aetna®

Aetna Better Health® of Virginia

TOPIC	DESCRIPTION	MCO PROCESS	MCO RESPONSE
		MCOs shall provide a brief description for each point within the topic area	
MCO Credentialing and Contracting	All EI providers must be credentialed and contracted by each MCO in order to provide services to members enrolled with the MCO. Any provider that is not contracted with the MCO is referred to as non-par. All EI providers must be certified by DBHDS and affiliated with a LLA prior to the MCO credentialing and contracting process.	✓ Credentialing process ✓ CAQH process ✓ Contracting process ✓ Credentialing and contracting educators and other non-traditional disciplines ✓ Credentialing and contracting service coordinators ✓ Handling of out-of-network providers	Credentialing process – Provider receives contract and credentialing documents by requesting them on our website – aetnabetterhealth.com/Virginia. Provider completes both contract documents and credentialing application and returns to Aetna Better Health of Virginia (ABHVA). Credentialing documents will be reviewed for completeness, provider verified on DBHDS approved EI provider list, and submitted to our Credentialing Department for review/approval. Provider will be loaded as non-par initially based on the date the signed contract/credentialing application is sent to us. The initial loading of providers as non-par facilitates claims submission during the credentialing process, though providers need to obtain prior authorizations for each claim submitted by contacting our UM Department at 1-855-652-8249 for CCC Plus and 1-800-279-1878. Upon approval from the Credentialing Department, provider will be changed from non-par to par in our system and the agreement will be countersigned and a copy returned to the provider. Credentialing process typically takes up to 30-60 days if all information is submitted completely, and correctly. However, providers are loaded as non-par upon receipt of completed application and paid at 100% of DMAS. Non-par EI providers will not be required to request authorizations for EI services. However, if billing non-EI services, authorizations will be required. Prior authorizations can be obtained by contacting our UM Department at 1-855-652-8249 for CCC Plus and 1-800-279-1878. Example: provider submits complete contract/credentialing application on 1/17/2020. Credentialing application is approved on 2/21/2020. Provider will end up with a non-par record from 1/17/2020 – 2/28/2020 and during this period will need to obtain prior authorizations for all claims submitted for services that are not EI related. They will be changed to par status on 3/1/2020 when contract is countersigned and only need to obtain prior authorizations for procedure codes that require it. Providers need to be on the state file, have a valid and recently attested CAQH account and a completed provider application are all required to participate in ABHVA's networks. ABHVA is not responsible for obtaining a CAQH account for a provider. If a provider maintains a CAQH account, they need to make sure it is up-to-date as their CAQH number will be submitted as part of the credentialing application and will be verified by our Credentialing Dept. Credentialing for educators, service coordinators and non-traditional disciplines will follow the above contracting/credentialing process. Providers seeking to join the network can access the following link: https://www.aetnabetterhealth.com/virginia/providers/join-our-network/

TOPIC	DESCRIPTION	MCO PROCESS	MCO RESPONSE
		MCOs shall provide a brief description for each point within the topic area	
			Out-of-network providers can call into our UM Department at 1-855-652-8249 for CCC Plus and 1-800-279-1878 for Medallion/FMAIS 4.0 to request a non-par auth which will pay claims at 100% DMAS
Malpractice Insurance for Educators	Providers must have malpractice insurance if they are not covered by the local system.	✓ Requirements related to malpractice insurance for educators and non-traditional disciplines	Aetna Better Health of Virginia's liability insurance requirements for non-traditional providers in VA are as follows: $1.0 million per occurrence/$1.0 million per aggregate; provider must have liability insurance and supply a copy of the liability insurance certificate for credentialing submission.
IFSP	IFSP must be on file with the MCO for the claim to be considered a Clean Claim. If the IFSP is not on file with the MCO prior to the MCO receiving the claim, the claim will not be considered clean and the 14-day timeframe does not apply.	✓ Method for LLAs to submit IFSP (fax, email) with the specific contact information ✓ Submission process of multiple IFSPs, i.e., batch or individual files ✓ Confirmation of receipt of IFSP	IFSP can be emailed to earlyinterventionservices@aetna.com or faxed to 866-261-0581. The process for multiples is not different, can use email or fax. If the member does not have an assigned Care Manager at the time the IFSP is received, the MCO will assign a Care Manager who will contact the Infant & Toddler Connection Service Coordinator upon receipt of the IFSP (via secure email, fax, or phone).
Clean Claim	Clean claims must be paid within 14 days.	✓ Process for non-clean claims, i.e., rejected or denied ✓ Process for handling non-clean claims with the provider	Non-clean claims (rejected or denied), the provider should review remit rejection/denial reason. If a billing error occurred provider should submit corrected claim(s). Providers can also contact our Claims Inquiry Claims Research Group at 1-855-652-8249 for CCC Plus claims questions and 1-800-279-1878 for Medallion/FAMIS 4.0 claims questions. Providers can also outreach their Network Relations Manager to assist in claims inquiry research. This team partners with the Health Plan Operations team to conduct research and communicate the results back to the provider as a second layer of defense from successful resubmissions or response from our Provider Service Center.
Decline to Bill Form and EOB	Families may decline to bill their private insurance for coverage of EI services and will sign the Decline to Bill Form. LLAs will have this form on file. If family does not decline to bill, the private insurance will send EOB	✓ Submission process for Decline to Bill Form ✓ Process for ensuring Claims Department is aware of Decline to Bill form ✓ Process for handling claims when Decline to Bill is or the EOB are not on file	Decline to Bill form should be submitted with the IFSP. When received by our UM Department, and the Decline to Bill form is included with the IFSP, they will add a member alert in the claims processing system. When a member alert is added, it automatically notifies Claims Processors that are processing EI claims to bypass primary insurance and process Medicaid primary. • Members with primary insurance can decline to bill primary, and ABH of VA will pay as primary as long as an attestation letter is on file for the DOS. The attestation letter should be dated by the provider and will be on file for one year from the date of the letter. The provider is required to submit a new letter after one year. • The letter can be received by Care Management as part of the IFSP submission, received in the EI mailbox (EarlyInterventionServices@aetna.com), **OR** it can be submitted as an attachment in EDI

TOPIC	DESCRIPTION	MCO PROCESS **MCOs shall provide a brief description for each point within the topic area**	MCO RESPONSE
			• If the Attestation letter is received by Care Management (CM) via the email box for IFSP submissions (EarlyInterventionServices@aetna.com, CM will forward the letter to the designated Health Plan Operations Claims Specialist through the EI mailbox. • If an Attestation/decline to bill primary insurance letter comes in through EDI as an attachment, the Claims Department will forward the claim number and attachment to the Health Plan Operations Claims Specialist via email (EarlyInterventionServices@aetna.com). • Upon receipt of the letter, the Health Plan Operations Claims Specialist will locate the member's account within QNXT and add the appropriate member alert to denote the letter has been received and the member's EI/ABA claims should be paid as primary and no coordination with their other insurance will be made for one year from the date of the letter. • Forms are stored in a secure location with a specific naming convention
EI Enrollment and Indicator	A child must have an EI indicator on the enrollment file in order for an EI service to be reimbursed. Due to timing of the enrollment file, if the provider bills prior to the MCO receiving the file listing the child as having the EI indicator, the claim will deny due to "child not enrolled in the EI". This impacts submission of a clean claim.	✓ Process to handle claims when the EI indicator is not on plan enrollment file	Under this scenario, if the Medicaid member is under three (3) years old, and the service billed is an EI service provided by an approved DBHDS - EI provider, these claims will pay full payment. There is nothing indicating that a partial payment is warranted. In May 2026 we will implement a front-end-claims edit that has a layer to identify members with one of the two indicators from the 834 as Early Intervention Waiver members before stepping into services billed and taxonomy billed on the claim. This edit is aimed at ensuring multi-specialty providers are billing the correct taxonomy on the claim: taxonomy code 252Y00000X.
Care Coordination	Plan care coordinators should collaborate with the EI Service Coordinator	✓ Role of the care coordinator ✓ Process for exchanging information between care coordinator and service coordinator ✓ Frequency of contact between coordinators, i.e., timeframe for initial contact and ongoing contact	Once IFSP is received, the member is assigned a Care Manager, who will outreach the service coordinator via telephone, secure email or fax to provide contact information. The Care Manager will review sections 1,5, and 6 from the IFSP to ensure required sections are received. The Case Manager will provide service coordination aligned with the family's needs and collaborate with the Service Coordinator. The Care Manager will also determine members who are aging out of Early Intervention and then sets a task for when members reach 2.5 years old or 6 months prior to them aging out to follow up and assess any needs.
Interpreter and Translation Services	Language assistance services, including but not limited to interpreter and translation services, are available free of charge.	✓ Process for providers, service coordinators, and/or families to access interpreter/translation services ✓ Timeframe for accessing interpreter/translation services	Service Coordinators coordinate interpreter services through member services or the assigned Case Manager. Real Time Phone interpretation is available through our Language Line: Priopio – 214-865-7715 or 1-866-386-1284 Materials in other languages are available and processed through Propio by Case Management.

TOPIC	DESCRIPTION	MCO PROCESS	MCO RESPONSE
		MCOs shall provide a brief description for each point within the topic area	
			Interpreter Services for medical visits are available with a minimum of 48 hours' notice by calling 1-800-385-4104 Helplines for Member Services - Call 1.800.279.1878
EI Specific Email Box	Specific email contacts for submission of IFSPs, Decline to Bill Forms, etc.	✓ List specific email address	IFSP and decline to bill forms can be sent to EarlyInterventionServices@AETNA.com

Anthem. HealthKeepers Plus
Offered by HealthKeepers, Inc.

TOPIC	DESCRIPTION	MCO PROCESS	MCO RESPONSE
		MCOs shall provide a brief description for each point within the topic area	
MCO Credentialing and Contracting	All EI providers must be credentialed and contracted by each MCO in order to provide services to members enrolled with the MCO. All EI providers must be certified by DBHDS and affiliated with a LLA prior to the MCO credentialing and contracting process.	✓ Credentialing process ✓ CAQH process ✓ Contracting process ✓ Credentialing and contracting educators and other non-traditional disciplines ✓ Credentialing and contracting service coordinators ✓ Handling of out-of-network providers	Anthem does not credential EI services in the traditional manner as other network providers. Only those individuals certified as Early Intervention Providers can service Anthem members for EI services. Providers must have an NPI number that can be verified through the NPPES registry and be certified through the proper state required process. If a therapist wishes to provide EI services for Anthem members, they would need to contact the agency they are providing services for to ensure they are on that agency's roster. Rosters from various EI agencies should be submitted to AnthemCCCPlus mailbox monthly. Anthem also relies on the DMAS monthly roster list to verify EI certification. Once Anthem receives that monthly roster from DMAS- individual therapist records are forwarded to Anthems verification department to be set up. Providers working for therapy groups or CSB's with existing provider records with Anthem share the "credentialing process, contracting and insurance requirements as the established agency. Those disciplines such as educators and other non-traditional disciplines who wish to provide services for Anthem are required to submit verification of malpractice/liability insurance coverage to Anthems Early Intervention Services Support email (EarlyinterventionServicesSupport@anthem.com) prior to being activated under an EI agreement in Anthem's system. Upon completion of all required documents, an EI agreement is established. The timeline of the process should take no longer than 30 days. EI providers do not go through the normal contracting process as other Anthem network providers. The following information is required to establish an EI provider record in Anthems system. A large portion of this information can found on the DMAS certification roster. Practitioners Name Primary address Gender Date of Birth Provider's NPI Tax ID # and name of Billing Agency or Individual NPI of Billing Entity

TOPIC	DESCRIPTION	MCO PROCESS	MCO RESPONSE
		MCOs shall provide a brief description for each point within the topic area	
			Anthem will reach out to the individual therapist, should additional information be needed. Credentialing and contracting educators and other non-traditional disciplines are handled in a similar manner to individual therapist. An OON record is established once all validation criteria is obtained and found to be accurate. Credentialing and contracting service coordinators Contact information EarlyInterventionServicesSupport@anthem.com. EI claim webform: https://www.anthem.com/provider/individual-commercial/contact-us/email
Malpractice Insurance for Educators	Providers must have malpractice insurance if they are not covered by the local system.	✓ Requirements related to malpractice insurance for educators and non-traditional disciplines	Malpractice insurance requirements are included in each group contract. EI providers are linked to INN group records with requirements to maintain professional liability /medical liability insurance- limits must comply with all state laws and/or regulations. Those disciplines such as educators and service coordinators who wish to provider therapy services for Anthem are required to send verification of malpractice/liability insurance coverage to Anthems Early Intervention Services Support email (EarlyinterventionServicesSupport@anthem.com) before receiving an active provider record.
IFSP	IFSP must be on file with the MCO for the claim to be considered a Clean Claim. If the IFSP is not on file with the MCO prior to the MCO receiving the claim, the claim will not be considered clean and the 14-day timeframe does not apply.	✓ Method for LLAs to submit IFSP (fax, email) with the specific contact information ✓ Submission process of multiple IFSPs, i.e., batch or individual files ✓ Confirmation of receipt of IFSP	• Currently, the plan receives IFSPs by fax to 866-920-4097 and email to EarlyInterventionServicesSupport@anthem.com. IFSPs that are faxed must be done individually as these are uploaded to the member's electronic record. • Providers may email IFSPs in bulk separately. • When the IFSP is received, a fax confirmation notification will be sent to the EI provider that the IFSP has been received and will include the name and contact information of the Care Coordinator if there is an assigned Care Coordinator. • It is important to know that for incoming emails originating from outside of Anthem, the security would need to occur on the end of the sender as we ensure all incoming emails have a level of security but we cannot dictate the security before items are sent to the plan ❖ Note: If a provider is requesting a secure email because they do not have one themselves a request can be made to the EI claim webform: https://www.anthem.com/provider/individual-commercial/contact-us/email who will send a secure email along with the designated email address EarlyInterventionServicesSupport@anthem.com. ❖ Per the contract: The LLA EI Service Coordinator will send to the Contractor the following sections of the IFSP: • Section I – Child and Family Information • Section V – Services Needed to Achieve EI Outcomes • Section VI – Other Services • Section VII - Transitioning Planning (once developed)
Clean Claim	Clean claims must be paid within 14 days.	✓ Process for non-clean claims, i.e., rejected or denied	Anthem consider a clean claim as a request for payment for a service rendered by a provider that: • Is submitted on time. • Is accurate.

TOPIC	DESCRIPTION	MCO PROCESS	MCO RESPONSE
		MCOs shall provide a brief description for each point within the topic area	
		✓ Process for handling non-clean claims with the provider	• Is submitted on a HIPAA-compliant standard claim form (CMS-1500, CMS-1450 (UB04) or successor forms). • Requires no further information, adjustment or alteration to be processed and paid. • Is not from a provider who is under investigation for fraud or abuse. • Is not a claim under review for medical necessity. No claims fall into this category and should be removed. HealthKeepers, Inc. will adjudicate clean claims to a paid or denied status within 30 calendar days of receipt for all claims. Claims related to CCC Plus and/or Medallion 4.0 early intervention services are required to be adjudicated within 14 days of receipt if the claims are deemed 'clean claims' (see below). If the claim is not paid within these time frames, HealthKeepers, Inc. will pay all applicable interest as required by law. See the following section for more information on clean claims for Anthem CCC Plus members. HealthKeepers, Inc. produces and mails an Explanation of Payment once per week, which shows the status of each claim that has been adjudicated during the previous claim cycle. If HealthKeepers, Inc. does not receive all of the required information, HealthKeepers, Inc. will deny the claim either in part or in whole within 30 calendar days of receipt of the claim. A request for the missing information will appear on the EOP. Once all requested information has been received, HealthKeepers, Inc. will process the claim within 30 calendar days. HealthKeepers, Inc. will return paper claims that are determined to be unclean with a letter stating the reason for the rejection. HealthKeepers, Inc. will return electronic claims that are determined to be unclean to the clearinghouse that submitted the claim.
Decline to Bill Form and EOB	Families may decline to bill their private insurance for coverage of EI services and will sign the Decline to Bill Form. LLAs will have this form on file. If family does not decline to bill, the private insurance will send EOB	✓ Submission process for Decline to Bill Form ✓ Process for ensuring Claims Department is aware of Decline to Bill form ✓ Process for handling claims when Decline to Bill is or the EOB are not on file	Anthem's Medicaid network is unable to submit electronic claims at this time. Therefore, providers are being asked to attach "Decline to bill" forms to the actual claim during the billing process. This process is similar to attaching an EOB for COB claims. These documents are stored in the members file and can be accessed through Macess. When claims are scanned for processing the waiver form is also attached and considered during the COB process with the claim. Providers can also submit Decline to bill forms to the EI claim webform: https://www.anthem.com/provider/individual-commercial/contact-us/email Anthem is currently updating its COB processes to automate the tracking of Decline to Bill forms. Claims requiring primary EOB or Decline to Bill form without documentation will be denied. EI lead normally receives DTB forms that are not on file, from providers. However, we are currently discussing other COB processes to better address DTB forms.
EI Enrollment and Indicator	A child must have an EI indicator on the enrollment file in order for an EI service to be reimbursed. Due to timing of the enrollment file, if the provider bills prior to the MCO receiving the file listing the child as having the EI	✓ Process to handle claims when the EI indicator is not on plan enrollment file	Anthem's frontend system is based on what each state has decided on how to handle these sort of occurrences. If the plan is unable to find the profile, we then look for an eligible profile for the mother. The rejection response is the same as all other member rejection responses: "Subscriber and subscriber id not found. When we receive claims for the VA market, they pend for 5 days on the front end before they are rejected back to the provider.

TOPIC	DESCRIPTION	MCO PROCESS **MCOs shall provide a brief description for each point within the topic area**	MCO RESPONSE
	indicator, the claim will deny due to "child not enrolled in the EI". This impacts submission of a clean claim.		During the 5 day period, Anthem maps EI members based on what comes on the 834, or unless a specific request is placed. We then manually update the plan based off DMAS guidance (834). The EI indicator comes only on the 834 and it does not come on any other supplemental file. That 5 day period is a grace period to see if any specific requests are received from enrollment.
Care Coordination Care Management	PlanCare Managers/care coordinators should collaborate with the EI Service Coordinator	✓ Role of the care coordinator ✓ Process for exchanging information between care coordinator and service coordinator ✓ Frequency of contact between Care Managers/Care Coordinators, i.e., timeframe for initial contact and ongoing contact	Role of the Care manager for the Medallion team is to reach out to members/families, assess their medical and social needs. CM can make appropriate referrals externally or to internal Social workers to assist with social needs and CM will also work with family on any medical/physical needs identified by the family. Care managers/Care Coordinators are assigned to members following the Cardinal Care Contract Requirements. Anthem care managers work collaboratively with families as needed to have their needs met through MCO or EI. Contact is made by attempting telephonic outreaches and unable to reach letters are sent if unable to contact member. The plan will respond to the SC upon receipt of the IFSP within 5 days and provide the assigned Care Coordinators name for all CCC Plus Members. EI Service Coordinators can also reach out to the Anthem HealthKeepers Plus Care Management Line 1- 800-901-0020 option 6 and Foster Care Specialty Plan 833-838-2605 option 2 for questions or to connect with the member Care Manager/Care Coordinator.
Interpreter and Translation Services	Language assistance services, including but not limited to interpreter and translation services, are available free of charge.	✓ Process for providers, service coordinators, and/or families to access interpreter/translation services ✓ Timeframe for accessing interpreter/translation services	For those instances when a provider cannot communicate with a member due to language barriers, interpreter services are available. Face-to-face interpreters for members needing language assistance, including American Sign language are available by placing a request up to one month in advance and no less than five days before a routine visit or 24 hours prior to rendering acute services. Note: The 24/7 Nurse Line has access to telephone interpreter services. Providers can call 1-800-901-0020 (customer service number on the member ID card) or Care Management 804-588-4521 Families needing interpreting/translation services should call 1-800-901-0020 Service coordinators should either coordinate services directly with care coordinators 1- 800-901-0020 option 6 or can also access these services for their member at 1-800-901-0020. Foster Care Specialty Plan for members and providers 833-838-2605 option 2 Provider can also request or report issues, complaints, feedback regarding interpreter requests via secured email at: AnthemHKPtranslation: AnthemHKPtranslation@anthem.com Anthem's third-party interpreter vendor recruits qualified staff and contract interpreters experienced in working in healthcare settings. Our vendor selects only the best available interpreters in the marketplace. Staff and contract interpreter competencies are documented in the interpreter's file and are made available to Anthem upon request. **Credentialing process consist of**: Interviews Language

TOPIC	DESCRIPTION	MCO PROCESS	MCO RESPONSE
		MCOs shall provide a brief description for each point within the topic area	
			Proficiency Testing, Health History (for Onsite interpreters) Background Check and Credential Verifications Qualification Verifications Training Program <u>Interpreter Services</u> Families/Serv Coordinators: 1-800-901-0020 Serv. Coordination w/ Care Coordination: 1-800-901-0020 option 6 Foster Care Specialty Plan: 833-838-2605 option 2
EI Specific Email Box	Specific email contacts for submission of IFSPs, Decline to Bill Forms, etc.	✓ List specific email address	Currently, there is an existing email mailbox designated to receive IFSPs. **EarlyInterventionServicesSupport@anthem.com** It is important to know that for incoming emails from outside of Anthem, the security would need to occur on the end of the sender as we ensure all emails incoming have a level of security but cannot dictate the security before it is sent to us. In regards to other EI documents, such as a Decline to Bill form, currently providers are required to attach the primary waiver form to each claim when billing. Note: Decline to bill forms can also be emailed to the EI claim webform: https://www.anthem.com/provider/individual-commercial/contact-us/email

Humana
Healthy Horizons.

<table>
<tr><th>TOPIC</th><th>DESCRIPTION</th><th>MCO PROCESS</th><th colspan="2">MCO RESPONSE</th></tr>
<tr><td></td><td></td><td>MCOs shall provide a brief description for each point within the topic area</td><td colspan="2"></td></tr>
<tr><td>MCO Credentialing and Contracting</td><td>All EI providers must be credentialed and contracted by each MCO in order to provide services to members enrolled with the MCO.

All EI providers must be certified by DBHDS and affiliated with a LLA prior to the MCO credentialing and contracting process.</td><td>✓ Credentialing process
✓ CAQH process
✓ Contracting process
✓ Credentialing and contracting educators and other non-traditional disciplines
✓ Credentialing and contracting service coordinators
✓ Handling of out-of-network providers</td><td colspan="2">All requests to join the Humana Healthy Horizons in Virginia network must begin by visiting our Network portal at Humana Healthy Horizons in Virginia: Join our Network
Within the Request to Join Portal, Early Intervention providers must complete the required actions based on their provider type and specialty to ensure accurate processing of their requests. The table below provides guidance and helpful tips to ensure all required documents are submitted and to help avoid delays in the credential and contracting process.

Category 1- Agency or Group:
(EIS Credentialing required)

▪ Complete an organizational provider assessment form, listing all services including Early Intervention Services (EIS) specialty.
▪ Must be enrolled with DMAS as EIS agency.
▪ Submit W9 form.
▪ Provide proof of professional liability insurance (PLI)
▪ Complete OIG “Disclosure of ownership” form
▪ If billing with a rendering provider:
§ Submit facility roster with practitioner details.
§ Collect and submit EIS certifications for each rendering practitioner.
▪ If billing without a rendering provider:
§ Must be enrolled with DMAS as EIS agency.
▪ Collaborate with assigned contracting manager to ensure contract execution and obtain effective date.
▪ Upon contract execution and effective date, complete onboarding with Provider Relations representative.

Category 2-Individual Practitioner (Primary PT/OT/ST)

♣ Maintain active CAQH profile with primary specialty.
♣ Provide complete work history (past 5 years).</td></tr>
</table>

<table>
<tr>
<td></td>
<td></td>
<td></td>
<td>
<table>
<tr><td>(EIS Credentialing required)</td><td>o For any gap in work history exceeding six months, submit a written explanation.
♣ Updated Early Intervention (EIS) as a secondary specialty on the Roster.
♣ Submit proof of EIS Certification
♣ Maintain active EIS Specialty enrollment with DMAS.
♣ Provide proof of professional liability insurance (PLI) (TIN Level)
♣ Complete OIG “disclosure of ownership” form (TIN Level)
♣ Provide W9 form (TIN Level)
♣ Collaborate with assigned contracting manager to ensure contract execution and obtain effective date.
♣ Upon contract execution and effective date, complete onboarding with Provider Relations representative.</td></tr>
<tr><td>Category 3-Individual (Non-traditional disciplines) Non-PT/OT/ST (Credentialing Assessment Required)</td><td>♣ Credentialing Team will Assess provider:
♣ Please submit a complete roster with provider’s information
♣ Primary listed as (Paraprofessional specialty) and EIS (Early Intervention Services) as secondary.
♣ Maintain active EIS Specialty enrollment with DMAS.
♣ Submit Proof of EIS Certification
♣ Provide proof of professional liability insurance (PLI)
♣ Submit W-9 form (TIN Level)
♣ Complete OIG ‘Disclosure of Ownership’ form (TIN Level)
♣ Collaborate with assigned contracting manager to ensure contract execution and obtain effective date.
♣ Upon contract execution and effective date, complete onboarding with Provider Relations representative.</td></tr>
</table>
Contact Information:
If you have submitted a request to join following the steps outlined above and need additional guidance, or if you have questions about credentialing procedures, please contact the contracting team listed on our website.
• For Virginia Early Intervention providers: VirginiaProviderUpdates@humana.com
• For Southwest Virginia counties (Bristol City, Buchanan, Dickenson, Grayson, Lee, Norton City, Russell, Scott, Smyth, Tazewell, Washington, Wise, Wythe): HumanaALTNproviderupdates@humana.com
</td>
</tr>
<tr>
<td>Malpractice Insurance for Educators</td>
<td>Providers must have malpractice insurance if they are not covered by the local system.</td>
<td>✓ Requirements related to malpractice insurance for educators and non-traditional disciplines</td>
<td>See above requirements under the Category 3-Individual (Non-traditional disciplines)</td>
</tr>
</table>

IFSP	IFSP must be on file with the MCO for the claim to be considered a Clean Claim. If the IFSP is not on file with the MCO prior to the MCO receiving the claim, the claim will not be considered clean and the 14-day timeframe does not apply.	✓ Method for LLAs to submit IFSP (fax, email) with the specific contact information ✓ Submission process of multiple IFSPs, i.e., batch or individual files ✓ Confirmation of receipt of IFSP	Humana requests all initial IFSPs, annual IFSPs, and IFSP reviews be sent to the following: **IFSP Fax** *(Preferred):* (888) 241-3745 **IFSP Email:** VAMCDCareManagement@humana.com ***Please fax IFSPs individually (per member) as IFSPs are attached to a member's EHR. Upon receipt of the IFSP, the EI Coordinator will send the Service Coordinator an email confirming receipt of IFSP and provide the Care Manager's name and email address, when applicable within 14 days.
Clean Claim	Clean claims must be paid within 14 days.	✓ Process for non-clean claims, i.e., rejected or denied ✓ Process for handling non-clean claims with the provider	Humana monitors all claims processing within the 14-day compliance timeframe. Providers will receive a remittance for all claims that are adjudicated.
Decline to Bill Form and EOB	Families may decline to bill their private insurance for coverage of EI services and will sign the Decline to Bill Form. LLAs will have this form on file. If family does not decline to bill, the private insurance will send EOB	✓ Submission process for Decline to Bill Form ✓ Process for ensuring Claims Department is aware of Decline to Bill form ✓ Process for handling claims when Decline to Bill is or the EOB are not on file	Decline to Bill Forms are sent to fax *(Preferred):* (888) 241-3745 or email: VAMCDCareManagement@humana.com If the Provider submits the Decline to Bil form, then Humana will process and pay as primary. If the Provider submits an EOC, then Humana will coordinate as secondary. If there is no EOC or Decline to Bill form, then Humana will deny the claim 08B
EI Enrollment and Indicator	A child must have an EI indicator on the enrollment file in order for an EI service to be reimbursed. Due to timing of the enrollment file, if the provider bills prior to the MCO receiving the file listing the child as having the EI indicator, the claim will deny due to "child not	✓ Process to handle claims when the EI indicator is not on plan enrollment file	Our systems will read the EI indicator from the 834 file, and if the member is eligible Humana will pay, if the member is not eligible the claim will deny.

	enrolled in the EI". This impacts submission of a clean claim.		
Care Coordination	Plan care coordinators should collaborate with the EI Service Coordinator	✓ Role of the care coordinator ✓ Process for exchanging information between care coordinator and service coordinator ✓ Frequency of contact between coordinators, i.e., timeframe for initial contact and ongoing contact	✓ Members identified as Early Intervention are assigned to a Physical Health Care Manager (PCM). ✓ Case Manager Support Associate (CMSAs) or EI Coordinator will upload IFSP. CMSAs are in receipt of the ISFP's when they are submitted via the shared mailbox and then uploaded in the members documents. The EI Coordinator occasionally receives these ISFP's directly from the agency Service Coordinator and then are uploaded in the members' documents. ✓ The frequency of initial contact is based on the member's risk level as indicated in the CCC Contract. Ongoing contact is also based on the member's risk level as indicated in the CCC Contract. ✓ EI Coordinator will attempt to outreach ITC Service Coordinator beginning 90 days prior to members' third birthday to offer support with transition.
Interpreter and Translation Services	Language assistance services, including but not limited to interpreter and translation services, are available free of charge.	✓ Process for providers, service coordinators, and/or families to access interpreter/translation services ✓ Timeframe for accessing interpreter/translation services	**Onsite Interpreter Request Process** **Email**: F2F_Interpreter_Services@humana.com Provide the representative with the following information: • Requestor Name • Requestor Phone Number • Requestor Email Address • Member's Name • Member DOB • Humana ID Number • Date of Appointment • Time & Duration of Appointment • Reason for Visit • Language Needed • Name of provider(s) *(if applicable)* • Provider Contact Number *(if applicable)* • Service Address (street, city, and zip) An automated confirmation email will be sent to the requestor. Confirmation numbers and information about assigned interpreters will come from our vendor (Propio). **Rules** 3) It is preferred that providers submit their requests no later than 5 business days prior to the member's appointment date.

<table>
<tr><td></td><td></td><td></td><td>3) Cancellation of service requests require a notice of at least 1 full business day.
3) If an interpreter is a no-show for a scheduled and confirmed request, please notify us at F2F_Interpreter_Services@humana.com</td></tr>
<tr><td>EI Specific Email Box</td><td>Specific email contacts for submission of IFSPs, Decline to Bill Forms, etc.</td><td>✓ List specific email address</td><td>EI Leads<table><tr><td>Sequoya Clay
(804) 456-4548
Sclay4@humana.com</td><td>Kelly Dodson
(757) 731-5831
kdodson6@humana.com</td><td>Brandi Fuller
(276) 240-5501
Bfuller5@humana.com</td></tr></table>All IFSPs, Decline to Bill forms, etc. must be sent to the Care Management fax/inbox.
Fax (Preferred): (888) 241-3745
Email: VAMCDCareManagement@humana.com</td></tr>
</table>

Sentara Health Plans

TOPIC	DESCRIPTION	MCO PROCESS	MCO RESPONSE
		MCOs shall provide a brief description for each point within the topic area	
MCO Credentialing and Contracting	All EI providers must be credentialed and contracted by each MCO in order to provide services to members enrolled with the MCO. All EI providers must be certified by DBHDS and affiliated with a LLA prior to the MCO credentialing and contracting process.	✓ Credentialing process ✓ CAQH process ✓ Contracting process ✓ Credentialing and contracting educators and other non-traditional disciplines ✓ Credentialing and contracting service coordinators ✓ Handling of out-of-network providers	The Plan accepts Organizational Providers into its network at its sole discretion based on the need for facilities in certain types, geographic areas, or similar considerations. Each Organizational Provider must meet minimum standards for participation in the Plan's Network. The Plan assesses Organizational Providers before they provide care to Plan members. A person who has direct or indirect ownership or controlling interest of five (5) percent or more in the entity and has been convicted of certain crimes or appear on state or federal exclusions are excluded from Network participation. Organizational Providers must submit a complete application at initial assessment and must meet the verification time limit of 180-days of the Medical Director or Credentialing Committee Decision. Primary source verifications are obtained by the Plan from approved NCQA entities within 120 days of the Medical Director or Credentialing Committee Decision for the following: • Current valid state license • Confirm the Organizational Provider is on the DMAS list of approved EI Providers • Medicare, Medicaid and state and federal sanctions and exclusions • Confirmation the Organizational Provider has an active NPI appropriate for their facility specialty type taxonomy • Accreditation status The organizational provider must hold a current, valid state license without restriction, hold current, valid Professional and General Liability coverage within the policy limits established by their governing state laws, be in good standing with state and federal regulatory bodies, have an acceptable Disclosure of Ownership, Controlling Interest and Management Statement required by 42 CFR Part §455, hold a current NPI appropriate for their facility specialty type taxonomy, non-accredited facilities must provide their most recent state or CMS site survey or allow the Plan to conduct a quality assessment if they do not have a state or CMS site survey to provide. Organizational Providers approved during the initial assessment will be sent a written notification indicating their approval within 30-calendar days of the decision date. Any that are denied or terminated from the Plan will be sent a letter within 30- calendar days of the decision date advising them of the Committee's decision and what their Appeal Rights are, if applicable. The Plan has documented policies and procedures for managing Ongoing Monitoring of the Network and implementing appropriate interventions when issues are identified. All out-of-network services require prior authorization.

TOPIC	DESCRIPTION	MCO PROCESS	MCO RESPONSE
		MCOs shall provide a brief description for each point within the topic area	
Malpractice Insurance for Educators	Providers must have malpractice insurance if they are not covered by the local system.	✓ Requirements related to malpractice insurance for educators and non-traditional disciplines	Sentara requires that the provider have the Virginia Cap Amounts either through their professional liability or malpractice is under the Excess/Umbrella policy. There are exceptions allowed in instances where the Virginia Cap does not apply (non-professionals).
IFSP	IFSP must be on file with the MCO for the claim to be considered a Clean Claim. If the IFSP is not on file with the MCO prior to the MCO receiving the claim, the claim will not be considered clean and the 14-day timeframe does not apply.	✓ Method for LLAs to submit IFSP (fax, email) with the specific contact information ✓ Submission process of multiple IFSPs, i.e., batch or individual files ✓ Confirmation of receipt of IFSP	Sentara prefers faxed IFSP individually. Confirmation of the fax is the sender's response of successful transmission. 757-390-4449. IFSPs may also be emailed individually to highriskpeds@sentara.com.
Clean Claim	Clean claims must be paid within 14 days.	✓ Process for non-clean claims, i.e., rejected or denied ✓ Process for handling non-clean claims with the provider	Sentara's claims department will deny a claim if the EI indicator is not on file. All clean claims are paid within 14 days of receipt. Unclean claims are either denied, rejected up front or outreach is made to the provider to remediate to capture any elements needed to process the claim(s).
Decline to Bill Form and EOB	Families may decline to bill their private insurance for coverage of EI services and will sign the Decline to Bill Form. LLAs will have this form on file. If family does not decline to bill, the private insurance will send EOB	✓ Submission process for Decline to Bill Form ✓ Process for ensuring Claims Department is aware of Decline to Bill form ✓ Process for handling claims when Decline to Bill is or the EOB are not on file	Even when Sentara Medicaid is secondary, Sentara will pay as the primary payer for these claims with no EOB required from the primary insurer when a Decline to Bill form is on file. If no EOB or Decline to Bill form is submitted or on file, Sentara will deny the claim for missing EOB from the primary carrier. A provider may submit a Decline to Bill form along with a paper claim.
EI Enrollment and Indicator	A child must have an EI indicator on the enrollment file in order for an EI service to be reimbursed. Due to timing of the enrollment file, if the provider bills prior to	✓ Process to handle claims when the EI indicator is not on plan enrollment file	The claim will be denied if the EI indicator is not on file.

TOPIC	DESCRIPTION	MCO PROCESS	MCO RESPONSE
		MCOs shall provide a brief description for each point within the topic area	
	the MCO receiving the file listing the child as having the EI indicator, the claim will deny due to "child not enrolled in the EI". This impacts submission of a clean claim.		
Care Coordination	Plan care coordinators should collaborate with the EI Service Coordinator	✓ Role of the care coordinator ✓ Process for exchanging information between care coordinator and service coordinator ✓ Frequency of contact between coordinators, i.e., timeframe for initial contact and ongoing contact	Role of Care Coordinator: Care Coordination is a collaborative process which assesses, plans, implements, coordinates, monitors, and evaluates plan of care options to meet the member's needs. The Care Coordinator will collaborate with the Service Coordinator to coordinate care and services, contract negotiations, and telephonic education in an effort to promote quality outcomes for each member. Process for exchanging info: Clinical Contacts: Sentara Health Plans Phone 1-800-881-2166, Email highriskpeds@sentara.com, Fax 1-757-390-4449. ISFPs are faxed to our Clinical team. Other communications between Care Coordinator and Service Coordinator are individually based per case, need and preference of each Coordinator may be phone or email communication. For Sentara Health Plans: Care Coordination Phone 757-552-8398 or 1-866-546-7924, Fax (Medallion) Fax 757-390-4449; Care Coordination (CCC Plus) Fax 1-844-552-7508. Frequency – Established on individual case need for each member's level of care, contact may occur a few times per month, monthly, or quarterly based on the needs of the member.
Interpreter and Translation Services	Language assistance services, including but not limited to interpreter and translation services, are available free of charge.	✓ Process for providers, service coordinators, and/or families to access interpreter/translation services ✓ Timeframe for accessing interpreter/translation services	Sentara Health Plan staff schedule interpreter appointments by calling our language vendor. Appointments can be made in various ways. For example: by a provider or member calling into the contact center, a care coordinator scheduling the service, or an e-mail sent to languagehelp@sentara.com. We do not give providers direct access to our vendor due to proprietary access fees. It is very important that we are notified as soon as possible if a member cancels their appointment as we are charged for missed appointments. Members: 1-855-687-6260 (TTY 711) Providers: 1-800-229-8822

TOPIC	DESCRIPTION	MCO PROCESS	MCO RESPONSE
		MCOs shall provide a brief description for each point within the topic area	
			languagehelp@sentara.com
EI Specific Email Box	Specific email contacts for submission of IFSPs, Decline to Bill Forms, etc.	✓ List specific email address	There is not a specific EI e-mail for Sentara Health Plans. IFSP should be faxed to Sentara Health Plans 757-390-4449 and the Decline to Bill should be sent as indicated in the Infant and Toddler Connection Provider Manual.

UnitedHealthcare Community Plan

TOPIC	DESCRIPTION	MCO PROCESS	MCO RESPONSE
		MCOs shall provide a brief description for each point within the topic area	
MCO Credentialing and Contracting	All EI providers must be credentialed and contracted by each MCO in order to provide services to members enrolled with the MCO. EI Providers are considered non-par (Providers are not contracted with the MCO) until they are credentialed. All EI providers must be certified by DBHDS and affiliated with a LLA prior to the MCO credentialing and contracting process.	✓ Credentialing process ✓ CAQH process ✓ Contracting process ✓ Credentialing and contracting educators and other non-traditional disciplines ✓ Credentialing and contracting service coordinators ✓ Handling of out-of-network providers	Please visit our website and watch a short video on the UHC medical (MD, RN, PT, OT, SLP etc.) credentialing process by accessing the link below or calling 877-842-3210. We have also embedded an FAQ document about credentialing that outlines the CAQH process and contracting process as well as PRSS enrollment guidance for EI providers. https://www.uhcprovider.com/en/resource-library/Join-Our-Network.html or call For Behavioral Health provider types visit: https://www.providerexpress.com/content/ope-provexpr/us/en/our-network/jon.html or call (877) 614-0484. Credentialing Application guide: https://www.providerexpress.com/content/dam/ope-provexpr/us/pdfs/ourNetworkMain/jon/ProvGuide-CredApp.pdf Lastly, United Healthcare does not formally credential non-licensed providers (educators and other non-traditional disciplines). Continue to include them on your LLA roster to be added by our plan and formal credentialing will be waived. For non-participating providers we do not require prior-authorization for Early Intervention services, however if an Early intervention provider has never billed claims to UHC, the claim will pend for additional information, outreach will be made to obtain a W-9 and validate DBHS certification. Once outstanding information is received, UHC will create an out-of-net network provider ID, load the claim, and complete claims processing.
Malpractice Insurance for Educators	Providers must have malpractice insurance if they are not covered by the local system.	✓ Requirements related to malpractice insurance for educators and non-traditional disciplines	UHC would expect that the individual practitioner or their group affiliation would have appropriate insurance in place.
IFSP	IFSP must be on file with the MCO for the claim to be considered a Clean Claim.	✓ Method for LLAs to submit IFSP (fax, email) with the specific contact information	• UHC receives IFSPs via secure fax (these convert to PDFs to a secured fax email) at the following numbers: o 855-770-7088

TOPIC	DESCRIPTION	MCO PROCESS	MCO RESPONSE
		MCOs shall provide a brief description for each point within the topic area	
	If the IFSP is not on file with the MCO prior to the MCO receiving the claim, the claim will not be considered clean and the 14-day timeframe does not apply.	✓ Submission process of multiple IFSPs, i.e., batch or individual files ✓ Confirmation of receipt of IFSP	• Our clinical team receives the IFSP, performs triage and assigns to the appropriate Care Coordinator for outreach to the LLA case manager. During the outreach, the Care Manager will introduce themself from the MCO and exchange contact information. • Individual IFSPs should be sent as these are appended in individual member electronic records. • UHC views your successful fax transmission report as valid confirmation of receipt.
Clean Claim	Clean claims must be paid within 14 days.	✓ Process for non-clean claims, i.e., rejected or denied ✓ Process for handling non-clean claims with the provider	• If we are missing information/documentation a claim is not considered “clean.” UHC will pend and either outreach to the provider or deny with a provider remittance advice (PRA) denial reason. UHC may pend/deny for various reasons. An example of pending the claim would be to contact the provider if missing provider data information was not available. An outreach to the provider to obtain the needed info would be made, then the processing of the claim would resume. A denial could occur if the provider is not contracted for the service. • If the claim is resubmitted with additional information, UHC will process as a clean claim based on the resubmission date.
Decline to Bill Form and EOB	Families may decline to bill their private insurance for coverage of EI services and will sign the Decline to Bill Form. LLAs will have this form on file. If family does not decline to bill, the private insurance will send EOB	✓ Submission process for Decline to Bill Form ✓ Process for ensuring Claims Department is aware of Decline to Bill form ✓ Process for handling claims when Decline to Bill is or the EOB are not on file	UHC does not require the Decline to Bill Form to be submitted. We process all EI claims and will conduct back-end audits for appropriate COB actions that apply. If providers choose to submit the form, it will need to be submitted attached to a claim.
EI Enrollment and Indicator	A child must have an EI indicator on the enrollment file in order for an EI service to be reimbursed. Due to timing of the enrollment file, if the provider bills prior to the MCO receiving the file listing the child as having the EI indicator, the claim will deny due to “child not enrolled in the EI”.	✓ Process to handle claims when the EI indicator is not on plan enrollment file	UHC claims processing platform has the ability to evaluate the age of the member in conjunction with the EI code to determine if EI reimbursement is allowed. Additionally, we conduct post payment reviews to ensure appropriate payments of claims for aid category and IFSP approved services.

TOPIC	DESCRIPTION	MCO PROCESS	MCO RESPONSE
		MCOs shall provide a brief description for each point within the topic area	
	This impacts submission of a clean claim.		
Care Coordination	Plan care coordinators should collaborate with the EI Service Coordinator	✓ Role of the care coordinator ✓ Process for exchanging information between care coordinator and service coordinator ✓ Frequency of contact between coordinators, i.e., timeframe for initial contact and ongoing contact	Our expectation is for Care Managers to contact the EI provider within ten (10) business days. After making initial contact with the EI provider, we verify receipt of the IFSP and discuss any immediate needs for the member that the Care Manager can help with. We will ask the EI provider for any previous quarterly EI meeting dates as well as the date of the next meeting scheduled for members to coordinate with the members' Interdisciplinary Care Team (ICT) to join in participation.
Interpreter and Translation Services	Language assistance services, including but not limited to interpreter and translation services, are available free of charge.	✓ Process for providers, service coordinators, and/or families to access interpreter/translation services ✓ Timeframe for accessing interpreter/translation services	Language interpreter services can be initiated by contacting our provider service centers who will then facilitate appoint setting with our vendor, Language Line. Cardinal Care Provider Services 844-284-0146 Language Line recommends requesting interpreter service 3-5 days in advance if possible. The Services Coordinator can work directly with the CC to set up services.
EI Specific Email Box	Specific email contacts for submission of IFSPs, Decline to Bill Forms, etc.	✓ List specific email address	UHC receives IFSPs via secure fax (these convert to PDFs to a secured fax **email**) at the following numbers which are viewed by a member of the clinical care team: 855-770-7088 If a specific email is required for additional clinical concerns cardinal_care_cac@uhc.com All billing concerns should be emailed to: va_hcbs_pr@uhc.com