

Provider Notice

Thank you for participating with Magellan Complete Care of Virginia (MCC of VA) to provide high quality healthcare services to our members.

We would like to update providers on our pricing and policies related to coordination of benefits. We follow Department of Medical Assistance Services (DMAS) guidance on coordination of benefits.

- Unless otherwise outlined below, MCC of VA coordinates with primary carriers by reimbursing:
 - 100% of the primary carrier’s copay; or
 - The lesser of: the sum of the primary carrier’s coinsurance and deductible **or** the difference between the provider’s allowable Medicaid rate and primary carrier payment. If the primary carrier’s payment exceeds the provider’s allowable Medicaid rate, no additional payment is issued.
- There are several services that will reimburse 100% of the primary carrier’s coinsurance and deductible. These services include Medicare Part B services rendered by nursing facilities, durable medical equipment rentals, Federally Qualified Health Center and Rural Health Clinic services, and services that are non-covered or unpriced (Individualized Consideration on the fee schedule) by Virginia Medicaid.
- There are also several services that will reimburse the difference between the primary carrier’s payment and the provider’s allowed Medicaid rate regardless of the primary carrier’s patient responsibility. These services include early intervention, nursing facility, Commonwealth Coordinated Care Plus waiver services, Community Mental Health Rehabilitative Services, and Addiction and Recovery Treatment Services.
- When the primary carrier’s full patient responsibility is due to a non-covered service or due to an out-of-network denial, MCC of VA will treat the claim as a primary claim and reimburse as such.
- Providers who are unable to bill Medicare and thus cannot obtain a Medicare explanation of benefits (EOB) should include attestation of such with claims submissions to ensure timely and accurate payment.
- MCC of VA does not require primary carrier EOBs on services that are known to be non-covered by Medicare or commercial carriers.
- MCC of VA does not require authorization for services that are covered by primary carriers. Standard authorization rules apply for non-covered services, including inpatient stays that occur after a member has met his or her Medicare benefit maximum.
- MCC of VA receives Medicare crossover claims automatically through the Centers for Medicare & Medicaid Services Coordination of Benefits Agreement feed. There is no need to submit these claims separately. Providers should wait at least 30 days after the Medicare pay date before submitting any Medicare coordination claims to allow the opportunity for the claim to be received automatically. When the crossover feed sends the claim to a commercial carrier in

addition to MCC of VA, MCC of VA, as the payer of last resort, will deny the claim requesting that the provider submit the other carrier EOB in order to coordinate.

- Providers may not balance bill Medicaid members for any unpaid amounts. Outside of Long Term Services and Supports patient pay and Family Access to Medical Insurance Security (FAMIS) copays, members have no patient responsibility in the Medicaid program.

These policies apply to coordination with both Medicare and commercial policies. Please note that this is a change from our current coordination on commercial policies. For commercial policies, the updated rules will take effect beginning with service dates of July 1, 2019.

If you have any questions please contact us at 1-800-424-4524 (TTY 711).