CCC PLUS GUIDANCE DOCUMENT

WHEN TO COORDINATE COVERAGE

CMHRS, ARTS, CCC Plus Waiver, and Early Intervention

Members with Medicare

Individuals with dual coverage (having both Medicaid and Medicare) and enrolled in the CCC Plus program, are not required to receive their Medicare coverage through a Medicare Dual Eligible Special Needs Plan (D-SNP). Their Medicare coverage can be provided through Medicare fee-for-service or any of the Medicare advantage plans available to them.

If your Member's Medicare provider does not participate with your plan, the provider must agree to accept payment from Medicare and Medicaid (if any), including through your CCC Plus Medicaid plan, as payment in full. If any Medicare provider does not agree, he/she will be in violation of their Medicare Provider Agreement and may be subject to sanctions (per Sections 1902(n)(3)(C), 1905(p)(3), 1866(a)(1)(A) of the Social Security Act). Pharmaceuticals covered under Medicare Part-D are non-covered under Medicaid; therefore, the plan is not responsible for the Medicare Part-D copayment.

Services for which the CCC Plus health plan pays secondary to Medicare do not require an authorization; this is an impediment to provider participation and has created barriers/delay in access to care and services for some dual members. If Medicare denies coverage for the service, and the health plan becomes the primary payer, the health plan can require an authorization.

When a claim is submitted for a member with Medicare as primary, the MCO should process the Medicaid benefit as secondary after Medicare, unless it meets the following exceptions:

- The requirement to coordinate benefits should also be based on the service definition, not simply the reimbursement code selected as certain DMAS services are structured different than other payers.
- Benefits exhausted, per Medicare EOB = Medicaid should pay as primary.
- Non-covered Medicare service = Medicaid becomes primary. Provider must submit the Medicare EOB or letter (on their letterhead) stating that Medicare does not cover the service unless the service is known to be an uncovered service.

If a provider type is not recognized by Medicare, Medicaid becomes primary. Since the provider is not contracted with Medicare they will not have an EOB from Medicare. Provider should attach a letter (on their letterhead) stating that their specific provider type does not contract with Medicare.

If providers inquire about additional resources, additional details regarding the prohibition on provider billing dually eligible individuals is provided by the Center for Medicare and Medicaid Services in the communication available at: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/se1128.pdf.

Members with Insurance other than Medicare

Per Sections 3 and 12.4.12.3 of the CCC Plus Contract, Members determined by DMAS as having comprehensive health coverage will be assigned to a CCC Plus health plan. Members will not be dis-enrolled due to having other comprehensive health coverage.

The CCC Plus health plan is responsible for coordinating all benefits covered under the CCC Plus Contract for its membership. When the other payer is a commercial HMO organization, the Contractor is responsible for the full copayment amount. The Member may not be billed by the provider other than any Patient Pay established by DSS towards LTSS services. The CCC Plus plan must ensure that the Member is held harmless from any monetary obligation for covered services (except for any Patient Pay towards long-term services and supports as determined by the Department of Social Services).

The CCC Plus health plan shall coordinate benefits with the Member's primary insurance carrier. This includes emergency, post-stabilization, and family planning services where the Member's provider is not in the CCC Plus health plan's network. The plan shall ensure continuity of care, including when the provider is not in the plans network, at least until the member can be safely and effectively transitioned to an in-network provider. Payments to non-par providers must include information to the provider that, under Federal law, any provider who receives Medicaid payment, including through the CCC Plus health plan, must accept payment received as payment in full. Providers may not balance bill the member.

Services Not Covered Through Medicare or Commercial Coverage

Prior to processing a claim for payment, the Contractor shall NOT require a provider to bill the primary carrier and include a denial for services that are known to be non-covered under Medicare or commercial insurance. The Contractor's request for an explanation of benefits (EOB) from the provider in these instances would delay timely payment of these services. Examples of these services include, but are not limited to LTSS waiver services such as personal care and respite care services.

One exception to this rule is private duty nursing (PDN) services as these are frequently covered through commercial insurance. The Contractor may only require an EOB for PDN services if the commercial carriers covers all or part of PDN services. Please refer to the bypass lists found on page 3 of this document.

CMHRS, ARTS, and other Related Services

The requirement to coordinate benefits should also be based on the service definition, not simply the reimbursement code selected as certain DMAS services are structured differently than other payers.

The Contractor should pursue other coverage as follows:

- Procedure codes beginning with 'S' – Would need a denial from the primary carrier or a letter by the provider attached the letter to the claim. This letter, on the provider's letterhead, would indicate that the primary carrier does not cover this service.

- Procedure codes beginning with 'T' – These codes are not accepted by Medicare but can be used by private insurance. Would need a denial from the primary carrier or a letter attached to the claim to inform that they do not cover.

Certain procedure codes can be by-passed for Third Party Liability (TPL) review. All other codes not found below are subject to Coordination of Benefits.

EPSDT Behavioral Therapy:

Commercial carriers use a "T" code (0364T and 0365T) for Behavioral Therapy and Medicaid recognizes the "H" code for this service. For commercial claims, the provider would bill the carrier using the "T" codes and receive payment. Then provider would bill H0032-UA and H2033 to CCC Plus Contractor with the EOB from commercial plan and the Contractor will coordinate the benefit for these two codes.

Medicare Bypass* List for CMHRS, ARTS, and CCC Plus Waiver:

The bypass list includes the following codes:

G9012, H0004, H0005, H0006, H0010, H0020, H0023, H0031, H0032, H0035HA, HA0035HA-UG, H0035HA-U7, H0036, H0039, H0046, H2012, H2017, H2019, H2034, H2021-TD, H2021-TE, S1019, S5102, S5160, S5160-U1, S5161, S5185, S9125-TD, S9125-TE, T1000-U1, T1001-U1, T1002, T1003, T1030-TD, T1031-TE, S5126, S5150, T1005, T1019, 99199-U4, 99509, A0120, H2000, H2015, S5109, S5116, S5165, T1028, T1999, T1999-U5, and T2038.

Commercial/Private Bypass* List for CMHRS, ARTS, and CCC Plus Waiver:

The bypass list includes the following codes:

G9012, H0004, H0005, H0006, H0010, H0020, H0023, H0031, H0032, H0035HA, HA0035HA-UG, H0035HA-U7, H0036, H0039, H0046, H2012, H2017, H2019, and H2034, H2021-TD, H2021-TE, S5102, S5160, S5160-U1, S5161, S5185, S9125-TD, S9125-TE, T1000-U1, T1001-U1, T1002, T1003, T1030-TD, T1031-TE, S5126, S5150, T1005, T1019, 99199-U4, 99509, A0120, H2000, H2015, S5109, S5116, S5165, T1028, T1999, T1999-U5, and T2038.

Early Intervention

For children with commercial insurance coverage, providers must bill the commercial insurance first for covered early intervention services except for any covered early intervention services where the family has declined access to their private health/medical insurance and, as such, those services are federally required to be provided at public expense.

Medicare and Commercial Bypass List for Early Intervention:
The bypass list includes the following codes:
1) T1023 and T1023-U1: Assessment/EI evaluation
2) T1024, T1024-U1: Development or review of the Individual Family Service Plan (IFSP); and,
3) T2022: Targeted case management/service coordination;
4) T1027-U1: Developmental services; and,

Under these circumstances, and in accordance with federal regulations, the Contractor shall require the Early Intervention provider complete the *Notification to the Department of Medical Assistance Services: Family Declining to Bill Private Insurance* form (http://infantva.org/documents/ovw-st-TaskF-Mtg-20090520Form-DecliningPriv_Ins.pdf) and submit it with the bill to the Contractor. The Contractor shall keep a copy of this form on the Member's file for a period of ten (10) years for audit purposes. Billing codes for EI services are reflected in the attached *CCC Plus Covered Services* chart.

Provider Communications

Clarification regarding coordination with Medicare has been posted on the DMAS website for providers/stakeholders at: http://www.dmas.virginia.gov/Content_atchs/mltss/Medical%20Provider%20CCC%20Plus%20Update%209.19.17.docx.

COBA Update

DMAS continues to work with CMS on the COBA implementation. This is a high priority for us. While we regret the delay, we are working hard to ensure that we have this right before we implement.

In Medicaid FFS, when Medicaid members move between plans and between CCC Plus and FFS, it was not an issue as the claim crossed over to FFS for all claims. For CCC Plus, we will be sending up multiple enrollment segments where claims will need to cross to the correct health plan with whom the member is enrolled based upon the date of service. We are in the final phases of testing to ensure that claims cross to the correct MCO. As soon as we receive the go-ahead from CMS we will let you know.