



Aetna Better Health® of Virginia

TOPIC	DESCRIPTION	MCO PROCESS	MCO RESPONSE
		MCOs shall provide a brief description for each point within the topic area	
<p>MCO Credentialing and Contracting</p>	<p>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.</p> <p>All EI providers must be certified by DBHDS and affiliated with a LLA prior to the MCO credentialing and contracting process.</p>	<ul style="list-style-type: none"> ✓ 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 	<p>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 auths 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. Effective date of par status will be the 1st of the month after the Credentialing Department’s approval date. Contract will be countersigned the 1st of the month after the approval date.</p> <p>Credentialing process typically take 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.</p> <p>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 auths 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 auths for procedure codes that require it.</p> <p>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:</p> <p>https://www.aetnabetterhealth.com/virginia/providers/join-our-network/</p>

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			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.	<ul style="list-style-type: none"> ✓ 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	<p>IFSP must be on file with the MCO for the claim to be considered a Clean Claim.</p> <p>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.</p>	<ul style="list-style-type: none"> ✓ 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 	<p>IFSP can be emailed to earlyinterventionservices@aetna.com or Faxed to 866-261-0581.</p> <p>The process for multiple is not different, can use the email or fax.</p> <p>We do make outreach to the provider once we receive it to inform of the case managers name and contact information assigned. This is often left via voice mail on the form received. *** NOTE** perhaps the providers are not receiving these messages, do they have a specific process or email that they would like for the MCO to use to inform them of this information?***</p>
Clean Claim	Clean claims must be paid within 14 days.	<ul style="list-style-type: none"> ✓ 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, 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.
Decline to Bill Form and EOB	<p>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.</p> <p>If family does not decline to bill, the private insurance will send EOB</p>	<ul style="list-style-type: none"> ✓ 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 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 claims processing system. When a member alert is added, it automatically notify Claims Processors that are processing EI claims to bypass primary insurance and process Medicaid primary.
EI Enrollment and Indicator	<p>A child must have an EI indicator on the enrollment file in order for an EI service to be reimbursed.</p> <p>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</p>	<ul style="list-style-type: none"> ✓ 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.

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	EI". This impacts submission of a clean claim.		
Care Coordination	Plan care coordinators should collaborate with the EI Service Coordinator	<ul style="list-style-type: none"> ✓ 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, member is assigned a CC. We outreach the service coordinator via telephone to provide contact information. This usually lends a message being left on a voice mail. The role of the CC at that point is to be available if any needs arise for the member. The CM then sets a task for 6 months out to follow up and assess for any needs.
Interpreter and Translation Services	Language assistance services, including but not limited to interpreter and translation services, are available free of charge.	<ul style="list-style-type: none"> ✓ 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 and it requires 3 days notice. If there are challenges in getting this set up, the CC can assist with issues. <u>Interpreter Services</u> Call Medallion 4.0 : 1.800.279.1878 Call CCC+: 866-261-0581
EI Specific Email Box	Specific email contacts for submission of IFSPs, Decline to Bill Forms, etc.	<ul style="list-style-type: none"> ✓ List specific email address 	Earlyinterventionservices@aetna.com for IFSP This email address is for IFSP's, but if decline to bill forms come through, they will be forwarded. Decline to bill should come with claims. They do have a separate email VAEIDeclinetoBillForm@AETNA.com



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<p>MCO Credentialing and Contracting</p>	<p>All EI providers must be credentialed and contracted by each MCO in order to provide services to members enrolled with the MCO.</p> <p>All EI providers must be certified by DBHDS and affiliated with a LLA prior to the MCO credentialing and contracting process.</p>	<ul style="list-style-type: none"> ✓ 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 	<p>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 NPES registry and be certified through the proper state required process.</p> <p>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.</p> <p>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.</p> <p>Upon completion of all required documents, an EI agreement is established.</p> <p>The timeline of the process should take no longer than 30 days.</p> <p>EI providers do not go through the normal contracting process as other Anthem network providers.</p> <p>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.</p> <p>Practitioners Name Primary address Gender Date of Birth Provider's NPI Tax ID # and name of Billing Agency or Individual NPI of Billing Entity</p>

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Malpractice Insurance for Educators	Providers must have malpractice insurance if they are not covered by the local system.	<ul style="list-style-type: none"> ✓ Requirements related to malpractice insurance for educators and non-traditional disciplines 	<p>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.</p>
IFSP	<p>IFSP must be on file with the MCO for the claim to be considered a Clean Claim.</p> <p>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.</p>	<ul style="list-style-type: none"> ✓ 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 	<ul style="list-style-type: none"> • 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. • Providers may email IFSPs in bulk. • 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 bernard.christmas@anthem.com who will send a secure email along with the designated email address EarlyInterventionServicesSupport@anthem.com.
Clean Claim	Clean claims must be paid within 14 days.	<ul style="list-style-type: none"> ✓ Process for non-clean claims, i.e., rejected or denied ✓ Process for handling non-clean claims with the provider 	<p>Anthem consider a clean claim as a request for payment for a service rendered by a provider that:</p> <ul style="list-style-type: none"> • Is submitted on time. • Is accurate. • 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.

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<p>Decline to Bill Form and EOB</p>	<p>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.</p> <p>If family does not decline to bill, the private insurance will send EOB</p>	<ul style="list-style-type: none"> ✓ 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 	<p>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 Maccess. 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 bernard.christmas@anthem.com</p> <p>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.</p>
<p>EI Enrollment and Indicator</p>	<p>A child must have an EI indicator on the enrollment file in order for an EI service to be reimbursed.</p> <p>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.</p>	<ul style="list-style-type: none"> ✓ Process to handle claims when the EI indicator is not on plan enrollment file 	<p>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.</p> <p>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 request are received from enrollment.</p>

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Care Coordination	Plan care coordinators should collaborate with the EI Service Coordinator	<p>MCOs shall provide a brief description for each point within the topic area</p> <ul style="list-style-type: none"> ✓ 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 	<p>Role of the Case 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.</p> <p>Case managers are assigned as needed per requests from member/family or EI Case managers. Anthem case managers work collaboratively with families as needed to have their needs met through MCO or EI.</p> <p>Contact is made by attempting 2 telephonic outreaches and one unable to reach letter before closing out the case. A new case can be established at any time the family, provider or EI Case manager determines a need for assistance. If member’s family consents to Case management/care coordination, outreach attempts must be made at least once every 30 days and case can be closed if family becomes Unable to reach.</p> <p>In addition CCC Plus will also have an EI coordinator assigned as well. 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.</p>
Interpreter and Translation Services	Language assistance services, including but not limited to interpreter and translation services, are available free of charge.	<ul style="list-style-type: none"> ✓ Process for providers, service coordinators, and/or families to access interpreter/translation services ✓ Timeframe for accessing interpreter/translation services 	<p>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.</p> <p>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.</p> <p>Anthems 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.</p> <p><u>Credentialing process consist of:</u> Interviews Language Proficiency Testing, Health History (for Onsite interpreters) Background Check and Credential Verifications Qualification Verifications Training Program</p>

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<p>El Specific Email Box</p>	<p>Specific email contacts for submission of IFSPs, Decline to Bill Forms, etc.</p>	<p>✓ List specific email address</p>	<p><u>Interpreter Services</u> Families/Serv Coordinators: 1-800-901-0020 Serv. Coordination w/ Care Coordination: 1-800-901-0020 option 6</p> <p>Currently, there is an existing email mailbox designated to receive IFSPs. EarlyInterventionServicesSupport@anthem.com</p> <p>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.</p> <p>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. See comment in Decline to Bill section? SEE REPLY</p> <p>Note: Decline to bill forms can also be emailed to bernard.christmas@anthm.com.</p>



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<p>MCO Credentialing and Contracting</p>	<p>All EI providers must be credentialed and contracted by each MCO in order to provide services to members enrolled with the MCO.</p> <p>All EI providers must be certified by DBHDS and affiliated with a LLA prior to the MCO credentialing and contracting process.</p>	<ul style="list-style-type: none"> ✓ 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 	<p>Onboarding/Credentialing Process- All EI providers are required to complete a Provider Information Form to be part of the Participating Provider Network for such services. Upon receipt of the Provider Information Form or roster, and contingent on initiation/existence of contract, MCC Network staff requests credentialing. MCC utilizes the CAQH Universal Practitioner Application in order to ease provider administrative burden and streamline the credentialing process. Once requested, Molina’s NCQA Accredited Credentialing Department access the provider’s CAQH application (or paper application for those providers who will not utilize CAQH) and starts the Primary Source Verification (PSV) process. Molina’s PSV process complies with NCQA, CMS, DMAS and Virginia State requirements. Molina confirms, through primary and secondary source verification that the providers meet all relevant requirements. Providers are considered by MCC Virginia’s Credentialing Committee. Notification of committee decision is sent to providers within 60 days. Notification of denials includes the reason for denial and details the provider’s appeal rights and process. Network providers are recertified no less frequently than every 36 months, in accordance with NCQA and DMAS requirements.</p> <p>Contracting Process- Once credentialing has been approved, MCC of VA will send contract documents to the provider reflecting negotiated reimbursement rates. The provider signs and returns the contract, which MCC of VA countersigns to execute. Process from submission of application to being contracted is approximately 60-90 days.</p> <p>Link to applications and forms - https://www.molinahealthcare.com/providers/va/medicaid/resources/forms.aspx</p> <p>Credentialing and contracting educators and other non-traditional disciplines-</p> <ul style="list-style-type: none"> • Credentialing- MCC VA has policies and procedures that outline the credentialing process for atypical and non-standard providers. We defer to NCQA, State and DMAS requirements in the development and execution of our credentialing policies and processes. • Contracting- Standard contracting processes apply as described above <p>Credentialing and contracting service coordinators</p> <ul style="list-style-type: none"> • Contracting- Standard contracting processes apply as described above. • Credentialing- The credentialing process for these providers follows the same process as other ancillary providers. <p>Handling of out-of- network providers- Out-of-network (OON) providers may submit an OON authorization request. If medical necessity criteria are met and there are no appropriately located in-network providers available, the Utilization Management department will approve the request at 100% of VA DMAS rates. If the provider insists upon higher rates, the Network team will work with the provider to negotiate rates for a Single Case Agreement.</p> <p>Providers may contact MCCVA-MCCVA-Provider@molinahealthcare.com for assistance with credentialing and contracting concerns.</p>

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Malpractice Insurance for Educators	Providers must have malpractice insurance if they are not covered by the local system.	<ul style="list-style-type: none"> ✓ Requirements related to malpractice insurance for educators and non-traditional disciplines 	Malpractice Insurance- Verification of malpractice insurance is a component of our credentialing process for all providers.
IFSP	<p>IFSP must be on file with the MCO for the claim to be considered a Clean Claim.</p> <p>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.</p>	<ul style="list-style-type: none"> ✓ 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 	<p>Method for LLAs to submit IFSP- IFSP is submitted via the Utilization Management fax for Medallion 4 and CCC Plus. Upon retrieval, it is then attached to the members case and tasked to the members Care Coordinator for review</p> <p>Submission process of multiple IFSPs- Same process applies to batch files. We ask that separate faxes be sent to ensure they are attached to the specific member.</p> <p>Confirmation of receipt- A fax confirmation is generated upon successful retrieval. 1.423.591.9127 is the local fax number 1.800.614.7934 is the toll free number</p>
Clean Claim	Clean claims must be paid within 14 days.	<ul style="list-style-type: none"> ✓ Process for non-clean claims, i.e., rejected or denied ✓ Process for handling non-clean claims with the provider 	Process for non-clean claims- Non-clean claims will reject and/or deny with a specific code to explain the reason why the claim cannot be finalized. The claim will need require resubmission to correct the coding/billing error.
Decline to Bill Form and EOB	<p>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.</p> <p>If family does not decline to bill, the private insurance will send EOB</p>	<ul style="list-style-type: none"> ✓ 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 	<p>Submission process for Decline to Bill Form- If the family chooses to decline access to their private insurance; Molina Complete Care of VA requires the Decline to Bill form be submitted with the bill for the services. Molina currently does not require a Decline to Bill form in order to process or pay the claim.</p> <p>Process for ensuring Claims Dept is aware of form- By having the family submit the form with the bill, our claims team is aware of their request at receipt of the bill.</p> <p>Process for handling claims when Decline to Bill or EOB is not on file- If the Decline to Bill or EOB are not on file, the EI claims are processed in the 14 day turn-around time, as per the contract.</p>
EI Enrollment and Indicator	<p>A child must have an EI indicator on the enrollment file in order for an EI service to be reimbursed.</p> <p>Due to timing of the enrollment file, if the provider bills prior to</p>	<ul style="list-style-type: none"> ✓ Process to handle claims when the EI indicator is not on plan enrollment file 	If the EI indicator is not present at the time of the claim processing, the claim will deny. If there is a question regarding a member's EI status, our Claims and Enrollment teams work collaboratively to verify the status of the member. The process used to verify member is EI prior to receipt of the next mid month 834 involves The Individual Family Service Plan used to identify EI members. This is uploaded to the members file.

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	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	<ul style="list-style-type: none"> ✓ 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 	<p>Role of the Care Coordinator – The role of the CC in this scenario is similar to any person with special needs. The CC reaches and conducts an initial screening, identifies that member’s needs, works with the providers (with the member’s guardians permission) to establish a plan of care (POC) that all parties involved agree upon. An ICT is held if requested by the provider or member’s rep.</p> <p>Process for exchanging information between CC and SC – The member’s assigned CC, routinely outreaches to the EI provider to obtain a copy of the IFSP and discuss any needs the member may have that would require intervention/coordination between the two coordinators. At that point, they can discuss needed frequency of contact based on the members needs/condition.</p> <p>Frequency of contact between coordinators – The CC will outreach upon initial assignment for collaboration in the member’s ICT meeting to formulate a POC. At that point they may discuss a needed frequency of contact based on the member’s needs, but at a minimum if there is a change in condition requiring a triggering assessment or upon routine reassessment (every 3 months on average)</p>
Interpreter and Translation Services	Language assistance services, including but not limited to interpreter and translation services, are available free of charge.	<ul style="list-style-type: none"> ✓ Process for providers, service coordinators, and/or families to access interpreter/translation services ✓ Timeframe for accessing interpreter/translation services 	<p>Process for providers, SC, and or families to access interpreter/translation services - For telephonic language line services, the CC will initiate contact to our contracted provider to request the needed translation services to place a call to the member/family. If Face-to-Face transition services are needed. The CC (and/or the member) can outreach to our member services line to facilitate that appointment.</p> <p>Timeframe for accessing interpreter/translation services – Telephonic translation services are available to members, families, and providers. Request submitted via translator app at least 24 hours in advanced to ensure a translator is available to assist. Translator is assigned to the case. For families, providers, and Service Coordinators, the request for a translator is sent to our Customer Service team and the same process is followed.</p> <p><u>Interpreter Services</u> Globo Interpretation Services 1-800-424-4518</p>
EI Specific Email Box	Specific email contacts for submission of IFSPs, Decline to Bill Forms, etc.	<ul style="list-style-type: none"> ✓ List specific email address 	We encourage providers and families to submit all documents through our fax lines below, however, the email box below is monitored daily.

TOPIC	DESCRIPTION	MCO PROCESS	MCO RESPONSE
		MCOs shall provide a brief description for each point within the topic area	
			<p>Fax Lines 1.423.591.9127 is the local fax number 1.800.614.7934 is the toll free number</p> <p>Gigi Edwards- germaine.edwards@molinahealthcare.com Pamela Aldridge-pamela.aldridge@molinahealthcare.com</p>




TOPIC	DESCRIPTION	MCO PROCESS	MCO RESPONSE
		MCOs shall provide a brief description for each point within the topic area	
MCO Credentialing and Contracting	<p>All EI providers must be credentialed and contracted by each MCO in order to provide services to members enrolled with the MCO.</p> <p>All EI providers must be certified by DBHDS and affiliated with a LLA prior to the MCO credentialing and contracting process.</p>	<ul style="list-style-type: none"> ✓ 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 	<p>Optima does not “credential” Early Intervention Providers, but rather a validation process that includes:</p> <ul style="list-style-type: none"> - Verification of licensure - Verification of Professional Liability Insurance - Verification of participation with DMAS - Certified as Early Intervention by DBHDS - Verification that EI provider is affiliated with a LLA – through the rosters <p>Optima requires that the EI provider contact Ashley Shell at ANBATES@Sentara.com, to obtain the application for completion. Once verification has been completed, the provider will be sent a contract for their review and execution. If the provider requesting credentialing and contracting is on the identified Local Lead Agency roster, the verification/contracting process takes approximately 30 to 60 days from the date of completed information. The process can take longer if outreach is needed to the Local Lead Agency on verification of affiliation, no longer than 90 days all together.</p> <p>Optima Health will require that all non-participating (any provider that is not contracted with the MCO) providers obtain an out of network authorization. Otherwise, claims will deny for not participating. Providers are considered non-participating until they are credentialed.</p>
Malpractice Insurance for Educators	Providers must have malpractice insurance if they are not covered by the local system.	<ul style="list-style-type: none"> ✓ Requirements related to malpractice insurance for 	Optima 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).

TOPIC	DESCRIPTION	MCO PROCESS	MCO RESPONSE
		<p style="text-align: center;">MCOs shall provide a brief description for each point within the topic area</p>	
		<p>educators and non-traditional disciplines</p>	
IFSP	<p>IFSP must be on file with the MCO for the claim to be considered a Clean Claim.</p> <p>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.</p>	<ul style="list-style-type: none"> ✓ 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 	<p>Optima prefers faxed IFSP individually. Confirmation of the fax is the sender’s response of successful transmission. 757-390-4449</p>
Clean Claim	<p>Clean claims must be paid within 14 days.</p>	<ul style="list-style-type: none"> ✓ Process for non-clean claims, i.e., rejected or denied ✓ Process for handling non-clean claims with the provider 	<p>Optima will reject non-clean claims and will not have the claim entered into the system for the following: Incorrect name, date of birth, or ID number. Optima will deny claims that are missing information, e.g., EOB from the primary carrier.</p>
Decline to Bill Form and EOB	<p>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.</p> <p>If family does not decline to bill, the private insurance will send EOB</p>	<ul style="list-style-type: none"> ✓ 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 	<p>Optima follows the guidance of the Infant and Toddler Connection provider manual, chapter 11, page 24, number 7, which states:</p> <p>“7. For children with Medicaid/FAMIS and commercial insurance coverage, providers must bill the commercial insurance first except in the following circumstances:</p> <ul style="list-style-type: none"> a. If a family has declined access to their private health/medical insurance for covered early intervention services, then the following steps may be taken to secure Medicaid reimbursement without billing the commercial insurance first: Check “yes” for box 11D on the CMS 1500 form and Complete and sign a Notification to the Department of Medical Assistance Services: Family Declining to Bill Private insurance form and attach it to the claim form.” <p>Optima houses the Decline to Bill form in their system.</p> <p>Optima’s claims policy and procedures describe the above steps and a copy of the form for reference to the claims processors as well as provider services department.</p> <p>If no EOB or Decline to Bill is submitted, Optima will deny the claim for missing EOB from the primary carrier.</p>

TOPIC	DESCRIPTION	MCO PROCESS	MCO RESPONSE
		<p>MCOs shall provide a brief description for each point within the topic area</p>	
<p>EI Enrollment and Indicator</p>	<p>A child must have an EI indicator on the enrollment file in order for an EI service to be reimbursed.</p> <p>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”.</p> <p>This impacts submission of a clean claim.</p>	<p>✓ Process to handle claims when the EI indicator is not on plan enrollment file</p>	<p>The claim is pended for a claims processor to ensure that there is no EOB and the member file to check for the Decline to Bill, the claims processor does not reach out to the provider. The provider is able to do a reconsideration with appropriate attachments/information.</p> <p>Optima will reimburse the T and G codes and do not have an edit to prevent payment.</p>
<p>Care Coordination</p>	<p>Plan care coordinators should collaborate with the EI Service Coordinator</p>	<p>✓ Role of the care coordinator</p> <p>✓ Process for exchanging information between care coordinator and service coordinator</p> <p>✓ Frequency of contact between coordinators, i.e., timeframe for initial contact and ongoing contact</p>	<p>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.</p> <p>Process for exchanging info: Clinical Contacts: Optima Family Care Phone 1-800-503-5828, Email OFC_CBCM@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.</p> <p>For OHCC: Care Coordination Fax (Medallion) Phone 1-866-546-7924 Fax 757-390-4449; Care Coordination (CCC Plus) Fax 1-844-552-7508. Email: OHCC_LTSS_TC@sentara.com (Team Coordinator’s)</p> <p>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.</p>

TOPIC	DESCRIPTION	MCO PROCESS	MCO RESPONSE
Interpreter and Translation Services	Language assistance services, including but not limited to interpreter and translation services, are available free of charge.	<p style="text-align: center;">MCOs shall provide a brief description for each point within the topic area</p> <ul style="list-style-type: none"> ✓ Process for providers, service coordinators, and/or families to access interpreter/translation services ✓ Timeframe for accessing interpreter/translation services 	<p>Interpreter appointments are scheduled immediately when Optima Staff call our Language vendor to schedule. An appointment can be set up in various ways: A provider or member would call member services phone number for language services, care coordination can schedule the interpreter or an e-mail can be sent to the languagehelp@sentara.com e-mail. We would 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.</p> <p>Members: 1-855-687-6260 (TTY 711) Providers: 1-800-229-8822 languagehelp@sentara.com</p>
EI Specific Email Box	Specific email contacts for submission of IFSPs, Decline to Bill Forms, etc.	<ul style="list-style-type: none"> ✓ List specific email address 	<p>There is not a specific EI e-mail for Optima Health. IFSP should be faxed to Optima and the Decline to Bill should be sent as indicated in the Infant and Toddler Connection Provider Manual.</p>



TOPIC	DESCRIPTION	MCO PROCESS	MCO RESPONSE
<p>MCO Credentialing and Contracting</p>	<p>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.</p> <p>All EI providers must be certified by DBHDS and affiliated with a LLA prior to the MCO credentialing and contracting process.</p>	<p>MCOs shall provide a brief description for each point within the topic area</p> <ul style="list-style-type: none"> ✓ 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 	<p>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've also embedded an FAQ document about credentialing that outlines the CAQH process and contracting process.</p> <p>https://www.uhcprovider.com/en/resource-library/Join-Our-Network.html or call</p> <div style="text-align: center;">  <p>Credentialing-FAQs.pdf</p> </div> <p>For Behavioral Health provider types visit:</p> <p>https://www.providerexpress.com/content/ope-provexpr/us/en/our-network/jon.html or call (877) 614-0484.</p> <p>Credentialing Application guide:</p> <p>https://www.providerexpress.com/content/dam/ope-provexpr/us/pdfs/ourNetworkMain/jon/ProvGuide-CredApp.pdf</p> <p>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.</p> <p>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</p>

TOPIC	DESCRIPTION	MCO PROCESS	MCO RESPONSE
		<p style="text-align: center;">MCOs shall provide a brief description for each point within the topic area</p>	
			<p>will be made to obtain a W-9 and validate DBHS certification. Once outstanding information is received, UHC will create an out of network provider ID, load the claim, and complete claims processing.</p>
<p>Malpractice Insurance for Educators</p>	<p>Providers must have malpractice insurance if they are not covered by the local system.</p>	<ul style="list-style-type: none"> ✓ Requirements related to malpractice insurance for educators and non-traditional disciplines 	<p>UHC would expect that the individual practitioner or their group affiliation would have appropriate insurance in place.</p>
<p>IFSP</p>	<p>IFSP must be on file with the MCO for the claim to be considered a Clean Claim.</p> <p>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.</p>	<ul style="list-style-type: none"> ✓ 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 	<ul style="list-style-type: none"> • UHC receives IFSPs via secure fax (these convert to PDFs to a secured fax email) at the following numbers: <ul style="list-style-type: none"> ○ CCC Plus 855-770-7088 ○ Medallion 4.0 844-207-2913 • 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 Coordinator will introduce his or herself 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.
<p>Clean Claim</p>	<p>Clean claims must be paid within 14 days.</p>	<ul style="list-style-type: none"> ✓ Process for non-clean claims, i.e., rejected or denied ✓ Process for handling non-clean claims with the provider 	<ul style="list-style-type: none"> • 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.
<p>Decline to Bill Form and EOB</p>	<p>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.</p> <p>If family does not decline to bill, the private insurance will send EOB</p>	<ul style="list-style-type: none"> ✓ 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 	<p>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.</p>

TOPIC	DESCRIPTION	MCO PROCESS	MCO RESPONSE
		MCOs shall provide a brief description for each point within the topic area	
EI Enrollment and Indicator	<p>A child must have an EI indicator on the enrollment file in order for an EI service to be reimbursed.</p> <p>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.</p>	<ul style="list-style-type: none"> ✓ Process to handle claims when the EI indicator is not on plan enrollment file 	<p>UHC claims processing platform has the ability to evaluate the age of the member in conjunction with the EI code to make a determination if EI reimbursement is allowed. Additionally, we conduct post payment reviews to ensure appropriate payments of claims for aid category and IFSP approved services.</p>
Care Coordination	<p>Plan care coordinators should collaborate with the EI Service Coordinator</p>	<ul style="list-style-type: none"> ✓ 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 	<p>Our expectation is for Care Coordinators to contact the EI provider within 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 Coordinator 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 member to coordinate with members Intensive Care Team (ICT) in order to join in participation.</p>
Interpreter and Translation Services	<p>Language assistance services, including but not limited to interpreter and translation services, are available free of charge.</p>	<ul style="list-style-type: none"> ✓ Process for providers, service coordinators, and/or families to access interpreter/translation services ✓ Timeframe for accessing interpreter/translation services 	<p>Language interpreter services can be initiated by contacting our provider service centers who will then facilitate appoint setting with our vendor, Language Line.</p> <p>Medallion Provider Services 844-284-0146</p> <p>CCC Plus Provider Services 877-843-4366</p> <p>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.</p>

TOPIC	DESCRIPTION	MCO PROCESS	MCO RESPONSE
EI Specific Email Box	Specific email contacts for submission of IFSPs, Decline to Bill Forms, etc.	<p>✓ List specific email address</p>	<p>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:</p> <ul style="list-style-type: none"> • CCC Plus 855-770-7088 • Medallion 4.0 844-207-2913 <p>If a specific email is required for additional clinical concerns</p> <ul style="list-style-type: none"> • Medallion 4 – Shane Ashby – shane_ashby@uhc.com • CCC Plus Saffie Quarshie – saffie_quarshie@uhc.com <p>All billing concerns should be first be addressed with Provider Services (numbers above).</p> <p>For escalated issues after contacting provider services, submit email to:</p> <ul style="list-style-type: none"> • UHC Community Plan of VA EI & HCBS Provider mailbox: va_hcbs_pr@uhc.com



TOPIC	DESCRIPTION	MCO PROCESS	MCO RESPONSE
		MCOs shall provide a brief description for each point within the topic area	
MCO Credentialing and Contracting	<p>All EI providers must be credentialed and contracted by each MCO in order to provide services to members enrolled with the MCO.</p> <p>All EI providers must be certified by DBHDS and affiliated with a LLA prior to the MCO credentialing and contracting process.</p>	<ul style="list-style-type: none"> ✓ 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 	<p>The Credentialing Department shall validate and/or confirm information related to the credentialing and/or recredentialing of a prospective or participating practitioner by utilizing the primary source or its designee(s) pursuant to requirements of VP, the Department of Medical Assistant Services (DMAS), the National Committee for Quality Assurance (NCQA), CMS (Center for Medicaid and Medicare Services) and/or any other applicable regulatory body. Information relied upon shall be current and valid at the time of the Credentialing Committee’s decision. An application will not be presented to the Credentialing Committee that is signed or dated more than 180 days prior to credentialing committee review.</p> <p>Verifications shall be conducted within 180 calendar days from the attestation date. The organization conducts timely verification of information to ensure that practitioners have the legal authority and relevant training and experience to provide quality care. Virginia Premier does utilize CAQH for application purposes only. The practitioner is solely responsible for enrolling with CAQH and the maintenance of the information required. The credentialing process does not differ for educators or non-traditional disciplines (guidance provide by the EI/CCC= Workgroup). Virginia Premier has set internal guidelines to include guidance from DMAS when credentialing service coordinators.</p>
Malpractice Insurance for Educators	<p>Providers must have malpractice insurance if they are not covered by the local system.</p>	<ul style="list-style-type: none"> ✓ Requirements related to malpractice insurance for educators and non-traditional disciplines 	<p>Credentialing: Malpractice History must be verified within 180 calendar days of the attestation (signature) date on the application. May obtain past five years of history of malpractice settlements from the malpractice carrier or must query NPDB or a copy of the current malpractice policy face sheet.</p>
IFSP	<p>IFSP must be on file with the MCO for the claim to be considered a Clean Claim.</p>	<ul style="list-style-type: none"> ✓ Method for LLAs to submit IFSP (fax, email) with the specific contact information 	<p>Providers can send individual IFSPs via fax (800-827-7192); once it is received at VA Premier a fax receipt is sent. Providers could also choose to email their IFSPs to (DLA_ACL-MedallionCMReports@sentara.com).</p>

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.	<ul style="list-style-type: none"> ✓ Submission process of multiple IFSPs, i.e., batch or individual files ✓ Confirmation of receipt of IFSP 	Once an IFSP is received by either route it is forwarded to a case manager who will then call to confirm receipt of the IFSP to the service providers providing contact information for further care coordination.
Clean Claim	Clean claims must be paid within 14 days.	<ul style="list-style-type: none"> ✓ Process for non-clean claims, i.e., rejected or denied ✓ Process for handling non-clean claims with the provider 	Claims process all clean claims within 14Ds of receipt. Unclean claims are either denied, rejected up front or provider is outreached to remediate in order to capture elements needed to process
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	<ul style="list-style-type: none"> ✓ 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 and EOB forms do not affect our care coordination efforts.
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.	<ul style="list-style-type: none"> ✓ Process to handle claims when the EI indicator is not on plan enrollment file 	All EI claims are processed as received by the system (auto-adjudication) EI Enrollment Indicator. Our claims system will utilize the members age (< 3) to qualify them for EI services.
Care Coordination	Plan care coordinators should collaborate with the EI Service Coordinator	<ul style="list-style-type: none"> ✓ Role of the care coordinator ✓ Process for exchanging information between care coordinator and service coordinator ✓ Frequency of contact between coordinators, i.e., timeframe for 	VA Premier care coordinators facilitate ongoing collaboration between the service providers, the families, specialists and the plan. Upon receipt of the IFSP, the care coordinator will review the IFSP for any needs and contact the service provider assigned. The initial contact to the service provider will be within 5 days of receiving the IFSP providing contact information and to discuss available benefits for the family, family needs along with the frequency for ongoing contact to best meet the healthcare goals of the member. The care coordinator will outreach the family with-in 14 days to offer the same support to the family directly.

TOPIC	DESCRIPTION	MCO PROCESS	MCO RESPONSE
		<p>MCOs shall provide a brief description for each point within the topic area</p>	
		<p>initial contact and ongoing contact</p>	
<p>Interpreter and Translation Services</p>	<p>Language assistance services, including but not limited to interpreter and translation services, are available free of charge.</p>	<ul style="list-style-type: none"> ✓ Process for providers, service coordinators, and/or families to access interpreter/translation services ✓ Timeframe for accessing interpreter/translation services 	<p>Virginia Premier provides telephonic interpretation services free of charge in 240 languages through a third-party interpretation vendor. We also employ an internal staff of bi-lingual agents to provide Spanish translation services in house as well as utilizing the Virginia Relay Service for Deaf and Hard of Hearing. Upon request, members are immediately conferenced in with an interpreter for their preferred language. The interpreter remains on the line with the member and Virginia Premier representative until all questions and concerns have been resolved. Should follow up calls be needed, Virginia Premier representative would utilize translation services for all subsequent calls to ensure member's requests are fully satisfied. When it comes to interpreters/translators for actual appointments, CM is contacted by member services or provider to provide the Translation Request Form to the provider and the provider submits to The Language Group for interpreter service request for <u>in office only</u>. We have a different process for Telehealth Interpreter request during the current Pandemic. Member Services owns the Language Line Process and will assist with providing the member an interpreter for Telehealth. <u>Interpreter Services:</u> The Language Group: 1-844-DIAL-SLL (1-844-342-5755)</p>
<p>El Specific Email Box</p>	<p>Specific email contacts for submission of IFSPs, Decline to Bill Forms, etc.</p>	<ul style="list-style-type: none"> ✓ List specific email address 	<p>Please use this email for these reports... DLA_ACL-MedallionCMReports@sentara.com</p>