Virginia Premier Elite Plus Provider Orientation

Our Mission

Virginia Premier Health Plan (VPHP) is a managed care organization that is part of the VCU Health brand.

By focusing only on Virginia, we take a person-centered approach on the accessibility of care for our members throughout the Commonwealth.

Who we are

- A subsidiary of the Virginia Commonwealth University Health System
- A Medicaid Managed Care Organization (MCO) with approximately 190,000 members
- We serve Medallion 3.0/FAMIS Plus, FAMIS, FAMIS Moms, Commonwealth Coordinated Care and Commonwealth Coordinated Care Plus recipients.
- We serve over 100 independent cities and counties in the Commonwealth.
- Operational since 1995
- 2nd largest Medicaid MCO in the state of Virginia

Our Service Area

Southwest | Roanoke/Alleghany | Western/Charlottesville | Northern/Winchester | Central | Tidewater

With offices across the state, we strongly believe in supporting our communities by providing employment opportunities to local residents.

Plan Summary

Product Line	Elite Individual	Elite Kids	CompleteCare	Advantage Elite	Elite Plus	ARTS
Applicable Dates	Current	Current	Ending 12/31/17	1/1/17	8/1/17	4/1/17
Eligible Members	Medicaid, Medallion 3.0	FAMIS, FAMIS PLUS, FAMIS MOMS	Qualified Dual Eligible Enrollees (Medicare Parts A + B) (Full Medicaid Beneficiaries)	D-SNP (Dual Special Needs Plan) 21 and older Full Medicare and Medicaid benefits	MLTSS (Managed Long Term Services and Supports) Full Medicare and full Medicaid benefits Medicaid LTSS Facility or HCBS Waiver Aged, Blind and Disabled	Elite Individual members CompleteCare members Elite Plus members
Benefits Offered	Our Medicaid Benefits Carve Out benefits administered through DMAS	Our Medicaid Benefits Carve Out benefits administered through DMAS	Medicaid Benefits Medicare Benefits	Medicare parts A, B, and D benefits Supplemental Benefits(vision, dental, hearing)	Medicaid Benefits HCBS Waiver benefits Choice of Medicare Benefits through us or other MCO	Addictive, Substance related, and co-occurring conditions

What is Virginia Premier Elite Plus?

- A new statewide Medicaid managed care program that begins in August 2017
- Participation is required for qualifying populations
- Uses an integrated delivery model that includes medical services, behavioral health services and long-term services and supports (LTSS)
- Includes care coordination and person-centered care with an interdisciplinary team approach

VA Premier Health Plan, Inc.

Member Benefits & Eligibility

Who are Virginia Premier Elite Plus Members?

- 65 and older
- Adults and children living with disabilities
- Individuals living in Nursing Facilities (NFs)
- Individuals in the Tech Assisted Waiver
- Individuals in the EDCD Waiver
- Individuals in the three waivers serving the DD populations for their acute and primary services
- CCC and Medallion 3.0 ABD populations transitioned to CCC Plus

Benefits

Your patients benefit from:

- Person-centered supports and coordination with an assigned Care Coordinator
- Increased involvement in their personal health care
- Access to a network of specialists providing preventative, rehabilitative, and community-based care
- Programs targeted to address their individual health care needs

Member Benefits Include

Services under Medicare	Services under Elite Plus (Medicaid)
Inpatient Hospital Care (Medical and Psychiatric)	Medicare co-payments
Outpatient Care (Medical and Psychiatric)	Hospital and Skilled Nursing – when Medicare benefits are exhausted
Physician and Specialist Services	Long Term Nursing Facility Care (Custodial)
X-ray, Lab and Diagnostic Tests	Home and Community based Waiver Services
Skilled Nursing Facility Care	Community Behavioral Health Services (Carved out until 1/1/18)
Home Health Care	Medicare non-covered services
Prescription Drugs	
Durable Medical Equipment	

Vendor Contact Information

Labs (Except for CLIA approved labs on the in-office lab list)	**Lab Corp:** 800-873-7251 **Solstas Labs:** 888-200-4775
Routine Vision	**VSP:** 800-877-7195
Dental	**DentaQuest (Smiles for Children):** 844-822-8115
Pharmacy Retail and Specialty	**Envision:** 855-872-0005 **Pharmacy Help Desk:** 855-408-0010
Radiology (CT, CTA, CCTA, MRI, PET scans, Nuclear Cardiology Imaging)	**NIA:** 800-642-7578 or www.RadMD.com
Behavioral Health and Substance Use	Beacon Health Options For BH call: 844-513-4951 For ARTS (fax): 888-237-3997 **www.beaconhealthoptions.com**

Verifying Member Eligibility

Eligibility should be verified monthly and prior to rendering services.

Verify eligibility using the following options:

- Our Interactive Voice Response (IVR) System at 877-719-7536
- Calling our Member Services at 877-719-7536
- Using our online Portal (www.vapremier.com)

Member Services Department

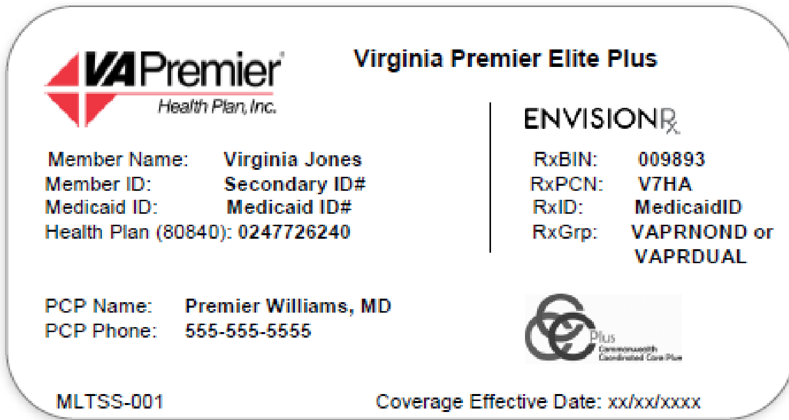
Hours of Operation: 8:00 am to 8:00 pm, Monday through Friday

We offer Spanish/Bilingual Representatives

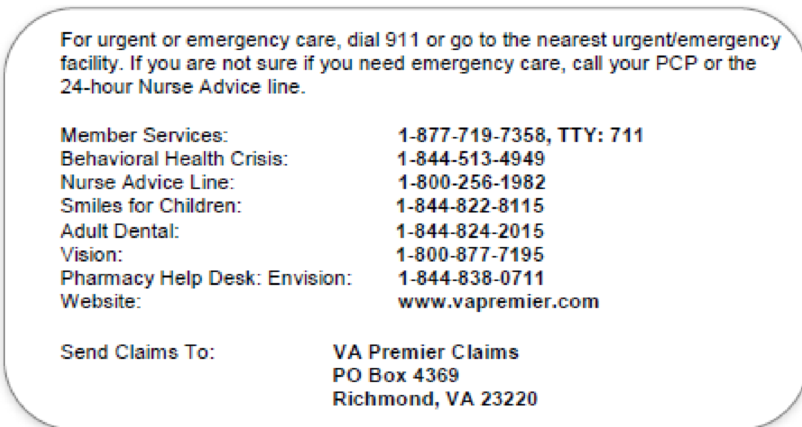
We assist providers and members with:

- Benefit Questions
- PCP Selection and Provider Participation
- Eligibility Verification
- Member Orientation and Education
- Claims Inquiries
- Member address changes and ID card requests

Member ID Cards



ID Card - front



ID Card - back

Transportation

We own and operate our transportation service, and we provide it free of charge to our members.

To schedule transportation for an appointment, the member, the member's caregiver or the provider are required to call Member Services at: 1-877-719-7358.

Please note:

- A 72-hour prior notification is required to schedule transportation.
- Must be a Virginia Premier Elite Plus member with valid ID card.
- Appointments are scheduled based upon availability of service.
- Members should not be referred to transportation service if the patient is in labor or is having a medical emergency.

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Claims and Filing Guidelines

Claims Department

Our Claims department is located in Richmond, VA.

On average, 99% of claims are processed within 30 days of receipt (Medicaid standard is 90%).

We strongly encourage providers to consider filing claims electronically which will ensure:

- Claims are submitted timely
- Timely filing denials are reduced
- And reduced claims administrative costs.

A complete listing of all EDI Clearinghouses that we accept can be found on our website at **www.vapremier.com**.

Providers may receive payments and remits electronically. In order to receive EFT, visit our website, click on Claims, and select the Forms tab to download the EFT forms. To receive ERA's please contact your clearinghouse directly.

Electronic Trading Partners

Clearinghouse	Contact Information	Virginia Premier Elite Plus Payer ID
Availity	800-282-4548 www.Availity.com	All Claim Types: VPEP1
McKesson (Relay Health)	800-981-8601 www.mckesson.com	837 Professional: 1244 837 Institutional: 4573

We strongly encourage providers to consider filing electronic claims which will reduce claims submission timeframes and increase account receivables payment for services rendered. Providers who wish to submit claims electronically must complete all necessary documents related to the process. Please allow at least thirty (30) business days to complete the process. Providers are encouraged to contact their claims clearinghouses to confirm that they are set up to submit claims electronically. Submitting claims without full clearance will cause processing delays.

Virginia Premier (MLTSS)
Attention: EDI Enrollment Team
Fax: 804-819-5174

Claims Processing

Primary Care Providers	Transportation
Virginia Premier Elite Plus PO Box 4369 Richmond, VA 23220-0207	Virginia Premier Elite Plus PO Box 4369 Richmond, VA 23220-5287
Hospital Claims	**Claims Appeals**
Virginia Premier Elite Plus PO Box 4369 Richmond, VA 23220-0120	Virginia Premier Elite Plus PO Box 4208 Richmond, VA 23220-0307

- Virginia Premier cannot accept copied version of claim forms
- All claims must be submitted on original red and white claim forms
- Handwritten claims are subject to be rejected

Claims Policies

Timely Filing: Participating providers are required to submit their claims to us within the timeframe established in their provider contract (**180 days** is the standard timeframe for most providers). Claims not submitted in accordance with the timely filing guidelines will be denied.

Claim Appeals: Appeals for denied claims must be submitted to us within **60 days** of the original date of the denial. Should a claims processing error be attributable to Virginia Premier, providers have up to 365 days after receipt of payment to appeal.

Claim Forms: Provider, ancillary and OP services should be submitted to us on the CMS-1500. Hospital and Facility claims should be submitted to us on the UB04 form. Providers must use original claim forms, copied or reproduced claim forms will not be accepted.

Pre-Authorization: For services that required an authorization, that number should be submitted to us in Box 23 on the CMS-1500 form. Failure to submit a pre-authorization number in Box 23 (if required) may result in your claim being denied.

Coding: Providers should always refer to the most current versions of the CPT and ICD10 coding manuals when billing services.

Coordination of Benefits

- CMS developed a model national contract, called the Coordination of Benefits Agreement (COBA), which standardizes the way that eligibility and Medicare claims payment information within a claims crossover context is exchanged.

- For members with another primary carrier, all Explanation of Benefits (EOB's) from the primary carrier will be required with claims submission for Virginia Premier to process secondary claims.

Coordination of Benefits

Scenario		Primary Carrier	Secondary Carrier	Claim Submission Info	Services on Claim	Dual? Non Dual?	Adjudication Results	Authorization Requirements
1	a	Virginia Premier Medicare D-SNP	Virginia Premier Elite Plus MCD	Claim is submitted to Virginia Premier. Coordination of benefits will happen automatically.	Medicare Covered Services Only	Dual	D-SNP pays Elite Plus denies for non-covered	If NPA list/rules say auth is required, D-SNP will require auth
	b				Medicaid Covered Services Only		D-SNP denies for non-covered Elite Plus covers	If NPA list/rules say auth is required, Elite Plus will require auth
	c				Medicare and Medicaid		Coordinate Benefits between our D-SNP and our Elite Plus	If primary payer allows, Elite Plus won't require an auth
2	a	Another Medicare MCO	Virginia Premier Elite Plus MCD	Claim is submitted to Medicare MCO. Provider will be required to submit primary EOB with claim to Virginia Premier to process Medicaid claim.	Medicare Covered Services Only	Dual	Elite Plus denies for non-covered	N/A - not covered
	b				Medicaid Covered Services Only		Elite Plus covers without requiring primary payer EOB	If NPA list/rules say auth is required, Elite Plus will require auth
	c				Medicare and Medicaid		Elite Plus: If primary payer EOB is present, coordinate benefits Elite Plus: If no primary payer EOB, deny for no primary EOB	If primary payer allows, Elite Plus won't require an auth
3	a	Medicare FFS	Virginia Premier Elite Plus MCD	Claim is submitted to CMS. Coordination of benefits will be automatic.	Medicare Covered Services Only	Dual	Elite Plus denies for non-covered	N/A - not covered
	b				Medicaid Covered Services Only		Elite Plus covers without requiring primary payer EOB	If NPA list/rules say auth is required, Elite Plus will require auth
	c				Medicare and Medicaid		Elite Plus: If primary payer EOB is present, coordinate benefits Elite Plus: If no primary payer EOB, deny for no primary EOB	If primary payer allows, Elite Plus won't require an auth

Appeals Process

Providers may appeal a claim outcome by completing a Claim Adjustment/ Appeal Request Form which can be found online at www.vapremier.com under the Claims tab. Appeals for denied claims must be sent or faxed to us within 60 days of the original denial date on the EOB.

Claims denied for non-medical reasons (duplicate claim, CPT/ICD 10 denial) should be appealed to:

Virginia Premier Elite Plus
Claims Appeals department
PO Box 4208
Richmond, VA 23220

Claims denied for medical reasons should be appealed with clinical documentation to:

Virginia Premier Elite Plus
Medical Management Grievances and Appeals
PO Box 5244
Richmond, VA 23220

Claims Customer Service

Please contact Claims Customer Service if you have claims issues. If you have issues that are not resolved to your satisfaction then please contact your local Provider Service Representative.

To reach the Claims Customer Service department, call:
1-877-719-7358

Claims Customer Service can help with questions related to claims:

- Verify claim status
- Research claims issues and denials

Claim status and claim line detail can be viewed online through the Virginia Premier Elite Plus portal

VA Premier Health Plan, Inc.

Medical Management

Emergency Services

- In the case an unexpected medical condition, Virginia Premier Elite Plus members are instructed to contact their PCP for medical advice – time permitting. If the member is unable to reach their PCP or the situation arises after business hours, members are instructed to call the **Nurse Advice Line at 800-256-1982.** The PCP or Nurse Advice Line will assess the member's medical condition and instruct the member on obtaining appropriate medical care.
- Members may also be directed to participating Urgent Care Centers for treatment of non-life threatening emergencies.

Referrals & Authorizations

- Members are required to visit participating providers for care and services
- We require providers to obtain pre-authorizations from the health plan for certain services, procedures and all hospital admissions. Failure to obtain pre-authorization from us for services will result in a denial of payment and the provider will be held responsible for the services.
- Members may be referred to an out-of-network specialist with prior authorization from Virginia Premier Elite Plus under specific circumstances (please refer to the Virginia Premier Elite Plus Provider Manual)
- We do **not** require a referral from the PCP in order for the member to obtain specialist services
- We maintain a list of OP procedures that do NOT require pre-authorization. The list can be found at **www.vapremier.com** located under Medical Management and Utilization Management

Pre-Authorization Requirements

Pre-authorization is required for services including, but not limited to, the following:

- All inpatient hospitalizations (and extensions beyond original LOS)
- All 23-hour observation admissions (excluding OB observations)
- Chemotherapy
- Cosmetic Surgery (e.g., Keolid and Scar Revisions, Varicose Veins, Mammoplasty, Reduction and Augmentation)
- Durable Medical Equipment (DME) (Includes Orthotics and Prosthetics when applicable)
- Enteral Nutrition and Total Prenatal Nutrition only available
- Home Health Services
- Hyperbolic Therapy
- Infusion Services
- Organ Transplant and Surgery
- Outpatient surgical procedures performed in a hospital/ambulatory surgical setting
- Out-of-network referrals
- Pain Management (e.g., joint injection, spinal cord stimulator)
- Rehab Therapy (e.g., Physical Therapy, Occupational Therapy)
- Radiological (non-routine imaging such as MRI, CT, MRA, Nuclear scan, PET, etc.) This is prior authorization through NIA www.RadMD.com or 800-642-7578
- Intensity-modulated Radiation Therapy
- Specialty Drugs

How to Obtain Authorization

To obtain a referral or authorization select one of the following:

a. Enter the request online through our Virginia Premier Elite Plus Portal at www.vapremier.com

b. Fax an IP/OP Authorization Form, which can be found at www.vapremier.com, to us at 800-827-7192

c. Call Virginia Premier at 888-251-3063 and select the option 3

How to Obtain Authorization

For Behavioral Health (BH) Authorizations:

Please **CALL** Beacon Health Options at **844-513-4951** for the following services (note: Beacon accepts requests for BH Authorizations via telephone only)

a. Inpatient Psychiatric Admissions
b. BH Partial Hospital Program Requests
c. BH Intensive Outpatient Program Requests

For Addiction and Recovery Treatment Services (ARTS) Authorizations:

Please **FAX** all ARTS requests, including the DMAS service authorization form to Beacon Health Options at **888-237-3997**

- **Beginning 1/1/2018, Beacon will also be receiving Community Mental Health Rehabilitation Services (CMHRS) authorization requests. Please FAX these requests to 888-237-3997.**

Radiology Procedures

National Imaging Associates, Inc. (NIA) provides our radiology network management services. NIA will provide utilization management services for outpatient diagnostic radiological services (i.e. CT, CTA, CCTA, MRI, MRA, PET scan) and Nuclear Cardiology imaging procedures.

You may obtain prior authorization through the NIA website (**www.RadMD.com)** or through the NIA call center at 800-642-7578.

Routine x-rays do not require prior authorization. If you are unsure whether your procedure requires an authorization, please confirm by using the NPA Search Tool at www.vapremier.com.

Admissions and Concurrent Review

All inpatient hospital stays will be reviewed using InterQual guidelines to determine medical necessity. At the time of the review for emergency admission, we'll determine if the admission was medically necessary. Pending availability of clinical data, determinations will be made within 24 hours with notification to providers within 24 hours of making the decision.

Concurrent or continued stay reviews are performed on all non-DRG hospitalized patients and DRG admissions that exceed length of stay (LOS). Medical record review will determine if the assigned LOS remains appropriate or if it should be modified given significant changes to the patient's condition. Continued stay decisions will be communicated by telephone to the appropriate contact in the facility's Medical Management department and to the attending physician's office

Medical Necessity Appeals

The Medical Necessity Appeals process is a mechanism through which a member's representative, attending physician/provider or facility can request a review of a non-certification decision by Virginia Premier Elite Plus. Appeals will be considered if received within **sixty (60)** days of the decision.

There are **2 types** of Medical Necessity Appeals:

- Expedited Appeal: May be required when a denial is made by us prior to, or during the course of treatment. If the member/or provider feels that our decision is not acceptable, a request to appeal should be faxed to Medical Management. Once the appeal is received, we will select a physician to review the case. This physician will be responsible for returning a decision within seventy-two (72) hours of receiving the information.

- Standard Appeal: Standard appeals are generally made after services have been rendered. All documentation and/or medical records should be faxed or mailed to:

Virginia Premier Elite Plus
Medical Management Grievances and Appeals
PO Box 5244
Richmond, VA 23220
Fax Number: 804-649-9647

Model of Care

The Model of Care (MOC) is a specific outline of care coordination processes designed and regulated to provide the best possible care and services for members participating in a designated program.

Virginia Premier's Care Coordination Model provides integration and coordination of medical and behavioral health to all members via the Care Team.

The Care Team is comprised of:

- Nurses,
- Social Workers
- Care Coordinators
- Community Outreach Workers
- Regional Transition Coordinator (RTC)

Supported by Disease Managers, Health Educators, Medical Directors, Long-Term Service and Support Coordinators, and Pharmacists, the member-based Care Team provides continuity for members as they move across and in between levels of care along the health care continuum.

Model of Care

Upon enrollment, Virginia Premier contacts all members to complete a Health Assessment. The assessment covers:

- Social
- Functional
- Behavioral
- Cognitive
- Long-Term Services & Support Review
- Wellness
- Preventative Health Screenings

From there, a unique member-centric care plan is developed based on the member's individual needs, in conjunction with the member's caregiver and Providers.

Model of Care

Member Care Plans are comprehensive, holistic, member-driven, and developed progressively over time.

The Interdisciplinary Care Team (ICT) is made up of the member, caregiver, Providers, and the Primary Care Coordinator.

The (ICT) meets regularly to discuss progress and update the Individualized Care Plan(ICP).

The ICT integrates member's needs, proactively identifying issues and addressing barriers. Utilizing the Care Team's expertise and resources needed to maintain optimal health status.

Disease Management Programs

Our Disease Management programs are designed to help members manage their chronic conditions. Our programs are based on nationally accepted guidelines, support the physician-patient relationship and are available at no additional cost to the members.

We provide Disease Management programs for the following conditions:

- Asthma
- Heart Disease
- Heart Failure
- COPD
- Bipolar Disorder
- Schizophrenia
- Chronic Kidney Disease (Stage 3-dialysis)
- Diabetes
- Cancer (Breast, Lung, Colorectral and Blood)

Call Medical Management for referrals or comments about our programs.

Medical Outreach

We recognize the importance and role of health education in the prevention of illness which is why we use a team of Medical Outreach Representatives to reach out to our members who may have specific health and/or social service needs.

All pregnant members are enrolled in our Healthy Heartbeats program with regular home follow-up visits. This program offers personalized prenatal care from conception to delivery to insure the best pregnancy and delivery experience for our members.

OB providers are encouraged to complete and fax the Virginia Premier Elite Plus OB Registration form after a member's first prenatal visit. This enables us to quickly enroll members into our Healthy Heartbeats program and target those at risk who may need additional interventions.

Healthy Heartbeats

Healthy Heartbeats is our prenatal care program that includes pregnant members from conception through birth.

Goal:

To improve health outcomes of mothers and infants by:

- Creating a partnership among the member, Obstetrician, and Virginia Premier
- Decreasing low birth weight and premature births
- Increasing early and consistent prenatal and postpartum care
  - Improving nutritional status of mothers and infants
  - Increasing knowledge of the importance of prenatal care
  - Ensuring member has postpartum visit within 21-56 days

Program Components

- Prenatal Doctor Visits
- Prenatal Classes
- WIC Enrollment
- Home and Outreach Visits
- Case Management
- Promote breastfeeding
- Provide breast pumps
- Incentive Awards

Watch Me Grow!

Watch Me Grow! is an early and periodic screening, diagnosis and treatment program offered to patients from birth to 20 years of age.

Medical Outreach representatives work with parents/guardians to encourage wellness checks and immunizations are done timely and at recommended ages:

- 1 month
- 2 months
- 4 months
- 6 months
- 9 months
- 12 months
- 15 months
- 18 months
- 24 months

Each time the patient (b-24mos) goes to the pediatrician for a wellness visit and to obtain immunizations, a tracking sheet is checked off and after all visits are completed, a gift card will be sent.

VA Premier Health Plan, Inc.

Pharmacy Benefits

Pharmacy Benefits

Covered prescription and over-the-counter (OTC) drugs are administered through Envision Pharmaceutical Services (Envision Rx).

Formularies can be downloaded on our website at www.vapremier.com.

Prescriptions or OTC drugs that require special authorization procedures shall have a response within 24 hours, in most cases.

For pharmacy and prescription related questions, please call Envision Rx at 855-872-0005.

Pharmacy Benefits

We cover the following over-the-counter drugs and supplies with a prescription from a participating provider:

Medication by Therapy Class	
Antacids	Laxatives and Cathartics
Antidiarrheal	Niacin
Antifungals – topical and vaginal	Nicotine gum and lozenge
Antihistamine/decongestant	Nicotine patch
Antihistamines	NSAID
Antiulcer	Oral analgesics/antipyretics
Calcium supplements	Prenatal Vitamins
Cough and cold products	Proton Pump Inhibitors
Decongestants	Salicylates and related drugs
Ferrous sulfate	Scabicides and pediculicides
Glucosamine/Chondroitin	Topical corticosteroid
Ketotifen	Vitamins and Minerals

Pharmacy Authorizations

Medications requiring prior authorization and excluded medications desired for the appropriate management of a patient may be requested by:

- Using *PromptPA* Portal found on our website at www.vapremier.com
- Calling Envision at 855-872-0005
- Faxing a completed authorization form to 866-250-5178 Authorization forms can be found at www.vapremier.com

VA Premier Health Plan, Inc.

Provider Services

Provider Services

Dedicated Provider Services Representatives conduct regular site visits to network providers and act as a liaison between the provider and Virginia Premier Elite Plus. They assist providers with issues, answer questions and conduct educational in-services, as needed.

Conduct quarterly educational meetings between Participating Providers and Virginia Premier.

Providers can find helpful resources on our website, **www.vapremier.com** such as:

- Claims
- Provider Notifications and Newsletters
- Forms
- The Virginia Premier Elite Plus Formulary
- FAQ's and much more

Provider Access Standards

Service	Virginia Premier Elite Plus Standard
Appointment for health assessment, EPSDT, general physical exams, first examinations (preventative)	Scheduled within 30 days of request
Initial health screens for new members under EPSDT regulations (preventative)	Scheduled within 30 days of request and completed within 3 months of enrollment date
Appointment for routine primary care and specialty care (non-urgent care for symptomatic conditions)	Scheduled within 14 calendar days of request
Routine primary care	Scheduled within 30 calendar days of the enrollee's request. Excludes appointments for routine physicals, regularly scheduled visits to monitor a chronic condition if the schedule calls for visits less frequently than once every 30 days, for routine specialty care like dermatology
Average wait time in PCP office	No more than 30 minutes following appointment time
Specialist appointment (non-urgent referral)	Scheduled within 30 calendar days, or sooner, of the request
Initial assessment	Scheduled within 10 days

Provider Access Standards (cont.)

Service	Virginia Premier Elite Plus Standard
Maternity Care – 1st Trimester Maternity Care – 2nd Trimester Maternity Care – 3rd Trimester High Risk Appointments	Scheduled within 14 calendar days Scheduled within 7 calendar days Scheduled within 3 business days Scheduled within 3 business days
Urgent Appointments	Provided within 24 hours of enrollee's request
Emergent Appointments	Immediately and/or referred to emergency facility
Access to after-hours care	Answering service/machine provides instructions on how to access care
Appointment for Behavioral Health/ Substance Abuse Services	• Care for non-life threatening emergency within 6 hours • Urgent Care within 48 hours • Routine visits within 10 business days • Follow-up visit after inpatient admission within seven (7) calendar days
Answering Telephone Hold	Within two (2) to four (4) rings, 30 seconds or less
Virginia Premier Elite Plus 24-hour Medical Help Line	Practitioners shall advise members to contact the Virginia Premier Elite Plus Nurse Advice Line for medical concerns prior to seeking services in the emergency room

Provider Service Representatives

Provider Services Dedicated Line:
1-877-719-7358 Option 4, 1

LTSS Dedicated Line:
1-877-719-7358 Option 4, 2

Your local Provider Service Representative is:

<insert name>

<insert phone/email>

Compliance

Fraud and Abuse Policy

It's our policy to report all occurrences of fraudulent behavior to the Department of Medical Assistance Services (DMAS) within **48** hours of initiation of an internal investigation, or notification by an external organization. Examples of fraudulent and/or abusive practices (not limited too):

- Submission of claims for services that were not performed
- Up-coding or billing for more complex procedures than were actually performed
- Providers being financially rewarded for referrals to an individual or company
- Capitated providers limiting their risk by restricting care
- Unbundling services that were included in a contract or discounted rate
- Balance billing Medicaid recipients (Providers may NOT bill members for missed appointments per DMAS and CMS)
- Billing for an unlicensed provider under an in-network credentialed providers name

False Claims Act

Virginia Fraud Against Taxpayers Act: The state false claims act allows the state Attorney General to bring suit against a provider, member, or other entity of suspected fraud and abuse. A provider, supplier or entity found in violation may be fined and/or excluded from participation in federal and state health care programs.

Federal False Claims Act Liability: Violations of the False Claims Act can result in civil monetary penalties ranging from $5,000 to $10,000 for each false claim submitted and repayment of three times the amount of damages sustained by the U.S. government. A provider, supplier or entity found in violation may also be excluded from participation in federal health care programs including Medicaid.

False Claims Act (cont.)

The Federal False Claims Act, 31 U.S.C. 3279-3733

The False Claims Act ("FCA") is a set of Federal statutes that cover fraud involving any Federally-funded contract or program, including Medicare and Medicaid. The FCA establishes liability for any person who knowingly:

- Presents or causes to be presented, a false claim for reimbursement by a Federal health care program, including Medicare or Medicaid;
- Makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim;
- Repays less than what is owed to the government;
- Makes, uses, or causes to be used, a false record or statement material to reduce or avoid repayment to the government; and/or
- Conspires to defraud the Federal government through one of the actions listed above.
- The term "knowingly" is defined to mean that a person, with respect to information:
    - Has actual knowledge of information in the claim
    - Acts in deliberate ignorance of the truth or falsity of the information in a claim; or
    - Acts in reckless disregard of the truth or falsity of the information in a claim.

Examples of Fraud

Examples of Medicaid Fraud Committed by Providers (but not limited to):

- Participating in kickbacks (payments or other types of compensation made in order to influence and gain profit from an individual or company).
- Forgery of a physician's signature
- Billing for medical services that were not given

Examples of Medicaid Fraud Committed by Members (but not limited to):

- Loaning/sharing ID cards to obtain health care services or prescriptions
- "Doctor shopping" and excessive trips to the ER for control substances (narcotics).
- Falsifying information on application in order to receive benefits

Reporting Fraud

Qui Tam Whistleblower Provisions, 31 U.S.C. 3730(h)

To encourage individuals to come forward and report misconduct involving false claims, the Federal Claims Act includes a "qui tam" or whistleblower provision. This provision essentially allows any person with actual knowledge of allegedly false claims to the government to file a lawsuit on behalf of the U.S. Government.

Qui Tam Procedure

The whistleblower/relator must file his or her lawsuit on behalf of the Government in Federal district court. The lawsuit will be filed "under seal", meaning that the lawsuit is kept confidential while the Government reviews and investigates the allegations contained in the lawsuit and decides how to proceed. If the Government determines that the lawsuit has merit and decides to intervene, the prosecution of the lawsuit will be directed by the U.S. Department of Justice. If the Government decides not to intervene, the whistleblower can continue with the lawsuit on his or her own.

Reporting Fraud (cont.)

Award to Qui Tam Whistleblowers

If the lawsuit is successful, and provided certain legal requirements are met, the qui tam relator or whistleblower may receive an award ranging from 15 to 30 percent of the amount recovered.

No Retaliation:

The Federal False Claims Act grants protection from retaliation for filing a lawsuit or assisting in a False Claims Act action. Providers should have a policy that prohibits any type of retaliation against those who report concerns. This policy works in conjunction with the Federal False Claims Act, and the Virginia Fraud Against Taxpayers Act in protecting those who report misconduct.

Quality of Care Reporting

Virginia Premier requires providers to comply with mandatory reporting requirements, such as:

- **Sentinel Events**

  Defined by the Joint Commission as an unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof.

- **Critical Incidents**

  Defined as any "validated" as a Critical Incident in accordance with DMAS reporting requirement for VA 3.1.

- **Serious Reportable Events**

  These include (but are not limited to): Death (unexpected, suicide or homicide), Falls (resulting in death, injury requiring hospitalization, injury that will result in permanent loss of function), Infectious disease outbreak, and all elopement in which a member with a documented cognitive deficit is missing for 24 hours or more

Reports should be made to the appropriate Protective Agency and to Virginia Premier within 24 hours of the event by calling 877-719-7358 option 1-3-1-1 or completing our Critical Incident Report Form located on our website

Quality of Care Reporting training is mandatory and can be completed on our website www.vapremier.com

A Word of Thanks

We recognize you're providing a needed service to your community, and we sincerely appreciate what you do.