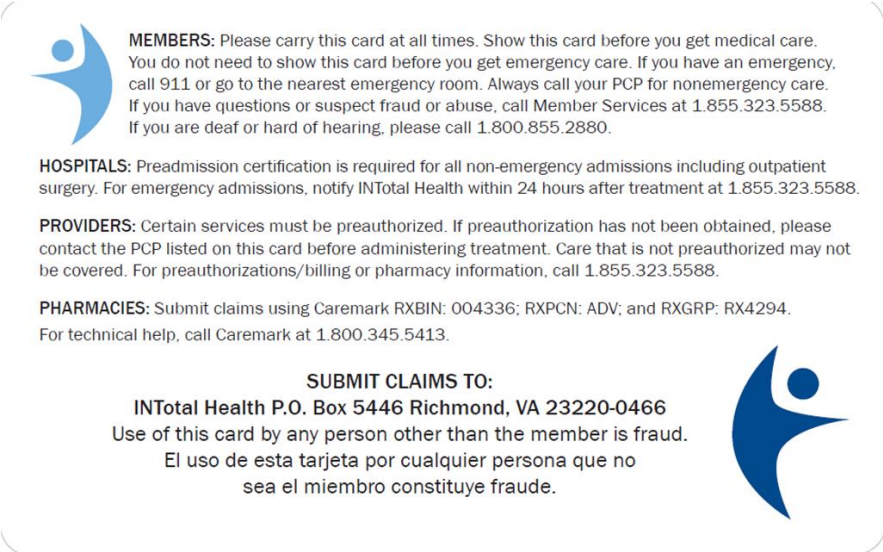

INTotal Health FAMIS ID Card
$2 Co-pay

FRONT

INTotal Health™

Effective Date: **EFF_DATE**
Date of Birth: **Member_DOB_Date**
Medicaid Number: **MED_ID**

Member Name:
Member_Name

Primary Care Provider (PCP):
Prov_Name

PCP Telephone #:
Prov_Phone_NO

Vision:
1.800.428.8789

Dental:
Smiles For Children
1.888.912.3456

Copays:
Inpatient Hospital: $15
Outpatient Hospital
or Doctor: $2
Pharmacy:
$2 (up to 34-day supply)
$4 (35 to 90-day supply)
Emergency Room Visits: $2
Vision: $5 (routine exam)

Member Services/
Nurse HelpLine
and Behavioral Health:
1.855.323.5588

Transportation:
Logisticare
1.800.894.8139 (appts)
1.800.894.8396 (status)

FAMIS
Covering Children With Affordable Health Insurance

INTotal Health
FAMIS Program

BACK

MEMBERS: Please carry this card at all times. Show this card before you get medical care. You do not need to show this card before you get emergency care. If you have an emergency, call 911 or go to the nearest emergency room. Always call your PCP for nonemergency care. If you have questions or suspect fraud or abuse, call Member Services at 1.855.323.5588. If you are deaf or hard of hearing, please call 1.800.855.2880.

HOSPITALS: Preadmission certification is required for all non-emergency admissions including outpatient surgery. For emergency admissions, notify INTotal Health within 24 hours after treatment at 1.855.323.5588.

PROVIDERS: Certain services must be preauthorized. If preauthorization has not been obtained, please contact the PCP listed on this card before administering treatment. Care that is not preauthorized may not be covered. For preauthorizations/billing or pharmacy information, call 1.855.323.5588.

PHARMACIES: Submit claims using Caremark RXBIN: 004336; RXPCN: ADV; and RXGRP: RX4294. For technical help, call Caremark at 1.800.345.5413.

SUBMIT CLAIMS TO:
INTotal Health P.O. Box 5446 Richmond, VA 23220-0466
Use of this card by any person other than the member is fraud.
El uso de esta tarjeta por cualquier persona que no
sea el miembro constituye fraude.

INTotal Health FAMIS No Copay FAMIS ID Card

FRONT

INTotal Health

Effective Date: EFF_DATE
Date of Birth: Member_DOB_Date
Medicaid Number: MED_ID

Member Name:
Member_Name

Primary Care Provider (PCP):
Prov_Name

PCP Telephone #:
Prov_Phone_NO

Vision:
1.800.428.8789

Dental:
Smiles For Children
1.888.912.3456

Copays:
Inpatient Hospital: $0
Outpatient Hospital
or Doctor: $0
Pharmacy:
$0 (up to 34-day supply)
$0 (35 to 90-day supply)
Emergency Room Visits: $0
Vision: $0 (routine exam)

Member Services/
Nurse HelpLine
and Behavioral Health:
1.855.323.5588

Transportation:
Logisticare
1.800.894.8139 (appts)
1.800.894.8396 (status)

FAMIS

INTotal Health
MEDICAID

BACK

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HOSPITALS: Preadmission certification is required for all non-emergency admissions including outpatient surgery. For emergency admissions, notify INTotal Health within 24 hours after treatment at 1.855.323.5588.

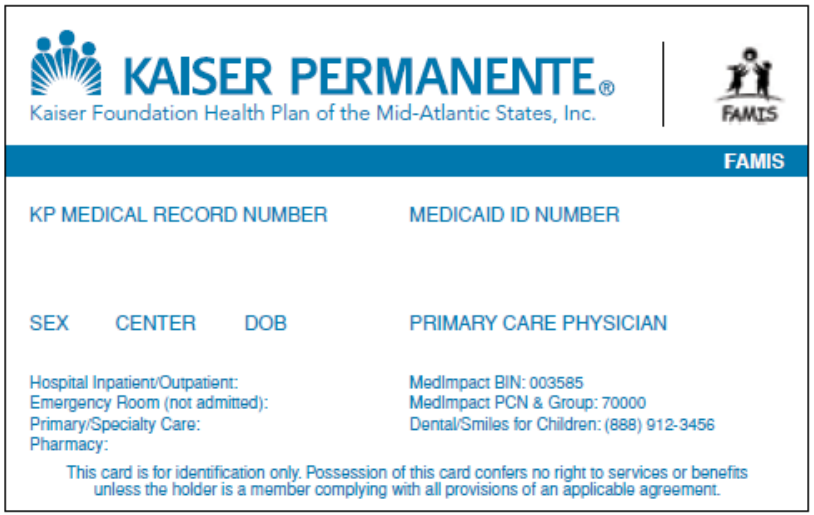
PROVIDERS: Certain services must be preauthorized. If preauthorization has not been obtained, please contact the PCP listed on this card before administering treatment. Care that is not preauthorized may not be covered. For preauthorizations/billing or pharmacy information, call 1.855.323.5588.

PHARMACIES: Submit claims using Caremark RXBIN: 004336; RXPCN: ADV; and RXGRP: RX4294. For technical help, call Caremark at 1.800.345.5413.

SUBMIT CLAIMS TO:
INTotal Health P.O. Box 5446 Richmond, VA 23220-0466
Use of this card by any person other than the member is fraud.
El uso de esta tarjeta por cualquier persona que no sea el miembro constituye fraude.

Kaiser Permanente FAMIS ID Card

FRONT


KAISER PERMANENTE®
Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.
FAMIS

FAMIS

KP MEDICAL RECORD NUMBER
MEDICAID ID NUMBER

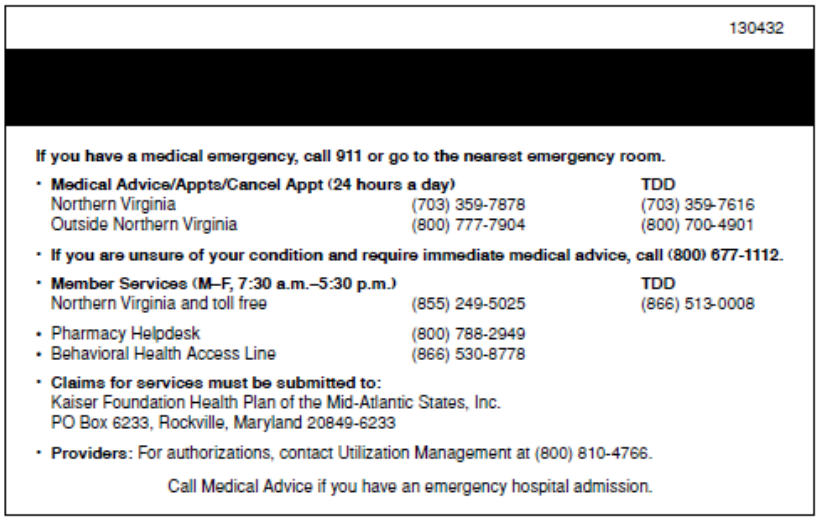
SEX CENTER DOB
PRIMARY CARE PHYSICIAN

Hospital Inpatient/Outpatient:
Emergency Room (not admitted):
Primary/Specialty Care:
Pharmacy:

MedImpact BIN: 003585
MedImpact PCN & Group: 70000
Dental/Smiles for Children: (888) 912-3456

This card is for identification only. Possession of this card confers no right to services or benefits unless the holder is a member complying with all provisions of an applicable agreement.

BACK


130432

If you have a medical emergency, call 911 or go to the nearest emergency room.

- **Medical Advice/Appts/Cancel Appt (24 hours a day)** — TDD
  Northern Virginia (703) 359-7878 (703) 359-7616
  Outside Northern Virginia (800) 777-7904 (800) 700-4901
- **If you are unsure of your condition and require immediate medical advice, call (800) 677-1112.**
- **Member Services (M–F, 7:30 a.m.–5:30 p.m.)** — TDD
  Northern Virginia and toll free (855) 249-5025 (866) 513-0008
- Pharmacy Helpdesk (800) 788-2949
- Behavioral Health Access Line (866) 530-8778
- **Claims for services must be submitted to:**
  Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.
  PO Box 6233, Rockville, Maryland 20849-6233
- **Providers:** For authorizations, contact Utilization Management at (800) 810-4766.

Call Medical Advice if you have an emergency hospital admission.

OPTIMA FAMIS ID Card
$2 Co-pay

FRONT

OptimaHealth

FAMILY CARE
FAMIS

Member Name: John Doe
Member Number: 9999999*99
Group Number: 999999
Member Effective Date: 99-99-99
PCP Name: ABC Provider
PCP Phone: 999-9999

OV: $2
ED: $2

FAMIS
Covering Children With Affordable Health Insurance

FAMIS #: 999999999999 DOB: 99-99-9999

Detailed benefit information is available at optimahealth.com

BACK

Preauthorization may be required for: hospitalization, outpatient surgery and therapies, advanced imaging, DME, home health, skilled nursing, acute rehab, or prosthetics.

IN CASE OF AN EMERGENCY: Call 911 or go to the nearest emergency room. Always call your Primary Care Physician for non-emergent care.

PHARMACY INFORMATION:

BIN# 610011 PROCESSOR CONTROL# OHPMCAID

Catamaran Pharmacy Help desk: 1-866-244-9113

Member Services:	757-999-9999 OR 9-999-999-9999
Provider Relations:	757-552-7474 OR 1-800-229-8822
Medical/Pharmacy Pre Authorization:	757-552-7540 OR 1-800-229-5522
Behavioral Health Pre Authorization:	757-552-7174 OR 1-800-648-8420
After Hours Nurse Advice:	757-552-7250 OR 1-800-394-2237
Smiles for Children:	1-888-912-3456

MEDICAL CLAIMS
P.O. Box 5028
Troy, MI 48007-5028

BEHAVIORAL HEALTH CLAIMS
P.O. Box 1440
Troy, MI 48099-1440

Offered by Optima Health Plan

OPTIMA FAMIS ID Card
$5 Co-pay

FRONT

OptimaHealth

FAMILY CARE
FAMIS

Member Name: John Doe
Member Number: 9999999*99
Group Number: 999999
Member Effective Date: 99-99-99
PCP Name: ABC Provider
PCP Phone: 999-9999

OV: $5
ED: $5
RX: $5

FAMIS #: 999999999999 DOB: 99-99-9999

FAMIS
Covering Children With Affordable Health Insurance

Detailed benefit information is available at optimahealth.com

BACK

Preauthorization may be required for: hospitalization, outpatient surgery and therapies, advanced imaging, DME, home health, skilled nursing, acute rehab, or prosthetics.

IN CASE OF AN EMERGENCY: Call 911 or go to the nearest emergency room. Always call your Primary Care Physician for non-emergent care.

PHARMACY INFORMATION:

BIN# 610011 PROCESSOR CONTROL# OHPMCAID

Catamaran Pharmacy Help desk: 1-866-244-9113

Member Services:	757-999-9999 OR 9-999-999-9999
Provider Relations:	757-552-7474 OR 1-800-229-8822
Medical/Pharmacy Pre Authorization:	757-552-7540 OR 1-800-229-5522
Behavioral Health Pre Authorization:	757-552-7174 OR 1-800-648-8420
After Hours Nurse Advice:	757-552-7250 OR 1-800-394-2237
Smiles for Children:	1-888-912-3456

MEDICAL CLAIMS
P.O. Box 5028
Troy, MI 48007-5028

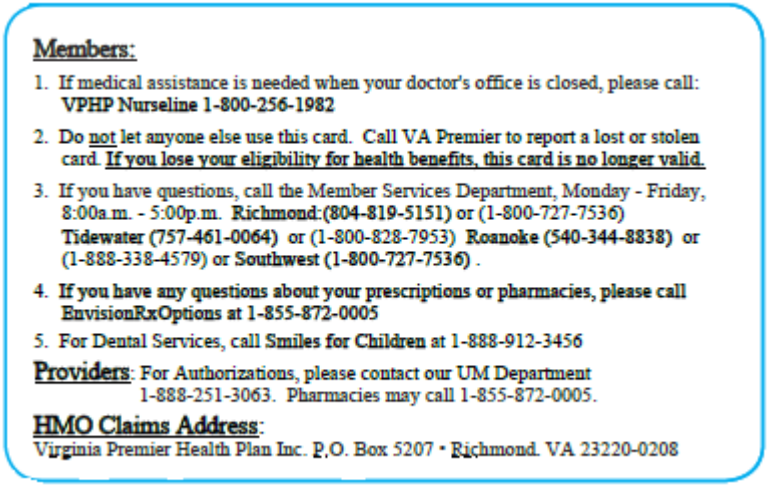
BEHAVIORAL HEALTH CLAIMS
P.O. Box 1440
Troy, MI 48099-1440

Offered by Optima Health Plan

VAPREMIER FAMIS ID Card

FRONT

BACK



Members:

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2. Do not let anyone else use this card. Call VA Premier to report a lost or stolen card. **If you lose your eligibility for health benefits, this card is no longer valid.**
3. If you have questions, call the Member Services Department, Monday - Friday, 8:00a.m. - 5:00p.m. **Richmond:(804-819-5151)** or (1-800-727-7536) **Tidewater (757-461-0064)** or (1-800-828-7953) **Roanoke (540-344-8838)** or (1-888-338-4579) or **Southwest (1-800-727-7536)** .
4. **If you have any questions about your prescriptions or pharmacies, please call EnvisionRxOptions at 1-855-872-0005**
5. For Dental Services, call **Smiles for Children** at 1-888-912-3456

Providers: For Authorizations, please contact our UM Department 1-888-251-3063. Pharmacies may call 1-855-872-0005.

HMO Claims Address:
Virginia Premier Health Plan Inc. P.O. Box 5207 • Richmond. VA 23220-0208

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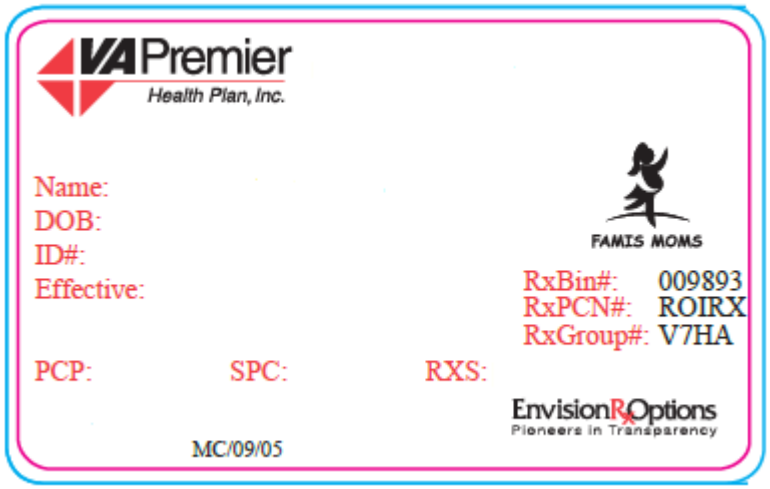

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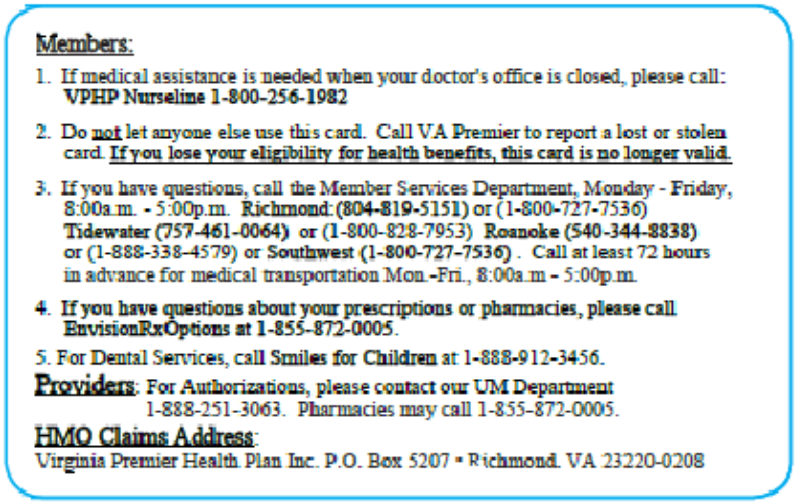

Members:

1. If medical assistance is needed when your doctor's office is closed, please call: **VPHP Nurseline 1-800-256-1982**
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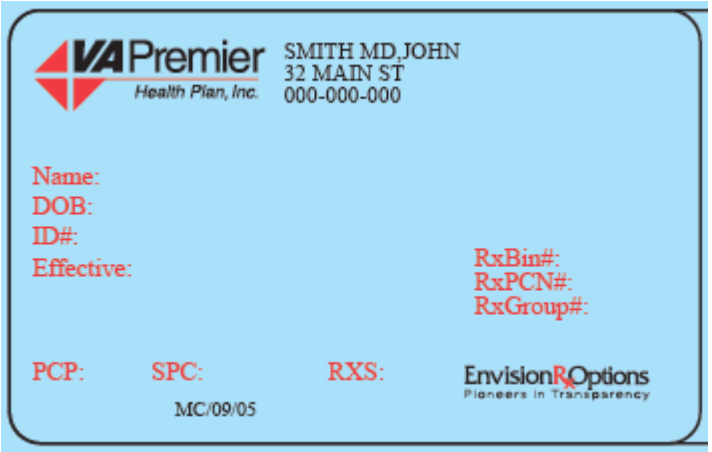

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DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

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