Individual and Family Plan Manual for Physicians, Providers and Hospitals
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A message for our valued providers

Thank you for your participation in Virginia Premier’s new network for providing individual and family plans on the federal exchange marketplace. These new plans – offered in eight counties in Central Virginia and the city of Richmond -- help us meet a goal of being able to offer health care coverage for all stages of life. But more important, they help us perform our mission of providing access to affordable, quality health care to people in need.

For those of you who may not be familiar with Virginia Premier, we have been proudly associated with VCU Health System since 1998. Formed in 1995 as a Medicaid HMO, Virginia Premier is now the second-largest managed care organization in Virginia, serving more than 265,000 members statewide. In addition to our new individual and family plans and Medallion Medicaid plan, we offer Medicare Advantage, as well as coverage for members eligible for both Medicare and Medicaid services. More information about us can be found on our website: virginiapremier.com.

We look forward to partnering with you to provide industry-leading health care to our new members in Central Virginia. This provider manual includes the pertinent information you need to affect a smooth working relationship with Virginia Premier. At any time, please feel free to contact us if you need additional assistance or have any questions.

Sincerely,
Patrick McMahan
Vice President, Contracting and Value Based Payments
Virginia Premier
Member Eligibility:
Please verify your patient's ID card and eligibility every visit. You can use one of these two options to verify member eligibility:

- Visit Virginia Premier's Provider Portal at [www.virginiapremier.com/providers/individual-family](http://www.virginiapremier.com/providers/individual-family)
  - Under the Provider tab, select Individual and Family plans to access the login page for the Provider Portal
- Call Virginia Premier directly at **1-833-672-8077**

Other Inquiries:

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<thead>
<tr>
<th>Service</th>
<th>Phone Number</th>
<th>Operating Hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>Member Services</td>
<td>1-833-672-8075</td>
<td>Monday – Friday 8 AM - 6 PM</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Sat 8 AM - 2 PM</td>
</tr>
<tr>
<td>Preauthorization and Notification</td>
<td>1-833-672-8076</td>
<td>Monday – Friday 8 AM – 5 PM</td>
</tr>
<tr>
<td>(Utilization Management)</td>
<td></td>
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<tr>
<td>Provider Services</td>
<td>1-833-672-8077</td>
<td>Monday – Friday 8 AM – 5 PM</td>
</tr>
<tr>
<td>Envision RX</td>
<td>1-833-626-1350</td>
<td>24/7</td>
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<tr>
<td>Virginia Premier Pharmacy</td>
<td>1-855-813-0363</td>
<td>Monday – Friday 8 AM – 5 PM</td>
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<tr>
<td>VSP (Pediatrics vision)</td>
<td>1-800-877-7195</td>
<td>Monday – Friday 5 AM – 8 PM (PST)</td>
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<td></td>
<td></td>
<td>Saturday 7 AM – 8 PM (PST)</td>
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<td></td>
<td></td>
<td>Sunday 7 AM – 7 PM (PST)</td>
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<tr>
<td>Complaints and Appeals</td>
<td>1-833-672-8075</td>
<td>Monday – Friday 8 AM – 6 PM</td>
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<td></td>
<td></td>
<td>Saturday 8 AM – 2 PM</td>
</tr>
<tr>
<td>Benefinder</td>
<td>1-877-643-1260</td>
<td>8:30 am – 5:00 pm</td>
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<tr>
<td>Nurse Advise Line</td>
<td>1-833-810-4970</td>
<td>24/7</td>
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<tr>
<td>LabCorp</td>
<td>1-800-845-6167</td>
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Preauthorization and Notification (Utilization Management)

Virginia Premier requires either an authorization or notification before certain services may be rendered to a Virginia Premier member. Please visit Virginiapremier.com/Providers/Individual-Family/ to review services requiring authorization. This will also be available on within the Provider Portal.

Providers can submit Medical authorizations by:

1. Calling Virginia Premier at 1-833-672-8076
2. Through the Provider Portal: www.virginiapremier.com/providers/individual-family/
3. Or by faxing to 1-833-810-4969

When requesting an authorization or notification, you should be prepared to provide the following information:

- Member’s name and date of birth
- Member’s ID number
- Actual date(s) of service or hospital admission
- Date of proposed procedure/service
- Corresponding procedure codes
- Bed type: Inpatient or outpatient
- TIN of treatment of facility (Where the service is being rendered)
- TIN of servicing provider (provider performing services)
- Applicable ICD diagnosis code
- Caller’s telephone number
- Attending physician’s telephone number
- Medical Record Information to support medical necessity

Providers should obtain prior authorization for all out-of-network services. Utilization Management can help you with this type of request. Call us at 1-833-672-8076.

Virginia Premier’s list of services requiring authorization is subject to change. We will notify you about changes to our authorization requirements through Provider Notices, in accordance with agreements. Failure to obtain proper authorization, when required, will result in the denial of the claim.

Our Medical Management department applies criteria and guidelines on a case-by-case basis, taking into account each individual’s unique circumstances. All denials of coverage that are based on medical necessity are made by the Health Plan Medical Director. You or a member can obtain the criteria used for a specific review decision by contacting the Medical Management department at 1-833-672-8076, Monday through Friday from 8:00 am to 5:00 pm. After-hours callers have the option of leaving a voice mail message and we will respond the next business day.

Disclaimer: Authorization/Notification is not a guarantee of payment. Billing services remains subject to the view for medical necessity, appropriately setting, billing and coding, plan limitation and eligibility at the time of service.
Claims Procedures

Clean Claim Submission
A “clean claim” is defined as a claim that has no material defect or impropriety, including any lack of any reasonably required substantiation documentation, which substantially prevents timely payment from being made on the claim or with respect to which Virginia Premier has failed timely to notify the person submitting the claim of any such defect or impropriety.

Submitting Claims to Virginia Premier:
You can submit claims to Virginia Premier in the following ways:

- Submit electronically: Availity® and RelayHealth (Change Healthcare):
  - Availity: 800-282-4548
  - RelayHealth (Change Healthcare): 800-981-8601
  - Payer ID: 251VA
- The Virginia Premier Provider Portal: virginiapremier.com/providers/individual-family/
- Submit paper claims to:
  Virginia Premier Individual and Family Plans
  P.O. Box 106020
  Pittsburgh, PA 15320-6020

Claims Resubmission
Corrected claims can be submitted electronically on an 837 file.

For additional questions, please contact Provider Services at 1-833-672-8077 (TTY:711).

Member Identification - ID Card
Virginia Premier Preferred members will be issued an identification card upon enrollment that will contain cost-share information and telephone numbers for benefit inquiries. Each member will be assigned a unique identification number by Virginia Premier. To protect the member’s privacy and comply with HIPAA regulations, we will not use a member’s social security number as an identifier. Please reference the sample ID card below.

Note: The Provider Services telephone number and the Payer ID are on the back of the card.
Covered Services

Individual and Family Plan Covered Benefits

For Virginia Premier to consider payment, a service must be medically necessary and covered by the member’s plan. The health plan identifies whether services are deemed medically necessary. You can verify covered and excluded services by calling our Provider Services department at the number listed on the back of the Member’s ID card.

You, the provider, may only bill a plan member for a non-covered service or item, if you inform the member before performing the service, of the following:

- The nature of the service;
- That the service is not covered by Virginia Premier; and
- The estimated cost to the member for the service.

Exclusions (For Individuals and their Families)

Below you will find a partial list of the products, services, and procedures that are generally excluded from our Preferred benefits. This section is only meant to be an aid to point out certain items that may be misunderstood as covered services. A member’s specific benefits can be viewed by visiting the Virginia Premier website at [www.virginiapremier.com/individual-family/](http://www.virginiapremier.com/individual-family/)

- Acupuncture
- Bariatric Surgery
- Corrective Eye Surgery
- Cosmetic Services
- Court-ordered services
- Custodial Care
- Dental Braces, Implants, and Treatment
- Experimental/Investigation Drugs, Items, Devices, Services or Procedures
- Eyeglasses/Contact Lenses – Adult
- Foot Care – Routine
- Genetic Testing and Counseling
- Hearing Aids
- Not Medically Necessary
- Physical examinations and immunizations required for enrollment for employment, education, sports participation, for licensing and other purposes
- Private Duty Nurse
- Routine Vision Care – Adult
- Spinal Manipulation and Manual Medical Therapy Services
- Surrogate Pregnancy
- Weight Loss Programs

Co-payments, Deductibles & Co-insurance
Virginia Premier contracted providers may only ask for payment from covered members for any covered services that includes co-payments, co-insurance, and/or deductibles at the time of service. Member’s cost-share can be found on the front of the member card. Member out-of-pocket expenses are contingent on the plan type, so we highly encourage providers to verify eligibility at the time of service. Asking for payment in full upfront is strictly prohibited.

Provider Reimbursement and Claims
Providers participating with us are required by their participation agreement to submit claims in the required format for all services rendered. For outpatient services, a CMS-1500 claim form must be used for physician, ancillary or other provider type services. For hospital or facility, a UB04 claim form must be submitted. When submitting claims, a provider should refer to the most recent version of the following professional resources for coding accuracy including: the American Medical Association Physicians’ Current Procedural Terminology (AMA/CPT Book), International Classification of Diseases, Revised Edition, Clinical Modification (ICD-10-CM) and HCPCS Level II Medicare Codes manuals.

For those providers who cannot submit on the corresponding CMS-1500 or UB04 claim form, a claim must be submitted through the Virginia Premier provider portal.

All claims submitted must be computer generated or typed to ensure accurate processing due to our claims imaging software. All required fields, and appropriate CPT and diagnosis codes, must be accurate on the claim form in order to be considered a clean claim. Virginia Premier cannot accept copied versions of claim forms. All claims must be submitted on original red and white claim forms.

Note: Handwritten claims are subject to be rejected.

Virginia Premier requires that all claims be submitted within the timeframes established in the provider contract. Please refer to your Virginia Premier contract for your specific timely filing period.

Note: It is very important that participating groups submit claims in accordance with the timely filing claims guidelines outlined in their agreement. We strongly encourage participating groups to educate their billing staff on the contractual claim submission terms in their agreement. Claims not submitted in accordance with the timely filing guidelines will be denied.

Three ways to submit claims:
1. Provider Portal
   
a. Provider may submit claims via provider portal at
   virginiapremier.com/providers/individual-family/

2. Paper Claim Submissions
   
a. Paper claims should be submitted to the following address:
   Virginia Premier Individual Plans
   P.O. Box 106020
   Pittsburgh, PA 15320-6020
   Payer ID: 251VA

3. Electronic Filing Clearinghouses
   
Electronic claims can be filed with Virginia Premier by using one of the following clearinghouses:
   
   - **Availity**: 800-282-4548
   - **RelayHealth (Change Healthcare)**: 800-981-8601

Virginia Premier strongly encourages providers to consider filing claims electronically, 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. A listing of participating clearinghouses along with enrollment forms can be accessed at [www.VirginiaPremier.com](http://www.VirginiaPremier.com). Please allow at least thirty (30) business days to complete this process. Providers are encouraged to contact their claims clearinghouses to confirm they are set-up to submit claims electronically. Submitting claims electronically without full clearance will cause claims processing delays.

**Inpatient Services**

Virginia Premier requires prior authorization for services provided in an inpatient setting. Understanding that emergent admissions are possible, we require immediate notification of any inpatient status for Individual and Family plan members. You can obtain an inpatient authorization by contacting utilization management:

- Call 1-833-672-8076
- Faxing in an authorization form to 1-833-810-4969

**Provider Claims Adjustment / Provider Termination / Member Complaints**

Providers have the right to file a complaint regarding services offered or performed by Virginia Premier. You also have the right to file an appeal regarding claims decisions.

**A. Provider Claims Adjustment Process**
If you disagree with the coverage/payment determination made by Virginia Premier or question a fee schedule, then you are encouraged to contact Virginia Premier by:

- Calling 1-833-672-8077: Provider Services representatives are available to take your call during regular business hours, Monday through Friday, 8:00 a.m. – 5:00 p.m.
- Visiting our Provider Portal and sending us an electronic message

You will have 60 calendar days from the receipt of your Explanation of Payment (EOP) to contact Virginia Premier to have your claim reconsidered. We will notify you of our resolution within 7-10 business days of the receipt of your complaint.

**B. Provider Claims Appeals Process**

If we uphold our coverage/payment determination after you have contacted Provider Services, you may file a written appeal to have your claim further investigated. You will have 60 calendar days from the receipt of your EOP to file a written appeal. Providers can submit a written request by printing and completing the Virginia Premier Practitioner and Provider Appeal Request form, which is available on the Provider Forms page at [www.virginiapremier.com/providers/individual-family/](http://www.virginiapremier.com/providers/individual-family/).

- If a provider appeal is a medical emergency or necessity, Virginia Premier will indicate whether medical records are required to be submitted with the appeal.
- Written requests can be submitted along with the any supporting documentation to:
  
  Virginia Premier Individual Plans  
  Attention: Claims Appeals  
  P.O. Box 5547  
  Richmond, VA 23220-0547

  Our appeals specialist will review the appeal, investigate and provide you with a decision within 60 calendar days of receiving the appeal.

**Office Procedures**

This section details the expectations of policies and procedures as it pertains to provider office operations.

**Medical Records**

Participating physicians are required to maintain adequate medical records and documentation relating to the care and services provided to our members. All communications and records pertaining to our member’s health care must be treated as confidential. No records may be released without the written consent of the member or their designated caregiver. The medical record is the mechanism that maintains and ensures the continuity, accuracy and integrity of clinical data. The medical record serves as the primary resource for information related to patient treatment, not only for the participating physician, but also for other health professionals who assist in patient care.

At a minimum, participating physicians are expected to have office policies and procedures for
medical record documentation and maintenance, which follow NCQA standards and ensure that medical records are:

- Accurate and legible
- Safeguarded against loss, destruction or unauthorized use
- Maintained in an organized fashion for all members receiving care and services, and accessible for review and audit by CMS or contracted External Quality Review Organizations
- Readily available for Virginia Premier’s Medical Management staff with adequate clinical data to support utilization management activities
- Comprehensive with adequate information to allow record transfer procedures to provide continuity of care when members are treated by more than one provider

We have established standards for medical record documentation and maintenance. These standards address medical record content, organization, confidentiality and maintenance. Virginia Premier requires medical records to be maintained by all affiliated practitioner offices and/or medical center locations in a manner that is current, detailed and organized, and which permits effective and confidential patient care and quality review. Medical record standards have been established to facilitate communication, coordination, and continuity of care and to promote efficient and effective treatment.

Note: Virginia Premier applies federal and state guidelines as it relates to medical record documentation.

Pharmacy Services

Pharmacy Benefits

Virginia Premier prescription benefits are administered through Envision Pharmaceutical Services (EnvisionRx), [www.envisionrx.com](http://www.envisionrx.com). To ensure maximum pharmacy benefits for our members, prescriptions must be filled at a network pharmacy.

The formulary (list of covered drugs) can be reviewed or downloaded from Virginia Premier’s website at VirginiaPremier.com/individual-family/. Virginia Premier has multiple formularies; please select the appropriate formulary when searching for covered medications. For pharmacy and prescription related questions, please call EnvisionRx at 1-833-626-1350 (TTY users call 711), 24 hours a day, 7 days a week.

Drugs covered under Medical Benefits

Drugs that are administered by a provider in an office, inpatient or outpatient facility are not covered under the Pharmacy Benefits. These drugs may or may not require authorization under the Medical Benefits.

Requests for authorization can be made through the Virginia Premier Provider Portal or by calling member services.

For more information about which drugs are covered under Medical Benefits visit our website at VirginiaPremier.com/individual-family/ or by calling our member services at 833-672-8075, Monday through Friday from 8 am to 6pm, Saturdays from 8 am to 2pm.
Pharmacy Network
In most cases, Virginia Premier will pay for prescriptions only if they are filled at the plan’s network pharmacies. To find a network pharmacy, visit our website at www.virginiapremier.com/individual-family/. Our network includes:

- Retail Pharmacies;
- Mail Order Pharmacies;
- Home Infusion Pharmacies;
- Specialty Pharmacies

Exceptions for out-of-network coverage will only be applicable during a Declared State of Emergency.

Formulary
Virginia Premier’s Pharmacy and Therapeutics Committee is composed of both internal and external Pharmacists and Medical Practitioners with various experiences and expertise. The Pharmacy and Therapeutics Committee maintains an evidence-based formulary that offers our members access to quality, affordable medications.

Additions to our formulary currently occur four times a year. For our members to receive their highest level of benefits, all Providers should use the formulary when prescribing medications. A copy of the formulary is available online at VirginiaPremier.com/Individual-family/

Virginia Premier offers a six-tier formulary. The member’s cost is determined by the plan type they are enrolled in and category of the tier medication. A member’s cost is typically lower for a generic medication than for a brand-name medication.

- **Tier 1 Preferred Generics**: This tier has the low cost or preferred medications. This tier mainly includes generic medications, some single source and multi-source medications.
- **Tier 2 Non-Preferred Generics**: This tier has non-preferred medications that generally are moderate in cost. This tier may include generic, some single source and multi-source medications.
- **Tier 3 Preferred Brands**: This tier has preferred medications that generally are moderate in cost. This tier may include generic, some single source and multi-source medications.
- **Tier 4 Non-Preferred Brands**: This tier has non-preferred medications that generally are higher in cost. This tier may include generic, some single source and multi-source medications.
- **Tier 5 Specialty Medications**: This tier has specialty medications that require specialized delivery and care for the members. This tier may include generic, some single source and multi-source medications.
- **Tier 6 Preventative Medications**: This tier has preferred medications used for the prevention of chronic disease states. This tier may include over-the-counter (OTC), generic, some single source and multi-source medications.

Virginia Premier is committed to helping members manage their health care benefits. Prior authorization, quantity limits, step therapy and dose optimization are edits to help ensure the members’ benefits provide them with access to safe, appropriate and effective medications. To determine if the medication prescribed requires a Coverage Determination, review our formulary
on our website at VirginiaPremier.com/individual-family/.

For more information about the edits and steps to request an exception, reference “Pharmacy Coverage Determination Guidelines” section below.

**Home Delivery Pharmacy Benefits (Mail Order)**

Our members can enroll in and use a Home Delivery Pharmacy, also referred to as Mail Order, to receive up to a ninety (90) day supply of maintenance medications, which are those medications used to treat chronic health conditions. Members usually have a reduced copayment (cost-share) and can save money by using a Mail Order Pharmacy.

To find a network Mail Order Pharmacy, search our Provider Search Tool online at Individual.VirginiaPremier.com/PST/.

**Specialty Pharmacy Benefits**

Specialty drugs are high-cost injectable, infused, oral or inhaled medications that are typically prescribed to treat complex chronic or long-term conditions that have few or no alternative therapies, such as cancer, HIV/AIDS, hepatitis C, multiple sclerosis and others.

Members who take specialty drugs require customized clinical monitoring and support to reduce their health risk and potentially serious side effects.

Most specialty drugs require prior authorization whether self-administered, administered in the office or by a home health service. Authorizations are based on medical necessity, which is determined by the drug policy, evidence-based medicine, regulations, contracts and medical judgement.

Access to specialty drugs are restricted to a Specialty Pharmacy network and will require members to enroll with the pharmacy. Virginia Premier’s network Specialty Pharmacies include Envision Specialty Pharmacy, Amber Pharmacy, and VCU Specialty Pharmacy.

**Pharmacy Coverage Determination Guidelines**

Whenever possible, you must use generic drugs when prescribing medication for our members. In the event a drug has restrictions and no substitution can be made, a coverage determination will need to be requested to ensure that the member is able to continue to get the prescription drug(s) he/she needs.

- **Prior Authorization:** For certain medications, Virginia Premier will need to obtain clinical information from the prescriber to confirm the medication’s medical necessity. The prior authorization criteria is based on current medical findings, manufacturer labeling information, and Food and Drug Administration guidelines.

- **Step Therapy:** To help make the use of prescription drugs safer and more affordable, Virginia Premier uses a Step Therapy program. A Step Therapy program is the process by which certain prescription drugs must be tried before the originally prescribed medications will be covered. Medications are grouped into two categories: Step 1 medications are recommended first, and usually generic; Step 2 medications are mostly brand name medications and only approved if a front-line medication (Step 1) does not
work. The provider can request an exception if it is medically necessary to use the originally prescribed medication.

- **Quantity Limit**: To help make prescription drugs more affordable, there might be limits on the amount of the drug (number of pills, etc.) that is covered during a particular time period. Quantity limits apply to medications that are more likely to be taken in amounts that exceed recommendations for dosage or length of treatment.

- **If the drug is not on the formulary (non-formulary)**: The member is recommended to speak to his/her provider about the option to either change the drug he/she is currently taking, or request a coverage determination. The provider can help determine if there is a different drug on the formulary that is equally effective for the member’s condition or if the non-formulary drug is medically necessary for the member to continue. In that case, the provider and/or member will need to ask Virginia Premier for a non-formulary exception to receive coverage for the drug.

The member and/or the provider can make the request for a formulary exception by contacting EnvisionRx either:

- By calling 1-833-626-1350 (TTY: 711); OR
- Electronically through CoverMyMeds or SureScripts OR through Virginia Premier’s website at VirginiaPremier.com/individual-family/
- Written by either faxing EnvisionRX at 1-866-250-5178 or mailing to:

  Envision Pharmaceutical Services, LLC  
  Attn: Coverage Determinations Dept.  
  2181 East Aurora Road  
  Twinsburg, OH 44087

**What if the request is denied?**

If the request is denied, the member has the right to appeal by asking for a review of our decision. The provider or the member has 180 calendar days from the date of our decision to request the appeal.

**Emergency Supply**

The member may also be eligible to receive up to a 72-hour supply of a drug, until a coverage determination decision can be made. For example, the member may be eligible to receive a temporary supply of a drug if he/she experiences a change in his/her “level of care” (i.e., if he/she has returned home from a stay in the hospital with a prescription for a drug that is not on the formulary.

There are other situations where the member may be entitled to receive a temporary supply.

**Patient Safety Monitoring Program**

Virginia Premier has a Patient Safety Monitoring Program (PSMP) in place. The program is designed to make sure that members are getting quality and safe health care, particularly with opioid and benzodiazepine medications. Members, who utilize opioids and/or benzodiazepines
with multiple prescribers and/or pharmacies, will be engaged to ensure their healthcare needs are being met with high regards to safety and effectiveness.

**Being considered for PSMP does NOT mean a member has done anything wrong.**
For any member who may be at risk for unsafe services, we are required to determine whether the member should be in enrolled into PSMP. If enrolled, the member will be allowed to see one provider and use one pharmacy for their opioid medications.

**Patient Safety Monitoring Program Member Rights**
Virginia Premier will send every PSMP member a letter about their enrollment into the program and the restriction of containing opioid medications to one pharmacy and provider. The letter will clearly state how the member can get emergency care and provide them with instructions on how they can appeal being placed into PSMP.

We collaboratively work with patients and providers to ensure safe and appropriate use of controlled substances. We use and promote:

- PMP checks
- Soft and hard pharmacy edits for benzodiazepine and opioid utilization
- Following CDC opioid guidelines
- Case management as appropriate

**Compliance/ Ethics**

**Compliance and Fraud, Waste and Abuse Requirements**
The Compliance Program department was established to support Virginia Premier’s commitment to the highest standards of conduct, honesty, integrity and reliability in our business practices. Compliance Program integrity is about “Doing the right thing” for the right reasons.

The Compliance Program is designed to assist the organization to uphold our continued commitment in making proper and ethical decisions. This program applies to officers, directors, employees and affiliated associates, such as providers, vendors, and subcontractors.

It consists of the following: policies and procedures, Code of Conduct, compliance oversight, education and training, monitoring and auditing, enforcement and discipline, and detection and prevention of fraud, waste, and abuse.

If you have questions or concerns related to:

- Potential Fraud, Waste, or Abuse
- Standards of Professional conduct
- Confidentiality
- Notice of Privacy Practices
- Potential Conflicts of Interest
- Or other regulatory requirements or laws, such as Sarbanes-Oxley and Stark Law

Call the Compliance Helpline: 1-800-620-1438, 24 hours a day, 7 days a week, or go on-line to: https://www.compliancehelpline.com/WelcomePageVCUHS.jsp. You may remain anonymous.

*If you have any questions regarding Compliance or HIPAA, you may also contact our Compliance Program department at 1-800-727-7536.

*To report Fraud, Waste, or Abuse contact 1-855-222-1046.

Corporate Compliance and Integrity Plan
Virginia Premier is committed to establishing, adopting, and implementing - through education of officers, directors, employees and affiliated professionals of Virginia Premier - a culture and collective attitude that will promote the prevention and detection of conduct that does not conform to federal and state laws and federal and state health care program requirements. Virginia Premier maintains a policy of “zero tolerance” for fraud, waste, and abuse in every aspect of our business. Product/Plan Overview

Health Maintenance Organization (HMO)
Virginia Premier offers an array of health care products that can be purchased directly by individuals and their families. We offer products available both on and off the Virginia Marketplace in Richmond City and these eight counties: Amelia, Caroline, Chesterfield, Goochland, Hanover, Henrico, New Kent, and Powhatan.

The HMO requires all participants to select a primary care provider (PCP) and use this provider for routine and preventive services. Members are allowed to visit in-network specialists without getting a referral. Out of network providers services are not covered unless medically necessary or authorized for care. The provider network is narrow in scope, with the focus on the VCU Health and Bon Secours provider network.

All plan designs require a co-payment, deductible and/or co-insurance, and the level of co-payment, deductibles and co-insurance depends on the various plan options.

Credentialing and Re-credentialing Program Description Overview
Virginia Premier’s Credentialing program is comprehensive to ensure that its practitioners and providers meet the standards of professional licensure and certification. The process enables Virginia Premier to recruit and retain a quality network of practitioners and providers to serve its members and ensure ongoing access to care. It consistently and periodically assesses and evaluates a practitioner’s or provider’s ability to deliver quality care between credentialing and re-credentialing cycles. It emphasizes and supports a practitioner’s and provider’s ability to successfully manage the health care of network members in a cost-effective manner.

Virginia Premier Board of Directors, the “Board”, has ultimate authority, accountability and responsibility for the Credentialing Program, including the evaluation process. The Board has delegated full oversight of the Credentialing Program to the Credentialing Committee. The Credentialing Committee accepts the responsibility of administering the Credentialing Program, having oversight of operational activities, which includes, but is not limited to, making the final
approval or denial decision on all practitioners and providers, as applicable.

**Credentialing Committee Structure and Activities**

The Chief Medical Officer or designee is responsible for the oversight and operation of the Credentialing Committee, and serves as Chairperson or may appoint a Chairperson, with equal qualifications. The Credentialing Committee is a peer-reviewed body that includes representation from a range of participating practitioners, including primary care (i.e., family practice, internal medicine, pediatrics, general medicine, obstetrics and gynecology) and specialty practice. Allied health representatives include mental health, rehabilitation, etc., and may be appointed to serve as non-voting members, on an ad-hoc basis. Members may be appointed or requested to attend the meeting representing Virginia Premier’s internal staff.

- Receive and review the credentials of all practitioners being credentialed or re-credentialed who do not meet the organizations established criteria, and to offer advice which the organization considers. This includes evaluating practitioner files that have been identified as problematic (e.g., malpractice cases, licensure issues, quality concerns, missing documentation, etc.).

- Review practitioner credentials and give thoughtful consideration to the credentialing elements before making recommendations about a practitioner’s ability to deliver care.

- Establish, implement, monitor, and revise policies and procedures for Virginia Premier credentialing and re-credentialing.

- Report to the HQUM and other proper authorities, as required.

- Annual Review of the credentialing program description, and other related objectives.

**Process and Requirements**

Virginia Premier credentials all practitioners prior to being admitted into the Virginia Premier Exchange Network. The intent of the process is to validate and/or confirm credentials information related to a prospective or participating practitioner by contacting the primary source of the issuing credential directly.

Each practitioner must submit a legible and completed application, a consent form that is signed and dated, a confidentiality form that is signed and dated, and any other required documentation. Practitioners may also submit their applications and/or information to the Center for Affordable Quality Healthcare (CAQH). Upon notification from the prospective practitioner that his/her application is filed with CAQH, our credentialing staff will promptly download the application to initiate the credentialing process.

The following information is obtained and verified according to the standards and using the sources listed under Initial Credentialing:

- Completed Virginia Premier application

- Copy of the unrestricted (*no limitations*), current and valid license or license number for the participating practitioner

- Copy of the unrestricted (*no limitations*), current DEA Certificate, if applicable
- Copy of the medical malpractice policy face sheet
- Copy of the board certificate or highest level of education; proof of education, training and competency
- Copy of the current Curriculum Vitae, which must include work history (gaps or interruptions in work history 6 months or greater must be explained)
- Primary Source Verification of associated credentialing documentation
- The Office of the Inspector General and the CMS Exclusions List will be checked monthly to ensure practitioners meet the specifications of CMS and are eligible for participation.
- The Credentialing Committee’s final decision (The practitioner shall be notified within 60 calendar days of the Committee’s decision)

**Primary Source Verification**

Our credentialing staff will conduct primary source verification as required by the most current and applicable Virginia Premier, CMS, and/or NCQA guidelines. We will contact the appropriate sources for verification of the various elements of the applicant’s application. These verifications may be completed in the form of documented phone calls, faxes and/or Internet website print outs.

**Note:** Virginia Premier reviews the Department of Human Services and OIG exclusion list frequently as defined by federal and state law. Should a provider appear on the current OIG list of excluded, we will take immediate action to remove the provider from participating in the Virginia Premier network, and take any corrective actions as applicable. Other sanctions, such as loss of licensure, are also grounds for immediate dismissal from participating with Virginia Premier.

**Quality / Disease Management**

**Quality Management**

Virginia Premier offers a variety of Quality Management programs and initiatives. Providers interested in additional information are encouraged to reach out to the Provider Services department for more information.

**Quality Management Initiatives:** Providers that participate agree to assist us with the operationalizing of our quality programs:

- **Medical Record Review** – Virginia Premier conducts medical record audits to meet the requirements of accrediting agencies and state and federal law. While we are not responsible for ensuring the accuracy or completeness of records, we will work closely with providers to ensure documentation accurately reflects the condition of the members. Documentation will be reviewed to evaluate provider adherence to evidence-based practice for select diagnoses. Results of these findings will be shared with the providers. Virginia Premier’s Quality Committees review and endorse selected clinical practice guidelines every year and these are disseminated on the provider website.
• **HEDIS** – Health Effectiveness Data and Information Sets are a set of clinical quality measures that are collected annually and reported to CMS. We hold the right to conduct medical record audits to identify care gaps for our members and will work collaboratively with providers to ensure identified gaps are closed.

• **CAHPS** – The Consumer Assessment of Healthcare Providers and Systems is a survey tool that provides us with member satisfaction and experience of care feedback regarding the care and services from a physician. These results are also part of the overall quality evaluation and are reported to CMS annually.

**Nurse Advice Line**

The Primary Care Physician (PCP) is the primary source of medical care for our members, and acts as the health care manager for their access to other sources of medical care. The PCP must provide, or arrange coverage, for 24-hour access for the purpose of rendering medical advice, determining the need for emergency or after-hours services and/or for providing authorization.

To support the PCP in this important role, Virginia Premier employs the services of a professional Nurse Advice Line available 24 hours a day, 7 days a week. We provide the member direct access through an RN for medical triage and health questions to assist our members in determining the most appropriate level of care for their condition. The responding nurse will give self-care instructions, provide notification back to our care managers or the member's PCP, or direct the member to a physician or facility for routine, urgent or emergency care. During normal business hours, members are instructed to contact their PCP for medical advice.

The Nurse Advice Line also provides the member with Case Management support. The nurse can provide the member with an appropriate course of action, including (but not limited to) medical advice, directing the member to an appropriate care setting, and referral to a care manager, including a physician if necessary. We ensure that if care management needs are identified for a member, the staff person facilitating the member’s issue has access to, and is familiar with, the enrollee’s Plan of Care.

After hours, in non-emergency situations, members may contact the Nurse Advice Line at: 1-833-810-4970. The same number is used for Care Management Support.

**Disease Management and Case Management**

**Disease Management Program:**

Virginia Premier offers disease-specific programs as additional support to members and their physicians. These programs are designed to complement a physician’s treatment regimen and empower the member through education and support. Physicians can identify those they believe are viable candidates to participate in disease management programs by contacting the Medical Management department at 1-833-810-4970, Monday through Friday, 8:00 am to 6:00 pm EST. All programs are coordinated with the member’s care manager and PCP.

**Case Management:**

We offer a Case Management Program to assist the most vulnerable members. The Care Management Team works closely with the member, family, caregiver, PCP, and specialists
to coordinate health care services across the continuum of care. Care Managers may also intervene when members demonstrate need for assistance or non-adherence to their treatment plan. Circumstances that warrant referral to the Care Management Team may include but are not limited to:

- Presence of progressive, chronic, or life-threatening illness
- Need for inpatient or outpatient rehabilitation
- Terminal illness
- High-risk pregnancies
- Acute/trauumatic injury, or an acute exacerbation of a chronic illness
- Complex social factors
- Multiple hospitalizations or emergency room visits.

**Rights and Responsibilities**

**Physician/Practitioner Rights and Responsibilities**

We have adopted specific policies for participating providers that are summarized below. Please note, this is not considered an all-inclusive list. There are additional responsibilities and rights referenced throughout this manual and in the Provider Agreement.

**Providers Must:**

- Meet all of our credentialing and re-credentialing requirements as defined by Virginia Premier and accrediting agencies.
- Must possess a professional degree and an unrestricted license to practice medicine in Virginia and bordering states.
- Be able to clearly define and provide documented experience, background, abilities, any malpractice information as requested, disciplinary sanctions or actions, and the physical and mental health status.
- Possess an unrestricted Drug Enforcement Administration (DEA) certificate, or if applicable a state Controlled Dangerous Substance (CDS) certificate.
- Possess a Clinical Laboratory Improvement Amendment (CLIA) as applicable.
- Be a clinical staff member in good standing with partnered hospital network systems, and must not have privileges revoked.
- Provide in writing to Virginia Premier within 24 hours of any revocation or suspension of DEA, CLIA, professional licensures, or hospital systems privileges.
- Not discriminate against members based on payment, age, race, color, national origin, religion, sex, sexual preference, and health status.
- Not discriminate against our members and non-members.
- Provide physician accessibility to members 24 hours a day, 7 days a week.
- Provide an on-call and after-hours service by a participating and credentialed Virginia Premier provider.

**Practitioner Rights**

- **Right to Application Status:** Each provider has the right to check the status of his/her application, correct erroneous information, and the right to review any information obtained during the credentialing process, at any time.
- **Right to Confidentiality of Information:** Credentialing information is considered highly confidential; therefore, information obtained from NPDB, OIG, DHP, AMA, etc. may not be provided via telephone.
- **Right to Appeal Adverse Quality Decisions:** If a provider is denied network participation due to quality issues, the provider has the right to appeal that denial. Please be aware that quality denials may need to be reported to the appropriate authorities.
- **Right to a Nondiscriminatory Process:** Virginia Premier’s credentialing process is nondiscriminatory. It is the plan’s policy to not discriminate based solely on an applicant’s race, ethnic/national identity, gender, age, sexual orientation or the types of procedures performed or patients treated. Please be aware that this does not preclude the plan from including in its network practitioners who meet certain demographic or specialty needs. It does not preclude the plan from denying participation to a provider, if the network is adequate.
- **Right to be Informed of Credentialing Outcomes:** Credentialing decisions will be communicated to providers, in writing, within 60 calendar days from the plan’s final decision.
- **Right to a Timely Application Process:** Applications will be processed with in accreditation and/or regulatory guidelines. The Plan will make every attempt to process applications within 90 calendar days of receipt in the Credentialing Department.

**Member Rights**

- Timely access to their PCP and referrals to specialists when medically necessary or as needed and timely access to all covered services, both clinical and non-clinical.
- Not be balance billed by any provider for any reason for covered services or flexible benefits.
- Not be discriminated against due to: medical conditions, including physical and mental illness, claims experience, receipt of health care and medical history.
- Treatment with quality care, respect and dignity - regardless of their race, physical or mental ability, ethnicity, gender, sexual orientation, creed, age, religion or their national origin, cultural or educational background, economic or health status, English proficiency, reading skills or source of payment for their care.

- Have health care services 24 hours a day, three hundred and sixty-five days a year, including urgent, emergency and post-stabilization services.

- Choose their personal Virginia Premier doctor/Primary Care Physician (PCP).

- Change their personal Virginia Premier doctor and choose another one from Virginia Premier’s Provider Directory (included in the enrollment/membership package).

- Make their own doctor/PCP appointments to be seen in their private office at their convenience.

- Not to be treated against their will.

- To see their doctor/PCP, get covered services and get their prescriptions filled within a reasonable period of time. They should not be afraid to ask their doctor/PCP questions.

- Call Member Services to file a complaint/grievance about Virginia Premier or to file an appeal if they are not happy with the answer to their inquiry (question), complaint/grievance, or care given.

- To privacy and to have their medical records and personal health information kept private unless they sign a permission form.

- Have timely access to their medical records in accordance with applicable State and Federal laws. They may be required to sign for release of those records.

- Participate with their doctor in making decisions about their health care, give their consent for all care, and make decisions to accept or refuse medical care to the extent permitted by law and be made aware of the medical consequences of such action.

- Have their doctor tell them about all treatment options and alternatives, presented in a manner that can be easily understood, regardless of the cost or benefit coverage. They can also receive a second opinion from Virginia Premier’s network of providers.

- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, as specified in Federal regulations on the use of restraints and seclusion.

- Free exercise of rights and the exercise of those rights that does not adversely affect the way Virginia Premier and its providers treat their members.

- Receive information about Virginia Premier, its services, costs, providers, network pharmacies, drugs, and Members’ Rights and Responsibilities.
• To know the names and qualifications of the physicians and health care professionals involved in their medical treatment.

• Make suggestions regarding Virginia Premier’s Member Rights and Responsibilities.

• Rights to reasonable accommodations.

• To use Advance Directives (such as a Living Will or a Power of Attorney).

• A right to a copy of the Privacy Notice annually or when requested.

**Supplemental Member Rights**

Virginia Premier members also have the right to:

• To see an in-network doctor in a timely manner.

• Get emergency care and family planning services in- or out-of-network without prior authorization. Family planning services, preventive services, and basic prenatal care do not need preauthorization, but the member should get care from an in-network doctor/provider.

• To obtain care from a doctor/provider acting within the lawful scope of practice.

Virginia Premier may not prohibit, or otherwise restrict, a member’s doctor/provider from advising or advocating on behalf of a member who is his/her patient related to the member’s health condition, medical care or treatment choices, including any other treatment that may be self-administered.

• Have the doctor’s medical record indicate whether or not the member has completed an advance directive.

• Not have the doctor/provider condition the delivery of care or discriminate against a member based on whether he/she has completed an advance directive form.

• To contact Virginia Premier staff that have been trained on advance directives and ask questions, if needed.

• File any type of grievance, including those related to advance directives, with Virginia Premier by calling the toll-free line at (833) 672-8075, the Center for Medicare Services, the Bureau of Insurance and the Department of Health.

• Give female members direct access (no referral needed) to a woman’s health doctor/provider in the network for covered routine and preventive care services. This is in addition to the member’s assigned primary care doctor/provider if that person is not a women’s health doctor/provider.

• Have his/her health care needs and information discussed and given to the doctors/providers they want. The member is advised to sign a release form with their current provider in order to have the information released.
- Confidentiality when coordinating care including medical records, member information and appointment records for the treatment of sexually transmitted diseases.

- To be held harmless (not responsible for the bill or extra costs) if out-of-network services are given to a member for emergency care or care that has been preauthorized.

- To see in-network doctors/providers with the same office hours as those for other patients who may not have Medicaid like private commercial insurance members and or other types of Medicaid members (fee-for-service), if the doctor/provider sees only Medicaid members.

- To see a doctor of his/her choice based on language and/or race and one who is sensitive to the member’s cultural needs, including those who cannot speak English well and those with different cultural and racial backgrounds.

- To have any service that has been stopped, reactivated, if a member’s location is known.

**Member Responsibilities**

- Choose a Virginia Premier Primary Care Physician (PCP) from the provider directory. Work with their PCP to help establish a proper patient/physician relationship.

- Get their health care from a participating PCP, hospital or other health care provider.

- Keep their doctor’s appointments or call to cancel them at least twenty-four (24) hours ahead of time.

- Carry their member ID card with them at all times.

- Inform Virginia Premier if they have other health insurance coverage.

- Tell the doctor that they are a member of Virginia Premier at the time that they speak with their doctor’s office.

- Give their PCP and other providers honest and complete information they need about their health to care for them.

- Learn the difference between emergency and urgent care. Know:
  - What an emergency is,
  - How to keep one from happening, and
  - What to do if one happens

- Follow plans and instructions for care given by their physician.

- Understand their health problems and discuss and/or agree upon a treatment plan with their physician.
• Advise their PCP of visits to other doctors so that he or she can be kept informed about the care that they are receiving.

• Act in a way that supports the care given to other patients and helps the smooth running of their doctor’s office, hospitals and other offices.

• Let Virginia Premier know if they have any problems, concerns or suggestions on how we can work better for them.

• Take into advisement the recommendations of the Case Managers and other health care professionals at Virginia Premier.

Members’ right regarding their protected health information

• **Right to Inspect and Copy** – Patients have the right to inspect and copy medical information that may be used to make decisions about their benefits. However, this does not include behavioral health management notes.

• **Right to Amend** – Patients have the right to amend medical information about them that they feel is incorrect or incomplete. The request should be in writing and provide a reason that supports the request to amend.

• **Right to an Accounting of Disclosures** – Patients have the right to request a list of disclosures made by the provider of medical information about them. The request should be in writing and specify the time period in question of the disclosures.

• **Right to Request Restrictions** – Patients can request a restriction or limit on the medical information used or disclosed about their treatment, payment or health care operations. This restriction or limit includes information disclosed to someone who is involved in the patient’s care, like a family member or friend. The provider does not have to agree to any restrictions or limits to information.

• **Right to Request Confidential Communications** – Patients have the right to request that a provider communicate with them about medical matters in a certain way or at a certain location. For example, a patient may request that communication to them only be made at work or by mail.

• **Right to be notified of a Breach** – Patients have the right to be notified in the event the provider or their business associate discovers a breach of unsecured protected health information.

• **Privacy Right to a Paper Copy of the Notice of Practices** – Patients have the right to receive a paper copy of the provider’s Notice of Privacy Practices.

Accreditation

National Committee for Quality Assurance (NCQA)

We demonstrate our commitment to delivering high-quality care through one of the most comprehensive evaluations in the industry, NCQA, with results based on clinical performance.
(HEDIS) and consumer experience (CAHPS).

Virginia Premier uses NCQA standards as a roadmap for improvement to ensure network adequacy and consumer protection—evaluating the quality improvement (QI) infrastructure, examining QI processes, and identifying validation that QI activities have produced measurable improvements in both clinical and service areas of the organization.

We collect HEDIS data from participating provider claims detail and medical records to measure both health plan and provider performance in several clinical areas. A consumer report is compiled to help consumers select a health plan, physicians, and/or their affiliates. HEDIS measures can be modified annually to reflect advances in clinical interventions and to identify areas requiring improvement.

Virginia Premier recognizes the need to align the health plan with its delivery system—hospitals, healthcare entities, person-centered medical homes (PCMH), and practitioners. As a Marketplace product, we intend to increase data sharing and transparency between the health plan and its providers.

**Delegation**

We have business relationships with external entities to perform specific functions on our behalf. These contracted agreements delegate or give the entity the authority to provide the following functions:

1. Case Management,
2. Claims,
3. Credentialing,
4. Pharmacy, or
5. Utilization Management.

When we delegate any of these functions to a provider, they become Delegated Providers. Virginia Premier assumes responsibility to any external regulatory agencies for the performance of the delegated activities. The delegated provider must demonstrate compliance with our established standards before the delegation is approved. Delegated providers must continuously comply with the expectations outlined in this Manual and the Delegated Services arrangement to retain delegation status. Noncompliance may result in revocation of any or all delegated functions.

Please contact Virginia Premier’s Provider Services Team for additional information on delegation at (833) 672-8077.
### Glossary

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
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<tr>
<td><strong>Abuse</strong></td>
<td>The use of health services by recipients which is inconsistent with sound fiscal or medical practices and that results in unnecessary costs to the Virginia Medical program or in reimbursement for a level of use or pattern of services that is not medically necessary, or (ii) provider practices which are inconsistent with sound fiscal or medical practices and that result in unnecessary costs to the Virginia Medicaid program, or (b) reimbursement for a level of use or a pattern of services that is not medically necessary or that fails to meet professionally recognized standards for health care.</td>
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<tr>
<td><strong>Appeal</strong></td>
<td>A request from a member, attending physician, provider or facility to reconsider a decision made by Virginia Premier to reduce or deny covered services.</td>
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<tr>
<td><strong>Authorization</strong></td>
<td>The process of obtaining prior approval from the health plan before rendering specified services or procedures to a member.</td>
</tr>
<tr>
<td><strong>Centers for Medicare &amp; Medicaid Services (CMS)</strong></td>
<td>The federal agency of the United States Department of Health and Human Services that is responsible for the administration of Title XIX and Title XXI of the Social Security Act. CMS provides program oversight for Medicaid Managed Care.</td>
</tr>
<tr>
<td><strong>Claim</strong></td>
<td>An itemized statement of services rendered by health care providers (such as hospitals, physicians, dentists, etc.) billed electronically or on HCFA 1500 or UB 04.</td>
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<tr>
<td><strong>Clean Claim</strong></td>
<td>A claim that has no defect or impropriety (including any lack of any required substantiating documentation) or particular circumstance requiring special treatment that prevents timely payments from being made on the claim under this title 1816 (c)(2)(b) and 1842(c)(2)(B) of the Social Security Act.</td>
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<td>Term</td>
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<tr>
<td>Complaint</td>
<td>Any oral or written communication made by or on behalf of a member expressing dissatisfaction with any aspect of the health plans, providers, or state’s operation, activities or behavior regardless of whether a remedial action is requested.</td>
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<tr>
<td>Co-payment</td>
<td>The member’s portion of the payment due at the time of service.</td>
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<tr>
<td>Emergency</td>
<td>A medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, that a prudent lay-person who possesses and average knowledge of health and medicine should reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to body functions, or serious dysfunction of any bodily organ or part.</td>
</tr>
<tr>
<td>Fee for Service</td>
<td>The traditional health care payment system through which physicians and other providers receive a payment for each unit of service they provide. This payment is contrasted with capitation, which pays per person, not per service.</td>
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<tr>
<td>Fraud</td>
<td>Intentional deception or misrepresentation made by a person or entity with the knowledge that the deception could result in payment of an unauthorized benefit.</td>
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<tr>
<td>Grievance</td>
<td>Any complaint or dispute, other than one that constitutes an organization determination under 42 C.F.R. § 422.566, expressing dissatisfaction with any aspect of the Contractor’s or Provider’s operations, activities, or behavior, regardless of whether remedial action is requested pursuant to 42 C.F.R. § 422.561. Possible subjects for Grievances include, but are not limited to, quality of care or services provided, aspects of interpersonal relationships, such as rudeness of a Primary Care Provider or employee of the contractor, or failure to</td>
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respect the Member’s rights, as provided for in 42 C.F.R. § 438.400. Grievances are overseen by the Virginia Premier Continuous Quality Improvement Committee (CQIC) and are related to the availability, delivery or quality of health care services, including the utilization review decisions that are averse to the member or the payment or reimbursement of health care service claims.

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<tr>
<th>Term</th>
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<tr>
<td>Health Risk Assessment (HRA)</td>
<td>A comprehensive assessment of a Member’s medical, psychological, cognitive and functional status in order to determine their medical, behavioral health, long-term services and support and social needs.</td>
</tr>
<tr>
<td>Interdisciplinary Care Team (ICT)</td>
<td>A team of professionals that collaborate, either in person or through other means, with the member to develop and implement a Plan of Care that meets their medical, behavioral, long-term care and supports and social needs. ICTs may include physicians, physician assistants, long-term care providers, nurses, specialists, pharmacists, behavior health specialists, and/or social workers appropriate for the member’s medical diagnoses and health condition, co-morbidities, and community support needs. ICTs employ both medical and social models of care.</td>
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<tr>
<td>Managed Care</td>
<td>Use of a planned and coordinated approach to provide health care with the goal of quality care at a lower cost. Usually emphasizes preventive care and often associated with an HMO.</td>
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<tr>
<td>Medical Necessity</td>
<td>Services sufficient in amount, duration, scope and environment to improve health status.</td>
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<tr>
<td>Member</td>
<td>An individual who is eligible for an Exchange plan and who is currently enrolled with Virginia Premier.</td>
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<tr>
<td>Model of Care (MOC)</td>
<td>The Model of Care is a specific outline of care management processes designed and regulated to provide the best possible care and services for members participating in a</td>
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<td>Term</td>
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<tr>
<td>National Committee on Quality Assurance (NCQA)</td>
<td>A not-for-profit organization performing accreditation review of managed care plans.</td>
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<tr>
<td>Network Provider</td>
<td>The health care entity or health care professional that has a contract with Virginia Premier or its subcontractor to render covered services to members.</td>
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<tr>
<td>Non-participating Provider</td>
<td>A health care entity or health care provider who is not contracted with Virginia Premier to provide services to members. Often referred to as an “out-of-network” provider.</td>
</tr>
<tr>
<td>Primary Care Physician (PCP)</td>
<td>A generalist trained physician in Internal Medicine, Family Practice, Pediatrics or OB/GYN, who is responsible for providing the majority of care to individuals and providing case management when additional services are required.</td>
</tr>
<tr>
<td>Plan of Care (POC)</td>
<td>A plan, primarily directed by the member and family members of the Member as appropriate, with the assistance of the Member’s Interdisciplinary Care Team to meet the medical, behavioral, long-term care and supports and social needs of the Member.</td>
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<tr>
<td>Urgent Care</td>
<td>A medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain; such that the absence of medical attention within 24 hours could reasonably be expected to result in:</td>
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<td>- Placing the patient’s health in serious jeopardy</td>
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<td>- Serious impairment to bodily function; or</td>
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<td>- Serious dysfunction of any bodily organ or part.</td>
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Hours of Operations
Monday – Friday, 8:00 am to 5:00 pm

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