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COMMONWEALTH of VIRGINIA
DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
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To: CCC Plus Managed Care Organizations

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Subject: Clarification on Coordination of Benefits with Medicare and Other Insurance

This memorandum is a follow up to the September 30, 2017 memo on coordination of benefits to advise and clarify important Contract provisions regarding coordination with Medicare and other insurance. This memo provides additional information to specify coverage liabilities under the Medicaid benefit for coinsurance and deductibles when applied by the primary carrier. The guidance offered in this memo is directed to clarify claims processing rules that would apply regardless of whether the member's primary carrier is delivering Medicare or Commercial insurance benefits in coordination with the Medicaid benefit. Please share this memo with all operations/system configuration, care coordination, network/provider relations and customer service staff who work with the Commonwealth Coordination Care (CCC) Plus Medicaid program and/or population. The clarification provided in this Memo will be incorporated in the CCC Plus Contract revision, January 1, 2019. All Department of Medical Assistance Services (DMAS) contracted health plans will need to ensure that claims configurations and staff training materials including customer service staff messaging match this guidance by August 31, 2018.

Coordination of Benefits

In accordance with the CCC Plus Contract, Section 12.4.11 and 12.4.12, the CCC Plus health plans are required to coordinate benefits with Medicare and other insurance carriers for services covered under the CCC Plus contract. In addition, the contract specifies in Sections 11.6 and 11.7 that the member is not subject to cost sharing and the member is not held financially liable for Medicaid covered services including coinsurance, copayments, deductibles, financial penalties, or any other amount other than

any Patient Pay established by Department of Social Services (DSS) towards Long Term Support Services (LTSS). In order to ensure that obligation is met for CCC Plus members, DMAS is providing further guidance to the Managed Care Organizations (MCO) on coordinating benefits between Medicaid, Medicare and commercial insurance benefits.

The Contractor shall coordinate all benefits with the Member's primary insurance carrier. 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.

Co-Payment

When the primary payer is a private insurance carrier or Medicare then the DMAS-Contracted MCO is responsible for the full copayment amount. The Member may not be billed for any balance owed by the provider other than any Patient Pay established by DSS towards LTSS services.

Deductibles

When the primary payer is a private insurance carrier or Medicare then the DMAS-Contracted MCO is responsible for the full deductible amount. The Contractor is responsible for the deductible payment by reimbursing for services using the *MCO contracted or DMAS reimbursement rate for the specific service. Deductible amounts should be reimbursed to the provider and payment applied to reimburse all services until the payment amounts to the provider equal the member's deductible amount. When Medicaid is the secondary payer after commercial or Medicare benefits are exhausted the MCO would reimburse using the *MCO contracted or DMAS reimbursement rate for the specific service. In some instances the DMAS reimbursement code will differ from what is used by the primary payer however, reimbursement will be coordinated by the contractor based on the service definition in use by DMAS. Providers may not balance bill the member since payment to the MCO provider must be accepted as payment in full.

If a Medicaid covered service is denied by the primary carrier then the Medicaid benefit provides reimbursement at the Medicaid fee schedule. The health plan may choose to pay and chase to coordinate benefits if that option is viable to pursue the third party liability.

Co-Insurance

When the primary payer is a private insurance carrier or Medicare then the DMAS-Contracted MCO is responsible for the payment of the co-insurance amount using the *MCO contracted or DMAS reimbursement rate for the specific service. Medicaid is the secondary payer after commercial or Medicare benefits. Medicaid payments are made when the reimbursement from the primary insurance amount was less than what Medicaid would reimburse for the exact unit amount and procedure code.

**See Section 12.4.2 for exceptional processing and payment rules for nursing facility, LTSS, CMHRS, ARTS, and early intervention providers.*

When Medicaid is the secondary payer after commercial or Medicare benefits are exhausted, the MCO will reimburse for any amounts using the MCO contracted or DMAS reimbursement rate for the specific service as defined by DMAS. The DMAS contracted MCO is responsible for the co-insurance payment by reimbursing for services using the *MCO contracted or DMAS reimbursement rate*for the specific When the primary payers reimburse less than the Medicaid reimbursement rate, the MCO shall pay up to the Medicaid rate. This is true even when the primary payers' explanation of benefits indicates there is no additional amount owed to the provider. For example: Early Intervention services as covered in the Medicaid program uses reimbursement rates which may be higher than the commercial rates for outpatient rehabilitation services. Additionally, in some instances the DMAS reimbursement code will differ from what is used by the primary payer however, reimbursement will be coordinated by the contractor based on the service definition in use by DMAS. An example of a service that uses different procedure codes is the DMAS Behavior Therapy service which is reimbursed by the department using H2033. Behavior Therapy includes the Applied Behavioral Analysis service and many commercial payers reimburse ABA services using a range of procedure codes such as 0365T which is different and include a portion of the service covered under H2033 using the DMAS service definition. Providers may not balance bill the member since payment from the MCO to the provider must be accepted as payment in full after primary and Medicaid benefits are applied and reimbursed.

Providers Not in Network with the Member's Primary Carrier (Non-Medicare)

When the primary carrier will deny or has denied a Medicaid covered service because the servicing provider does not participate or is not a provider type contracted or covered by the carrier, then claims for Medicaid covered services can be submitted by that provider and will be processed and paid up to the Medicaid allowed.. The service provider may attest to the Contractor that they are not participating with the primary commercial insurance carrier. The DMAS contracted MCO shall verify and manage the network provider according to the appropriate MCO contractual requirements. Submission of an Explanation of Benefits (EOB) shall not be a requirement for providers who attest that they are not participating with the commercial carrier as a provider of the service in question.

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. For those members who do not have the Medicare Part A or Medicare Part B benefit Medicaid is the primary payer for the impacted services. 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 and over-the-counter medications (OTCs), including those that are not covered under Part D for dual eligible individuals and certain Community Mental Health Rehabilitation Services (CMHRS).

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.

**See Section 12.4.2 for exceptional processing and payment rules for nursing facility, LTSS, CMHRS, ARTS, and early intervention providers.*

In cases where the Medicaid reimbursement code differs from the code billed to and accepted by Medicare or a commercial carrier, coordination of benefits should be based on the service definition, not simply the reimbursement code. 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.

Third Party Liability "Bypass" Lists

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 H2033 as the 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 for the assessment and H2033 for the service to CCC Plus Contractor with the EOB or denial from commercial plan or letter by the provider attached to the claim 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, H0015, H0020, H0023, H0024, H0025, H0031, H0032, H0035HA, HA0035HA-UG, H0035HA-U7, H0036, H0039, H0046, H2012, H2017, H2019, H2034, H2021-TD, H2021-TE, S0109, S5102, S5160, S5160-U1, S5161, S5185, S9125-TD, S9125-TE, T1000-U1, T1001-U1, T1002, T1003, T1030-TD, T1031-TE, S5126, S5150, T1005, T1012, T1019, 99199-U4, 99509, A0120, H2000, H2015, S5109, S5116, S5165, T1028, T1999, T1999-U5, and T2038and S9445

Commercial/Private Bypass* List for CMHRS, ARTS, and CCC Plus Waiver:
The bypass list includes the following codes:

**See Section 12.4.2 for exceptional processing and payment rules for nursing facility, LTSS, CMHRS, ARTS, and early intervention providers.*

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, 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, T2038 and S9445.

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: EI Assessment/EI Evaluation;
2) T1024, T1024-U1: Development or review of the Individual Family Service Plan (IFSP);
3) T2022: EI Targeted case management/service coordination;
4) T1027 and T1027-U1: Developmental services, individual and group

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.

Members with Medicare

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 the CCC Plus Medicaid MCO, 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.

The Contractor shall coordinate benefits with the member's Medicare carrier (fee-for-service or MCO) when 1)the provider is not in the Contractor's network; and 2) without the requirement of service authorization.

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

the health plan becomes the primary payer, the health plan can require an authorization.

Additional details regarding the prohibition on 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 the CCC Plus contractor. Members will not be dis-enrolled due to having other comprehensive health coverage.

Contractors may apply service authorization requirements to Medicaid covered services that are also covered by the member's commercial insurance. Coverage of services and coordination of benefits will be managed as set forth in this memorandum.

The Contractor shall take responsibility for identifying and pursuing comprehensive health coverage (e.g. Medicare, commercial insurance, and Workers' Compensation). Any moneys recovered by third parties shall be retained by the Contractor. The Contractor shall notify DMAS monthly of any Members identified during that past month that were discovered to have comprehensive health coverage.

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.

Please let us know if you have any questions or require any additional clarification.

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