CardinalCare
Virginia's Medicaid Program
dmas.virginia.gov

Frequently Asked Questions about Claims, Billing and Service Authorization in Virginia Dual Eligible Special Needs Plans

Many individuals who are eligible for both Medicare and Medicaid coverage are enrolled in special Medicare Advantage plans designed for Medicaid enrollees known as Dual Eligible Needs Plans (D-SNPs). Effective January 1, 2025, all enrollees in Virginia D-SNPs will be required to enroll with the Medicaid Managed Care Organization (MCO) operated by their D-SNP MCO. Medicare policy requires that the member have choice of Original Medicare/Medicare Advantage coverage, so the individual's Medicaid enrollment is determined by their choice of D-SNP. This means that if a member who is eligible for both Medicare and **full** Medicaid coverage elects to enroll in Company A's D-SNP, they must also be enrolled in Company A's Medicaid MCO plan.

This arrangement, which is referred to as Exclusively Aligned Enrollment (EAE), will provide for greater integration of the member's Medicare and Medicaid benefits and services. For providers, this will mean some processes, such as billing and service authorization, will be integrated. This document provides an explanation of how this integrated process will work.

For further information and assistance, please contact the DMAS D-SNP team at DSNP@dmas.virginia.gov. If you have health plan specific questions, please submit them to the appropriate health plan.

D-SNP Billing and Claims Processes

Effective January 1, 2025, a dual eligible member that is enrolled in an aligned D-SNP (i.e., enrolled with the same MCO for Medicare and Medicaid) will have one member ID card issued by the D-SNP. This card will be co-branded with the D-SNP logo and Cardinal Care logo, and will include the member's Medicare and Medicaid ID numbers. The card will also provide contact information for members and providers to use if they have questions.

Providers should use the information on this card to bill for **all** services. This includes those services that are only covered by Medicare, services that are only covered by Medicaid, and those services that are covered by both Medicare and Medicaid. This means that providers will be billing the D-SNP, a Medicare Advantage Plan, for services that are covered by Medicaid in most cases. (Technically, the Medicaid portion is being paid using Medicaid dollars. The D-SNP is coordinating the payment behind the scenes so the provider gets one payment).

Billing for Medicare-Only Services

- If the services being billed for are **Medicare-only** services, the D-SNP will adjudicate the claim using Medicare rules (medical necessity, amount, duration and scope, etc.).
    - If the claim is denied, in part or in full, the provider will receive a notice stating why the claim was rejected and how to appeal.
    - If the claim is paid in full, the D-SNP will pay for the Medicare potion of the service and the Medicaid cost sharing amount at the same time. This means the provider will not have to bill twice, i.e., once for the Medicare portion and once for the Medicaid coinsurance amount. (Technically, the Medicaid portion is being paid using Medicaid dollars. The D-SNP is coordinating the payment behind the scenes so the provider gets one payment).

Billing for Medicaid-Only Services

- If the service being billed for is a **Medicaid-only** service, providers can still bill the Medicaid MCO directly. However, providers may also bill the DSNP for a Medicaid-only service, the D-SNP will identify it as such and then will automatically "send" it to the Medicaid side of the house where it will be adjudicated using Medicaid rules (medical necessity, amount, duration and scope, etc.). **There are no changes to Medicaid rules as a result of the move to exclusively aligned enrollment.**
- If the claim is denied, in part or in full, the provider will receive a notice stating why the claim was rejected and how to appeal.
- If the claim is paid in full, the D-SNP will pay for the service. (Technically, Medicaid-only covered services are being paid using Medicaid dollars. As with Medicare cost sharing, the D-SNP is coordinating the payment behind the scenes).

Billing for Services Covered by Both Medicare and Medicaid

- If the service is covered by **both Medicare and Medicaid,** the D-SNP will identify it as such and adjudicate the claim using Medicare rules first as Medicare is the primary insurer and payer). Then, if necessary, the D-SNP will adjudicate the claim using Medicaid rules (see below).
- If the claim is denied, in part or in full, using Medicare rules, the D-SNP will automatically send the unpaid balance to the Medicaid side of the house where it will be adjudicated using Medicaid rules.
    - If the claim is denied in full using both the Medicare and Medicaid rules, the provider will receive a notice saying why it was rejected using Medicare rules, why it was rejected using Medicaid rules, and how to appeal both decisions.
    - If the claim is denied in part by Medicare but paid using Medicaid rules, the provider will receive a notice that it was rejected using Medicare rules but is being paid using Medicaid rules and how to appeal the Medicare decision.
- If the claim is paid in full, the D-SNP will pay for the Medicare portion of the service and the Medicaid cost sharing amount at the same time. This means the provider will not have to bill twice as you do today, i.e., once for the Medicare portion and once for the Medicaid coinsurance amount. (As stated above, technically, the Medicaid portion is being paid using Medicaid dollars, but the D-SNP is coordinating the payment behind the scenes so the provider gets one payment).

Service Authorizations

Throughout the explanation above we've described the process for claims processing. The same processes apply to service authorization requests: The provider submits all requests to the D-SNP and the plan coordinates the adjudication. There will be no change in the timeframe for approval/denial of service authorizations.

Frequently Asked Questions about DSNP Billing

Question 1: When will this billing policy apply? Will the billing requirement changes include all services billed after 1/1/25 regardless of service date?

Answer 1: It applies to services provided on and after 1/1/2025.

Question 2: Will the provider bill non-covered Medicare services (such as Waiver services) to the D-SNP Medicare plan even though this service is not covered by the D-SNP?

Answer 2: Providers can choose to bill either the Medicaid plan or the DSNP for Medicaid-only services. Please see explanation above of policies for Medicaid-only covered services and services that are covered by both Medicare and Medicaid.

Question 3: What happens when the provider bills the D-SNP for a service that is either covered by both Medicare and Medicaid, or is only covered by Medicaid but Medicare rules don't allow the provider to provide the service? This can happen where state licensure rules allow a certain provider type to provide a service but Medicare requires a different licensure type (for example, Medicare requires a service to be provided by a Nurse Practitioner but Medicaid allows the service to be provided by a Licensed Clinical Social Worker), or when Medicare doesn't allow a license-eligible staff to bill under the supervising licensed clinician's credential but Medicaid does.

Answer 3: The D-SNP will coordinate the adjudication of the claim/service auth request and apply Medicaid rules as necessary. Let's use the example of a service that is covered by both Medicare and Medicaid for which Medicare requires the services to be provided by a NP but Medicaid rules allow a LCSW to provide the service. If the LCSW provides the service, the D-SNP will reject the claim under Medicare rules but will automatically apply Medicaid rules and pay the claim (assuming everything else on the claim was correct). ***NOTE: UnitedHealthcare is the exception to this rule. UHC requires the provider to bill the Medicaid plan if the clinician is not credentialed with Medicare.***

Question 4: Should providers continue to obtain service authorizations from the Medicaid plans and not the D-SNP?

Answer 4: Providers can still obtain service authorizations from the Medicaid plans if they so desire, but the D-SNP will coordinate the service authorization process as well. All SA requests should be sent to the D-SNP and the D-SNP will coordinate the adjudication of the SA using both Medicare and Medicaid rules.

Question 5: If a member's current health plan doesn't require a service authorization for a specific service but the new health plan does, what is the timeframe to transition to a new authorization?

Answer 5: The new MCO must provide coverage at the Medicaid FFS rate for any previously scheduled medical appointments, surgeries, durable medical equipment, prosthetics, orthotics or other supplies determined to be medically necessary by the Department and/or the previous MCO. This includes any services that don't have existing SA's. DMAS provides the new MCO with 2 years of previous claims experience for each member. However, while DMAS provides the new MCO with a transition report that includes the services the member is receiving (not just those with open SA's), it is possible the new MCO could misidentify what those services are. In light of that possibility, it may be safer to submit a new SA request to the new MCO. You may also want to discuss this with the new MCO.

Question 6: Will there be any change in the D-SNP/MCO response time for service authorization approvals, denials, etc.?

Answer 6: No. Per CMS regulations, plans must provide a decision on prior authorization requests within 72 hours for urgent situations and fourteen (14) calendar days for standard requests. This is the requirement for both Medicaid and D-SNP/Medicare Advantage service authorizations.

Virginia DSNP MCO Claims and Billing Portal Information and Instructions

Aetna Better Health of Virginia

Claims may be submitted to:
Aetna Virginia (HMO D-SNP)
Payor ID# 128VA
P.O. BOX 982980
El Paso, TX 79998
Phone number: 1-855-463-0933 (TTY: 711)

Portal links can be found at https://www.aetnabetterhealth.com/virginia-hmosnp/providers/portal.

Additional claims information can be found at https://www.aetnabetterhealth.com/virginia-hmosnp/providers/hmo-snp-pr/claims

Anthem Healthkeepers

Full instructions for submitting claims to Anthem DSNP are provided in the Anthem Provider Orientation document at https://providers.anthem.com/docs/gpp/VA_CAID_AnthemFullDualAdvantageHMODSNP.pdf?v=202502121502.

Paper Submissions	Electronic submission payers	EDI hotline
Anthem P.O. Box 6101 Virginia Beach, VA 23466	Availity Essentials: 800-282-4548 Website: Availity.com Payer ID: 00423	Phone: 800-590-5745

Molina Health Care of Virginia

Information for Provider Claims Submissions can be found on the Molina Provider Claims Submissions Site: https://www.molinahealthcare.com/providers/va/medicaid/claims/edi.aspx

Claims may be submitted either on paper or electronically. Electronic submission is preferable, and there are two options to submit claims electronically:

- https://www.availity.com/molinahealthcare/ or
- https://products.ssigroup.com/molinaregistrationportal/register.

If electronic submission is not possible, paper claims may be submitted to:
Molina Healthcare of Virginia, LLC
P.O. Box 22656
Long Beach, CA 90801

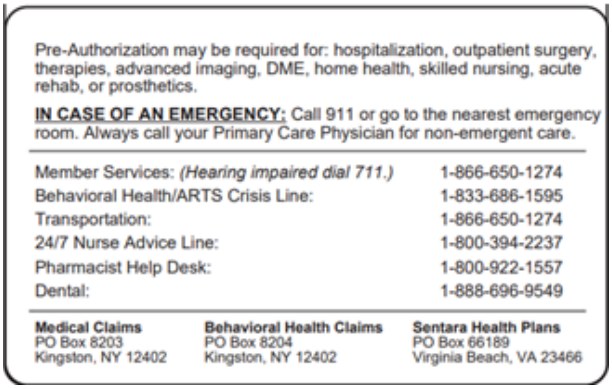
Please keep in mind when submitting paper claims that paper claims should be submitted on original, red-colored CMS 1500 Claims forms and must be printed using black ink. Authorizations can be found and/or submitted at https://www.molinahealthcare.com/providers/va/medicaid/claims/authorization.aspx.

Sentara Community Complete

All claims for our DSNP plan should be submitted to:
Medical Claims
P.O. Box 8203
Kingston NY, 12402

This address is located on each member's ID Card, shown at right.

The provider can also submit though the clearinghouse they currently use for Sentara Health Plans.


Pre-Authorization may be required for: hospitalization, outpatient surgery, 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.

Member Services: *(Hearing impaired dial 711.)*	1-866-650-1274
Behavioral Health/ARTS Crisis Line:	1-833-686-1595
Transportation:	1-866-650-1274
24/7 Nurse Advice Line:	1-800-394-2237
Pharmacist Help Desk:	1-800-922-1557
Dental:	1-888-696-9549

Medical Claims	Behavioral Health Claims	Sentara Health Plans
PO Box 8203 Kingston, NY 12402	PO Box 8204 Kingston, NY 12402	PO Box 66189 Virginia Beach, VA 23466

The claims will be processed under Medicare, then under Medicaid. Those services not covered under Medicare will be processed under the members Medicaid benefit.

Helpful links and contacts:

- Additional billing and claims information can be found at https://www.sentarahealthplans.com/en/providers/billing-and-claims
- Provider portal: https://www.sentarahealthplans.com/en/providers/provider-connection-registration
- Providers can call our Sentara Health Plans Provider Relations team at 1-844-512-3172 or email at ProviderRelations@sentara.com

UnitedHealthcare

For UHC DSNP claims, providers can submit via the UHC Provider Portal. More information can be found a https://www.uhcprovider.com/en/resource-library/provider-portal-resources.html .

Providers can also find additional resources related to claims submission via the portal at https://chameleon-4-prod.s3.amazonaws.com/clients/39-64ecae4085df9/courses/558-6528183db3513/prod/index.html#/en-US.

If additional assistance is needed, Provider Services can be reached at 844-368-7151.