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MEDICAID MEMO

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CCC Plus Waiver Provider Manual Update, Chapters II and IV; New Appendix E, Extraordinary Care Guide; and DMAS-97A/B and DMAS-99 Forms Update

The purpose of this provider manual update memorandum is to inform providers of CCC Plus Waiver services of updates to the CCC Plus Waiver Provider Manual and forms.

In addition to changes to conform with regulations and recent bulletins on LRI policies and Services Facilitators requirements, the following substantive updates have been made:

Chapter II of the CCC Plus Waiver Provider Manual:

1. Addition of sections “Signatures by an Advance Practice Registered Nurse or Nurse Practitioner” and “Person-Centeredness”;

2. Private Duty Nursing licensure requirements that had been removed in error; and

3. Clarifications for Criminal Background Checks and Agency-Directed Personal Care Aide training requirements.

Chapter IV of the CCC Plus Waiver Provider Manual:

1. Consumer-Directed Requirements: Using the DMAS-95 Addendum or DMAS-95B for all new Employers of Record; justification for 30 or 60 day routine visits; Reassessment Visit activities; Management Training documentation; and describing involuntary disenrollment reasons;

2. Requiring the personal care agency/Services Facilitator to document the time per task on the Plan of Care for personal care;

3. PERS: Prohibition on billing for member self-installation and annual documentation of the DMAS-100A;

4. Additional clarifications on developing the Plan of Care annually; critical incidents; Start of Care date (when the nurse/Services Facilitator performs the initial assessment for CCC Plus Waiver services before any aide starts services); who can and cannot sign certain forms; and not requiring a composite score on the respite Plan of Care.

The Extraordinary Care Guide is being added to the CCC Plus Waiver Provider Manual as Appendix E.

The DMAS-97A/B Plan of Care form has been updated with the following:

1. Boxes to check if the Plan of Care is for personal care/assistance, respite, or LRI personal care/assistance;

2. More room and details to explain the required backup plan; and

3. Addition of questions and instructions for LRI Plans of Care.

The DMAS-99, Community-Based Care Member Assessment, has been updated with the following:

1. Removal of the Start of Care Date field;

2. Addition of questions related to the member's care and support system, including primary care visits and whether the member has a LRI as an aide/attendant; and

3. Additional questions on the frequency of routine visits and critical incident reporting.

It is required that providers adopt the new versions of the DMAS-97A/B and DMAS-99 no later than October 1, 2026. Use of older versions of these forms after this date will result in denial of service authorization requests.

The provider manual and forms can be found on the Medicaid Enterprise System (MES) website.

To avoid disruption to claims payment through FFS and the MCOs providers must periodically

check the DMAS provider portal, also known as the Provider Services Solution (PRSS), to ensure that the provider's enrollment, contact information, and license information is up to date, for all of the provider's respective service locations. Under federal rules, MCOs and DMAS are prohibited from paying claims to network providers who are not enrolled in PRSS. Additional information is provided on the MCO Provider Network Resources webpage and includes links to resources, tutorials and contact information to reach Gainwell with any provider enrollment or revalidation related questions. Dental providers should continue to enroll directly through the DMAS Dental Benefits Administrator, DentaQuest.

PROVIDER CONTACT INFORMATION & RESOURCES

Virginia Medicaid Web Portal **Automated Response System (ARS)** Member eligibility, claims status, payment status, service limits, service authorization status, and remittance advice.	https://vamedicaid.dmas.virginia.gov/
Medicall (Audio Response System) Member eligibility, claims status, payment status, service limits, service authorization status, and remittance advice.	1-800-884-9730 or 1-800-772-9996
Provider Appeals DMAS launched an appeals portal in 2021. You can use this portal to file appeals and track the status of your appeals. Visit the website listed for appeal resources and to register for the portal.	https://www.dmas.virginia.gov/appeals/

Managed Care Programs

Cardinal Care Managed Care and Program of All-Inclusive Care for the Elderly (PACE). In order to be reimbursed for services provided to a managed care enrolled individual, providers must follow their respective contract with the managed care plan/PACE provider. The managed care plan may utilize different guidelines than those described for Medicaid fee-for-service individuals.

Cardinal Care Managed Care	https://www.virginiamanagedcare.com/en
PACE	Program of All-inclusive Care
Provider Enrollment	In-State: 804-270-5105 Out of State Toll Free: 888-829-5373 Email: VAMedicaidProviderEnrollment@gainwelltechnologies.com
Provider HELPLINE Monday–Friday 8:00 a.m.-5:00 p.m. For provider use only, have Medicaid Provider ID Number available.	1-804-786-6273 1-800-552-8627

Aetna Better Health of Virginia	https://www.aetnabetterhealth.com/virginia/providers/index.html Prior Auth requests can be faxed or called to the following numbers: Phone: 1-800-279-1878 Med4/ FAMIS Fax: 1-866-669-2454 CCC Plus Fax: 1-855-661-1828
Anthem HealthKeepers Plus	http://www.anthem.com/ Prior Authorization information can be found here: https://providers.anthem.com/virginia-provider/resources/prior-authorization-requirements Call Provider Services: 1-800-901-0020 TTY: 711 Fax medical prior authorization request forms to: Inpatient fax: 1-866-920-4095 Outpatient fax: 1-800-964-3627 LTSS fax: 1-844-864-7853
Humana Healthy Horizons Provider Services Call Center	https://provider.humana.com/medicaid/virginia-medicaid Prior Authorization information can be found here: https://provider.humana.com/medicaid/virginia-medicaid/prior-authorization Submit request via Availaty porta, phone or fax: Phone requests: 1-855-223-9868 or 1-844-881-4482 (TTY: 711) Fax complete form to: 1-877-486-2621.
Sentara Community Plan	1-800-881-2166 https://www.sentarahealthplans.com/providers Submit authorizations via portal or phone Portal information can be found here: https://www.sentarahealthplans.com/en/providers/claims-authorizations/authorizations Phone request: 1-757-552-7474 or 1-800-229-8822
United Healthcare	www.uhcprovider.com/ 1-844-284-0146 To notify UHC or request a medical prior authorization: Portal information can be found here: UHCprovider.com/priorauth or call provider services 1-844-284-0146
Acentra Health Behavioral Health and Medical Service Authorizations	https://vamedicaid.dmas.virginia.gov/sa 1-804-622-8900
Dental Provider DentaQuest	1-888-912-3456
Fee-for-Service (POS) Prime Therapeutics	https://www.virginiamedicaidpharmacyservices.com/ 1-800-932-6648