VirginiaPremier™

Provider Newsletter

Fall 2021

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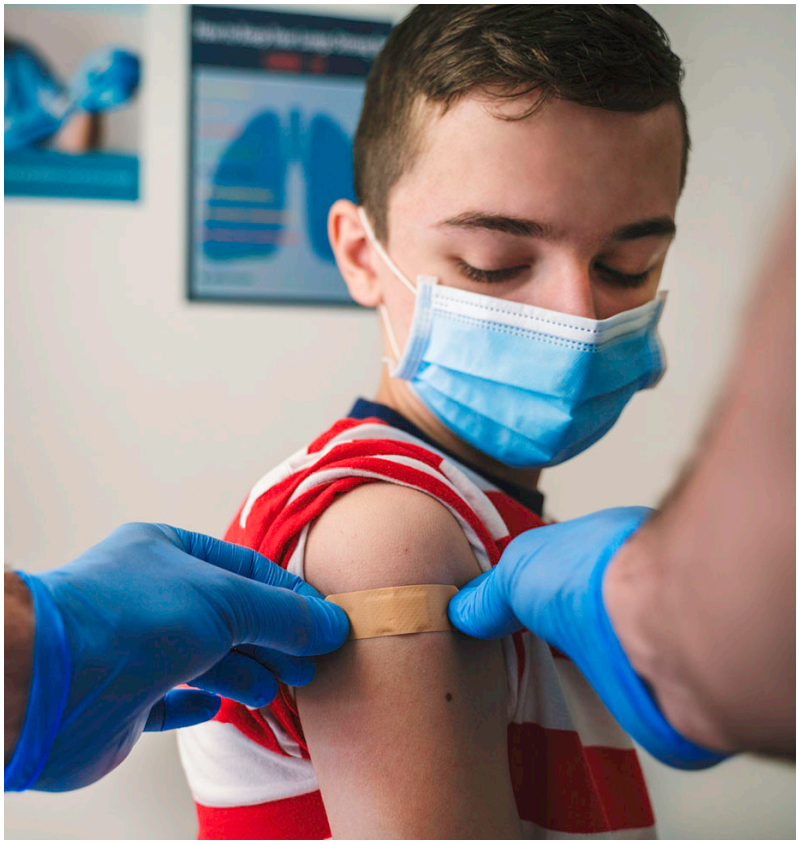
Table of Contents

Incentives Available Through December 31 for Qualifying Vaccines



To encourage full vaccination among our young members, Virginia Premier is announcing a new incentive program that benefits you and your patients. From September 1, 2021, through December 31, 2021, we will increase the administration fee for certain child and adolescent vaccines from $11 to $15. In addition, our members can earn up to three $50 Walmart gift cards. Only participants in the Virginia Vaccines for Children program are eligible.

The incentives apply to many vaccines for children and adolescents including those for COVID-19, meningitis, human papillomavirus (HPV) and more. **Click here** for a complete list of the vaccines eligible for the incentives.

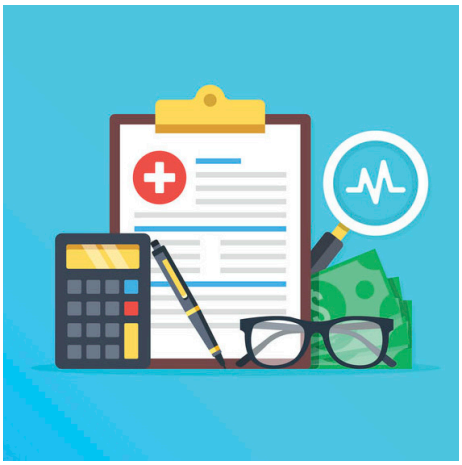
Connecting Members with COVID Vaccines

We appreciate everything you do to help our members stay well. If you have any questions, please contact your Virginia Premier representative at 1-800-727-7536.

As a health care provider, you understand how important immunizations are to saving lives. We have contacted our members by phone, email and mail to offer them the vaccine. In addition, we have hosted in-house vaccine clinics.

If you need assistance in getting our members vaccinated, please reach out to your representative. We are here to help. View our **COVID-19 resources** to learn more.

Virginia Premier Medical Policy Updates



The following **medical payment guidelines** have been updated.

- abdominoplasty, lipectomy and panniculectomy
- stretching devices
- real-time remote heart monitor
- apheresis

The medical payment guideline on infant home apnea monitors has been retired. Providers can access the Virginia Premier medical payment guidelines on our **website**.

What Behavioral Health Providers Need to Know: Project BRAVO Phase 2

As you know, the Virginia Department of Behavioral Health and Developmental Services (DBHDS) and the Department of Medical Assistance Services (DMAS) are implementing changes to improve the availability of behavioral health services to Medicaid members. As you prepare for Project BRAVO (Behavioral Health Redesign for Access, Value and Outcomes), Virginia Premier wants you to be aware of the following updates.

Services Begin on December 1, 2021

Multisystemic Therapy (MST): MST is an evidence-based, intensive home- and community-based treatment for youth with significant clinical impairment in disruptive behavior, mood and/or substance use. MST has a large evidence base that has demonstrated robust clinical and systems outcomes, including reducing the need for inpatient hospitalization, residential treatment and other out-of-home placements for youth. MST involves significant training, supervision, monitoring and fidelity practices.

- MST is a new service for youth; it does not replace any existing services.
- MST will use procedure code H2033. Modifiers are to be determined.

Functional Family Therapy (FFT): FFT is a short-term, evidence-based treatment program for at-risk and justice-involved youth who have been referred for behavioral or emotional problems by the juvenile justice, mental health and school or child welfare systems. FFT has a large evidence base that has demonstrated robust clinical and systems outcomes, including reducing the need for inpatient hospitalization, residential treatment and other out-of-home placements for youth. FFT involves significant training, supervision, monitoring and fidelity practices.

- FFT is a new service for youth; it does not replace any existing services.
- FFT will use the procedure code H0036. Modifiers are to be determined.

Mobile Crisis: Mobile Crisis involves brief, focused assessment, and treatment that reviews precipitating events leading to a crisis, the history of the crisis, a mental status exam and disposition planning. Service components include: 1) mobilizing resources to defuse the crisis and restore safety, 2) implementing interventions that minimize the potential for psychological trauma and prevent further deterioration of functioning and 3) facilitating linkage to other supports and services to avert inpatient hospitalization.

- Mobile Crisis will replace, and serve as an enhancement to, the current crisis intervention [H0036] service for youth and adults.
- Mobile Crisis will serve both youth and adults.
- Mobile Crisis will use procedure code H2011. Modifiers are to be determined.

Community Stabilization: Community Stabilization provides short-term services designed to support continued de-escalation and crisis stabilization following initial crisis intervention/response that are provided to individuals in their natural environment.

- Community Stabilization will replace, and serve as an enhancement to, the current crisis stabilization [H2019] service for youth and adults.
- Community Stabilization will serve both youth and adults.
- Community Stabilization will use the procedure code S9482. Modifiers are to be determined.

23-Hour Observation: 23-Hour Observation provides short-term, walk-in psychiatric/substance related crisis evaluation and brief intervention services. This service supports individuals who are experiencing an abrupt and substantial change in behavior noted by severe impairment of functioning typically associated with a precipitating situation or a marked increase in personal distress. Services are accessible 24/7. Individuals participate in the service for up to 23 hours in a residential crisis stabilization unit.

- 23-Hour Observation is a new service and will use procedure code S9485.
- 23-Hour Observation will serve both youth and adults.
- 23-Hour Observation is a service provided within a licensed facility setting.

Residential Crisis Stabilization: Residential Crisis Stabilization units provide short-term, 24/7, facility-based psychiatric/substance related crisis evaluation and brief intervention services to support individuals experiencing an abrupt and substantial change in behavior noted by severe impairment of functioning typically associated with a precipitating situation or a marked increase in personal distress.

- Residential Crisis Stabilization will replace and serve as an enhancement of the current crisis stabilization [H2019] service for youth and adults.
- Residential Crisis Stabilization will serve both youth and adults.
- Residential Crisis Stabilization will use procedure code H2018.

Review the **DMAS Provider Manual** to learn more.

Contract Reminder: Maintaining Health Care Professional Liability Insurance

Remember, the Virginia Premier contractual agreement specifies that providers shall maintain health care professional liability insurance per occurrence of not less than the amount set forth in the Virginia Code § 8.01-581.15 and three times such amount in the annual aggregate. They must also provide COI coverage upon request and will notify us within five (5) days of reduction or cancellation or material change in coverage.

Authorization Requirements and Workflow for ABA

Beginning **December 1, 2021**, the following applied behavior analysis (ABA) codes will require authorization: 97153, 97155, 97154, 97158, 97156, 97157, 0362T and 0373T.

To obtain real-time confirmation of all authorization requirements, providers should refer to the Virginia Premier **Prior Authorization Tool**.

To fax authorizations for Project BRAVO Services, please use the following:

- Crisis Services, MH-PHP, MH-IOP: 804-799-5105
- All Medallion 4.0 MHS other than above: 804-343-0304
- All MLTSS other than above: (804)799-5104

DBHDS CONNECT Web Portal Goes Live November 3, 2021

Effective October 18, the Office of Licensing no longer accepts any paper service modifications, renewal applications, or initial applications. The Web Portal allows providers to electronically submit all required paperwork such as initial applications, license renewal applications, service modifications, corrective action plans (CAPs) and variances. More information can be found on the **DBHDS website**.

Please note: Provider licensure for services will impact ability to provide and be reimbursed for those services beginning December 1, 2021.

Critical Incident Reporting to Virginia Premier

Providers must report Critical Incidents to Virginia Premier within 24 hours of learning about the event. To report, call (804) 819-5703, ext. 38008, or email **criticalincident@virginiapremier.com**.

A critical incident is any incident that threatens or impacts the well-being of the member. Critical incidents include, but are not limited to, the following: medication errors, severe injury or fall, theft, suspected physical or mental abuse or neglect, financial exploitation and death of a member.

2020 Quality Improvement (QI) Activities and Programs

Our quality program is committed to providing members with care that is safe, culturally sensitive and compliant with National Committee for Quality Assurance (NCQA) standards. We are also committed to improving the health and resources found within the communities we serve by participating in public health initiatives at the national, state and local levels.

You can find our Quality Improvement (QI) program on our **website**. You can also request a copy by calling 1-800-727-7536.

Major Accomplishments in 2020

Demonstrating commitment to quality, the Medallion and Commonwealth Coordinated Care Plus (CCC Plus) Quality Improvement Programs highlight key accomplishments for 2020:

- Maintained NCQA Commendable Accreditation Status; NCQA Star Rating 3.5
- The Healthcare Effectiveness Data and Information Set (HEDIS®) On-site Medical Record Review scored 100%
- External Quality Review Organization Data Submission: No deficiencies
- 2020 Performance Measure Validation Audit: No deficiencies
- Completed 127 Quality Management Reviews (QMR) and recognized, by the Department of Medical Assistance Services (DMAS), as having "Best Practice" in the state

2021 Quality Program's Core Indicators

- NCQA Accreditation (includes Clinical and Service Medallion 4.0 HEDIS Measures)

- Achieve 90% or greater on NCQA Internal Audits
- Member Experience Rating
- Member Grievances and Appeals
- Quality of Care/Service Indicators
- Member Safety Program
- Culturally & Linguistically Appropriate Services (CLAS)

2021 Quality Goals

- Achieve NCQA Star Rating of 5.0 or greater for Medicaid health plans
- Achieve first in the Commonwealth and Top 30 Best Medicaid Plans National NCQA Rating
- Achieve the 75th Percentile or Greater for Targeted HEDIS Performance Withhold Program (PWP) Measures
- Improve the Member Experience through Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Survey Education for Membership, Providers, and Internal Staff

References: National Committee for Quality Assurance. (2020). NCQA health insurance plan ratings 2020-2021: Summary Report. Retrieved from **https://reportcards.ncqa.org**

Virginia Premier Prior Authorization List

Virginia Premier continues to update the Prior Authorization List on a regular basis. Providers are encouraged to visit the Prior Authorization List website prior to submitting a request for authorization in order to determine the authorization requirements for their request.

The Prior Authorization List is available on our **website**.

Clinical Guidelines for Authorization of Advanced Imaging

National Imaging Associates have updated the medical necessity guidelines for advanced imaging. The **new guidelines** will be effective January 1, 2021.

Understanding Magellan's Initial Review and Peer-to-Peer Process

Virginia Premier values our partnership with Magellan Healthcare and their commitment to providing the best care to our members. To help you advocate for your patients, Magellan is sharing tips to help you make the most of an initial review and prepare for a peer-to-peer discussion. See below to learn more:

Making the Most of Magellan Healthcare's Initial Review

Denials and appeals can be lengthy and costly processes in terms of outcomes and costs, not to mention the time they can take. The good news is that 90% of all denials are preventable. Preventive action is an effective approach that can lead to more timely review, greater patient satisfaction, and a better experience for you. Consider the following recommendations from Magellan:

1. Look out for faxes from Magellan Healthcare. In these communications, they will tell you exactly what is required for approval of a study.
2. Complete the **Magellan Healthcare Conservative Treatment History form**. It will help you answer clinical questions and document recent conservative treatment efforts, which is information needed for most requests.
3. Participate in the initial review. During the initial review, make sure that all information requested by Magellan Healthcare via fax is provided to Magellan. When a history of conservative treatment is needed, submit a completed Magellan Healthcare Conservative Treatment History form, which is specifically designed to capture required information.

Magellan Healthcare's Peer-to-Peer Process

In addition, Magellan also wants to help providers know what to expect during a peer-to-peer discussion. A peer-to-peer discussion may be initiated at any time during the prior-authorization process by calling 1-800-642-7578.

- A peer-to-peer discussion may not be necessary if the requested clinical documentation is sent prior to contacting Magellan Healthcare.
- A peer-to-peer may be initiated by the office staff (non-clinical) but the case discussion must be conducted by a licensed clinician from the provider's office.
- Plan to call a few minutes prior to licensed clinician's availability to provide necessary case information.
- Identifying member information will need to be provided before the call is transferred to an appropriate clinical reviewer that is specific to the case and modality.
- The case will then be discussed, including any additional information that may be necessary for the

case to meet medical necessity. This discussion may be for consultation purposes only if the re-open timeframe has expired or a re-review is not available.

- Verbal clarification of clinical information from the medical records that were submitted may be discussed during the peer-to-peer. Examples include clarification of conflicting information in the notes or typographical errors.
- Any new information necessary to approve the request must be submitted in writing by uploading on our online portal **RadMD.com** or faxing to 1-800-784-6864 before a new determination can be made.
- If the case cannot be approved at the time of the peer-to-peer, the ordering/rendering provider is asked to follow the appeal instructions provided within the denial notification.

If you would like to provide feedback regarding a peer-to-peer discussion, please contact your dedicated Magellan Healthcare provider relations manager.

Monitoring for Over- and Under-Utilization Improves Member Outcomes

Virginia Premier carefully monitors the over- and under-utilization of services provided to our members to ensure appropriate, cost-effective care. Over-utilization is monitored by analyzing trends among key performance indicators that demonstrate effective utilization of resources.

Using licensed health care staff and board-certified physicians, Virginia Premier can ensure that decisions reflect a member-centric philosophy that incorporates evidence-based practice. While monitoring over-utilization is important, under-utilization can be equally hazardous to both members' overall health and total health care costs. When members do not receive the care they need, when they need it, they may relapse and require a higher level of service to treat their condition.

Virginia Premier monitors both routine and preventive services for utilization trends and will follow up with members when utilization is noted to be low.

Evaluating New Technology Helps Providers Deliver Excellent Care

An ever-changing health care market presents new rules, regulations, trends and best practices and the need to adapt to new technology. Our review committee evaluates new technology for its usefulness in the health care space. Our Healthcare Quality and Utilization Management (HQUM) committee appraises the inclusion of new technology and the new application of existing technology in its benefits plan, including medical and behavioral health care procedures, pharmaceuticals, and devices.

While reviewing new technology, the HQUM committee evaluates the utilization, potential for harm, cost, clinical trials, and peer-reviewed medical literature. It's all part of our commitment to helping you provide the best care possible.

Locating Up-to-Date Clinical Practice Guidelines

Virginia Premier adopts and disseminates clinical practice guidelines relevant to our membership for the provision of health, acute, and chronic medical services, and for preventive and non-preventive behavioral health services. All adopted clinical or preventive health practice guidelines are:

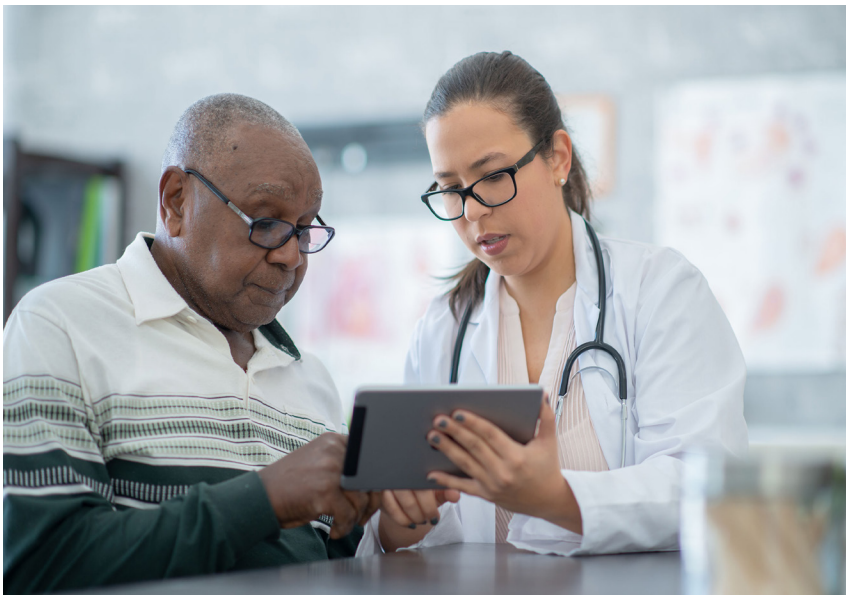
- Based on valid and reliable clinical evidence, or a consensus of health care professionals in the respective field
- Reviewed in consultation with contracting health care professionals
- Reviewed and updated periodically, a minimum once every two years
- Disseminated to practitioners and members annually, at a minimum,
- Developed to consider the needs of members
- Provided as a basis for utilization decisions, member education and service coverage.

Every two years, physicians who serve on the Virginia Premier Healthcare Quality and Utilization Management (HQUM) Committee review and approve updated guidelines. For 2021, there are 15 clinical practice guidelines. To view the 2021 clinical practice guidelines:

- Visit **VirginiaPremier.com** and type "guidelines" in the search feature on the home page.
- Request a copy by email, fax, or mail.

Alerts are sent throughout the year if clinical practice guidelines change. For questions about changes, call provider relations, 804-968-1529 (TTY: 711).

Close Quality Gaps in Care by December 31



Virginia Premier recently implemented a campaign to close quality gaps in care. We improve health every day by making it easy for our members, your patients, to get the care they need, when they need it. We are calling members who may have care gaps that can be closed if they are seen in your office by **December 31, 2021**.

We are encouraging our members to make an appointment with your office. Please make every effort to accommodate these important appointment requests on or before **December 31, 2021,** to achieve optimal outcomes.

Here is what you can do:

1. **Visit our value-based care website for tips on closing care gaps for the following measures:**
    - Child and Adolescent Well-Care Visits (WCV)
    - Childhood Immunization Status (CIS)
    - Comprehensive Diabetes Care (CDC)
    - Follow-Up after Emergency Department Visit for Alcohol And Other Drug Abuse Or Dependence (FUA)
    - Follow-up after Emergency Department Visit for Mental Illness (FUM)
    - Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET)
    - Prenatal and Postpartum Care (PPC)
    - Refer Virginia Premier members who reside in Hampton Roads and have Diabetic Eye Gaps to Integrated EyeCare Group (IEG) for mobile and in-office visits.
2. **In-office visits OR monthly drive-through events**
    - **Contact**: 1-757-502-7603 (phone), 1-757-226-8013 (fax), **carecoordinator@iegva.com** (email) or **www.integratedeyecaregroup.com**
    - **Location:** Virginia Eye Consultants, 241 Corporate Blvd, Norfolk, VA 23502
    - **Date**: December 16, 2021: 4 to 5:30 pm
3. **Share this information with your clinical care teams.**

NOTE: Reviewing, faxing and/or mailing medical records as part of the annual HEDIS process takes time and effort. Virginia Premier is committed to optimizing this process whenever possible and would like to remind you that granting limited, secure EMR access to our quality staff can help alleviate these burdens by allowing us to directly retrieve relevant HEDIS medical record information. For more information about this process and the benefits associated with it, please contact us at **VPHPHEDIS@virginiapremier.com** *with the subject line "EMR Access Request" and we will outreach to you with more information.*

Understanding the CAHPS Survey and Improving the Patient Experience

The Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey is a patient experience survey that asks consumers to report on and evaluate their experiences with health plans, providers, and health care facilities. This survey is performed once a year on a sub-set of members to gauge their experiences. The survey questions cover aspects of care for which the patient is the best and only source of information. We use CAHPS surveys to assess the quality of the health plan and develop sound strategies that health plans and providers can collaboratively use to improve patients' experiences with care.

Beginning in 2022, the weight of CAHPS measures (from a Medicare Stars perspective) will increase to four times the weight of previous years – only further indicating the importance of the member's experience. To continue to improve the member's experience, below are a few tips on ways that you as a medical group can help!

Top tips:

- Reduce wait time perception (check on a patient, give them a health brochure to read, etc.).
- Offer to help schedule appointments with specialists or show patients what to do if the next available appointment time cannot be scheduled within a timeframe appropriate to their level of care needs.
- Review prescriptions with every patient.
- Suggest 90-day refill and home delivery services as convenient ways to receive prescriptions.
- Ask for a call back if the patient cannot fill a prescription to help them assess their next steps.
- Stay informed on patients' specialty care.
- Clearly identify a platform or way that the patient will receive their test results.
- Reserve priority appointment spots for new Medicare patients.

Key CAHPS Questions Virginia Premier is Focused on:	
CAHPS Measures	Related Questions
Getting Needed Care	In the last six months, how often was it easy to get the care, tests, or treatments you needed?
	In the last six months, how often did you get an appointment to see a specialist as soon as you needed?
Getting Appointments and Care Quickly	In the last six months, when you needed care right away, how often did you get care as soon as you needed?
	In the last six months, how often did you get an appointment for a check-up or routine case as soon as you needed?
	In the last six months, how often did you see the person you came to see within 15 minutes of your appointment time?
Care Coordination	In the last six months, when your personal doctor ordered a blood test, X-ray, or other test for you, how often did someone from your personal doctor's office follow-up to give you those results?
	In the last six months, when your personal doctor ordered a blood test, X-ray, or other test for you, how often did you get those results as soon as you needed them?
	In the last six months, how often did your personal doctor seem informed and up-to-date about the care you got from specialists?

Stars Measure Performance

With only a few months remaining in the performance year (ends December 31), it is imperative that our members get the necessary gaps closed. We have highlighted a few focus measures below for your review.

Annual Flu Vaccine	
Key Points: • Remind members that they are eligible for a reward if they receive their annual flu shot. • Talk with members about the importance of receiving the flu vaccine. • Talk with members about the health risks related to flu when additional health concerns are noted.	**Procedure Codes for Filing Claims:** • G2163, G8482

Controlling Blood Pressure:

Key Points:

- Talk with members about what a lower goal is for a healthy blood pressure reading.
- Be sure to record the blood pressure in the medical record.
- Controlled blood pressure is <140 systolic and <90 diastolic.
- Be aware that the new guidelines allow self-reported blood pressures to be documented in the EMR during telehealth visits as long as the blood pressure was taken with a digital machine in the home.

Documentation Requirements:

- If a blood pressure is listed on a vital flow sheet, it must have date of service listed as well.
- If your office uses manual blood pressure cuffs, don't round up the blood pressure reading.
- Member self-reported blood pressure should be documented during the telehealth visit with a note saying the blood pressure was obtained with a digital cuff in the home.
- The use of CPT category II codes helps Virginia Premier identify clinical outcomes such as diastolic and systolic readings. It can also reduce the need for some chart review.

Please note, CPT II codes are for reporting purposes only and are not separately reimbursable. If you receive a claim denial, your reporting code will still be included in the quality measure.

CPT Category II Codes for Filing Claims:

- 3077F: blood pressure >= 140
- 3074F: systolic < 140
- 3080F: diastolic >=90
- 3079F: diastolic 80-90
- 3078F: diastolic < 80
- Remote blood pressure monitoring: 93784, 93788, 93790, 99091, 99453, 99454, 99457, 99473, 99474

Osteoporosis Management in Women Who Had a Fracture:

Key Points:

This impacts women 67 to 85 years of age as of December 31 of the measurement year.

Exclusions:

- women in hospice
- women who had a bone density test during the 730 days prior to the episode date
- women who received a dispensed prescription or had an active prescription to treat osteoporosis during the 365 days prior to the episode date
- women who received palliative care during the intake period through the end of the measurement year
- women who are enrolled in an institutional SNP any time during the measurement year or living long term in an institution any time during the intake period through the end of the measurement year

Documentation Requirements:

- CMS requires health plans to report treatment as a quality measure. Therefore, it is encouraged to have appropriate follow-up within six months after the diagnosis of a fracture and documentation provided in the patient's medical record.
- Appropriate follow-up may include completing a bone mineral density test and/or beginning treatment for osteoporosis with documentation provided in the patient's medical record.

CPT Category II Codes for Filing Claims:

- 77080 & 77081: DEXA bone density test
- 77078, 77081, 76977, & G0130: screening for osteoporosis

VirginiaPremier™

Call us at 1-800-727-7536 (TTY: 711)
or visit us online at VirginiaPremier.com.

Hours of Operations
Monday through Friday; 8 am – 6 pm

Information in this newsletter – such as plan benefits for members, offerings to providers and other details – is subject to change.