Virginia Premier

PO Box 5307
Richmond, VA 23220
1-800-727-7536 (TTY:711)
VirginiaPremier.com

Hours of Operation
Monday – Friday,
8:00 am - 8:00 pm, EST

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Dear Provider:

Thank you for becoming a participating provider with Virginia Premier. Attached is the 2020 - 2021 Virginia Premier Provider Manual with the information you need to answer questions related to pre-authorizations, claims, appeals and grievances, credentialing / re-credentialing, quality and utilization management programs, Interdisciplinary Care Team (ICT), plans of care (ICP), health risk assessments (HRAs) and compliance.

To request a hard copy of the manual or to receive additional provider training, please contact your Provider Services Representative. Updates and revisions to the provider manual are communicated through inserts, website announcements and provider mailings, and are considered part of the Network Provider Agreement. Should you have questions concerning the manual, please contact your Provider Services Representative at the numbers listed below:

| Central / Northern Virginia | 800-727-7536  
| press 6 |
| Roanoke | 888-338-4579  
| press 4 |
| Tidewater | 800-828-7989  
| press 6 |

Thank you,

Network Development Department
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INTRODUCTION AND WELCOME

Virginia Premier Health Plan, Inc. (Virginia Premier), is pleased to welcome you to its participating provider network. At Virginia Premier, our goal is to improve the health care status of the Virginia Premier populations in the Commonwealth of Virginia. We believe these underserved populations are entitled to the same quality health care as commercially insured populations but require a focused approach that is specifically designed to meet the needs of these unique populations.

OUR MISSION

Virginia Premier’s mission is to inspire healthy living within the communities we serve, especially those in need. We do this through innovation, strategic partnerships, and industry-leading healthcare. Founded in 1995 as a Medicaid HMO, Virginia Premier is the first and only nonprofit managed care organization in the Commonwealth, now serving more than 280,000 members statewide. It offers Medicare, Medicaid, and health insurance exchange plans. Virginia Premier is jointly owned by the integrated, not-for-profit health system Sentara Healthcare, based in Norfolk, Va., and VCU Health System based in Richmond, Va.

OUR VISION

To be a leading health care organization by connecting all members to innovative, quality and affordable health care for all phases of life.
# HOW TO REACH US

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<th></th>
<th>Physical Address</th>
<th>Mailing Address</th>
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<tbody>
<tr>
<td><strong>Corporate Office</strong></td>
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</tr>
<tr>
<td>Central Virginia</td>
<td>600 East Broad St, Suite 400 Richmond, VA 23219-1800</td>
<td>P.O. Box 5307 Richmond, VA 23220-0307</td>
<td>800-727-7536 804-819-5151</td>
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<tr>
<td><strong>Innsbrook</strong></td>
<td>10800 Nuckols Road GlenAllen, VA 23060</td>
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<td>804-819-5151</td>
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<tr>
<td><strong>Roanoke</strong></td>
<td>5060 Valley View Blvd. NW Roanoke, VA 24012</td>
<td>P.O. Box 1751 Roanoke, VA 24008</td>
<td>888-338-4579 540-344-8838</td>
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<tr>
<td><strong>Southwest (Bristol)</strong></td>
<td>105 Village Circle Bristol, VA 24201</td>
<td>105 Village Circle Bristol, VA 24201</td>
<td>866-285-8963</td>
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| General Phone Number for Virginia Premier | 877-719-7358 |
| Medical Admission Authorization (other than Behavioral Health) | Phone 888-251-3063, Fax 877-739-1365 |
| Outpatient Service Authorization (Excluding LTSS and BH) | Phone 888-251-3063, Fax 877-739-1371 |
| Behavioral Health Authorizations Inpatient Fax | Phone 855-214-3822, Fax 804-799-5105 |
| Behavioral Health CCC Plus Outpatient Fax | Fax 804-799-5104 |
| Behavioral Health Medallion Outpatient Fax | Fax 804-343-0304 |
| Long Term Support Services Fax or Contact Care Coordination | Fax 877-794-7954 Phone 877-719-7358 option 2, 4 |
| Appeals and Grievances | Phone 855-813-0349, Fax 877-307-1649 |
| Nurse Advice Line (24/7) | 800-256-1982 |
| Provider Services | 877-719-7358 |
| Member Services (8am - 8pm) | 877-719-7358 |
| Virginia Premier’s Eligibility Number | 877-719-7358 |
| DM AS AVRS Line (Automatic Voice Response System) | 800-884-9730 |
Interpreter Services

Providers are required to assist members with obtaining interpreter services if their speech cannot be understood (for example, if the language they are speaking is not understood by the provider, or if they have a speech disturbance).

**COMMONWEALTH COORDINATED CARE PLUS (CCC PLUS)**

Commonwealth Coordinated Care Plus (sometimes referred to as MLTSS) is an innovative program designed to better serve individuals who are receiving Long Term Services and Supports in Virginia. The goal of the program is to improve the lives, satisfaction and health outcomes of participants by providing a seamless, one-stop system of services and supports and assisting with navigating the complex service environment. By integrating medical and social models of care, supporting seamless transitions between service settings and facilitating communication between providers, Virginia Premier will ensure members receive person-centered care driven by individual choice and rights.

Members enrolled in the Virginia Premier program will receive comprehensive, patient-centered care. Virginia Premier will ensure that patient-centered care can accommodate and support self-direction, while being provided to members in the least restrictive community setting and in accordance with the member’s wishes and Individualized Care Plan (ICP). Each member is assigned a care coordinator upon enrollment who is responsible for facilitating the ICP. The ICP provides a roadmap for the patient-centered care and is developed by the member, their caregivers, and their Interdisciplinary Care Team (ICT).

The ICT provides a variety of health professionals that collaborate with the member to develop and implement an ICP that meets their medical, behavioral, long-term services and supports, and social needs. ICTs may include physicians, physician assistants, long-term care providers, nurses, specialists, pharmacists, behavior health specialists, caregivers and/or social workers appropriate for the member’s medical diagnoses and health condition, co-morbidities, and community support needs. Long Term Services and
Supports (LTSS) or Long Term Care (LTC) providers play a key role in aiding the members who are living independently in their communities. LTSS providers offer a number of services and supports that help elderly individuals and/or individuals with disabilities meet their daily needs for assistance and improve the quality of their lives.

Virginia Premier and the ICT will ensure that all medically necessary covered benefits are provided to members in a manner that:

- is sensitive to the member’s functional and cognitive needs, language and culture
- allows for involvement of the member and caregivers and;
- is provided in a caresetting appropriate to the members’ needs, with a preference for the home and the community.

Virginia Premier currently operates within the six (6) regions identified by the Commonwealth of Virginia. These regions are outlined in the “Virginia Premier Service Regions” chapter.

**WHO ARE CCC+ MEMBERS**

CCC+ members are:

1. Dual eligible individuals with full Medicaid and any Medicare coverage (Medicare A and/or B).

2. Non-dual eligible members who receive long term services and supports (LTSS), either through an institution or through one of the five (5) DMAS’ home and community-based services (HCBS) waivers:
   a. Building Independence (BI)
   b. Commonwealth Coordinated Care (CCC) Plus
   c. Community Living (CL)
   d. Family and Individual Supports (FIS)

3. Non-dual individuals who do not receive LTSS

Medicaid covered benefits shall be provided in accordance with 42 CFR 438 and with the requirements in the approved Medicaid State Plan, including any applicable State Plan amendments and §1915(c) EDCD Waiver, and in accordance with the requirements specified in DMAS’ RFP. The requirements in this manual are subject to change based on any state or federal regulatory updates. We will send out a notification informing all providers of the change. We will make the update to the Provider Manual during the next schedule of revisions.
# Virginia Premier Service Regions

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### Northern/Winchester

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**Transportation Services**

**Introduction**

The purpose of this guide is to aid in the submission of claims to Virginia Premier for completed ambulance trips. This guide is not designed to replace the billing guidance provided by CMS or DMAS, but supplement the standards defined by the governing organizations. These step-by-step instructions will assist you in billing Virginia Premier and will help reduce processing delays and possible denials relating to billing errors. Claims can be submitted electronically on a Professional 837 EDI file or on an original red-and-white CMS-1500 form.

**Eligibility Verification**

It is important to note that Ambulance Transportation is a Medicare covered service in some instances, however if Virginia Premier is paying a claim under a Medicaid program the claim submission must come with an Explanation of Benefits (EOB) from the Medicare provider. Virginia Premier must schedule all requests for transports as Medicaid will pay for all transports that meet medical necessity. Virginia Premier may arrange for the transport, but cannot authorize payment utilizing Medicaid funds for Medicare covered services without the appropriate EOB.

Our transportation resources will transport members to and from scheduled medical appointments with participating providers, health education classes and to meet with their Department of Social Services (DSS) caseworker for re-certification. This service is offered to Virginia Premier members free of charge. FAMIS recipients do not qualify for Non-Emergency Transportation Services (NEMT).

To arrange Non-Emergency Transportation Services (NEMT), call Virginia Premier at:

- 877-719-7358 or
- 800-727-7536

To schedule transportation for an appointment, members, member’s caregiver or providers are required to call the Virginia Premier Member Services Department at least three working days prior to the scheduled medical appointment. Virginia Premier case managers / care coordinators may also assist with arranging transportation as well. Re-occurring trips may be set up under most circumstances.

The Member Services Representative will ask a series of questions to verify a member’s eligibility and to set up the transportation request. In order to schedule transportation, the
following information will need to be provided: the member’s name, identification number (listed on the member’s card), date of birth, pick up address, telephone number, date, time, address for the appointment, the name and the telephone number of the medical provider, number of additional passengers (if any), level of transport required (ambulatory, wheelchair, stretcher, ambulance), and any special needs or comments, i.e., member is blind, member will be carrying a portable oxygen tank.

Transportation services may not be scheduled for appointments less than three working days except in the following circumstances:

• Dialysis Appointments
• Oncology / Chemotherapy Appointments
• Cardiology Appointments
• OB/GYN Appointments
• Surgery or pre-op appointments
• First time new enrollees for the current month
• Appointment is requested by the member’s PCP or specialist for medically urgent appointments

Medical emergency transportation is to be arranged by calling 911 for immediate medical assistance. Members should not be referred to Virginia Premier’s transportation service under medical emergency circumstances (i.e., seizures, chest pain, asthma, loss of consciousness, labor). This type of transportation will not be coordinated through Virginia Premier’s Transportation department.

Submission Standards

Effective February 1, 2019, Virginia Premier will operate utilizing one Virginia Premier Payer ID: VAPRM or the Exchange Program ID: 251VA. This universal payer ID will be used for submission of electronic claims for the following lines of business under Virginia Premier:

• Medallion 3.0: VAPRM
• Medallion 4.0: VAPRM
• CCC Plus: VAPRM
• Dual Special Needs Plan (DSNP): VAPRM

Medicare Advantage Exchange Program electronic claim submission should be submitted utilizing Payer ID 251VA. Virginia Premier’s Commercial Insurance Line of Business

Please begin making the necessary adjustments to your claims filing process. All electronic file submissions on or after February 1, 2019 must be submitted utilizing the Virginia Premier Payer ID: VAPRM or the Exchange Program ID: 251VA. Submitting electronic claim files utilizing any other Payer ID will be rejected. If you have any questions, please contact Provider Services. We are available Monday through Friday from 8:00 am to 6:00 pm at 804-819-5151 or toll-free 800-727-7536, then select option 2 followed by option 6

Paper claims must be mailed. Faxed claims will not be accepted and will be returned to you. Virginia Premier Health Plan uses claims imaging software to process paper claims.

Below are some standard guidelines that every provider submitting paper claims should follow:
The font should be:
- Legible (Change typewriter ribbon/PC printer cartridge frequently, if necessary. Laser printers are recommended.)
- In black Ink
- Pica, Arial, 10, 11 or 12 font type
- CAPITAL letters

The font must NOT have:
- Broken characters
- Script, italics or stylized font
- Red ink
- Mini font
- Dot Matrix font

Do NOT bill with:
- Liquid correction fluid changes.
- Data touching box edges or running outside of numbered boxes (left justify information in each box). Exception: when using the 8-digit date format, information may be typed over the dotted lines shown in date fields, i.e., Item 24a.
- More than six service lines per claim (use a new form for additional services);
- Narrative descriptions of procedure, narrative description of modifier or narrative description of diagnosis (the CPT, Modifier or ICD-10-CM codes are sufficient);
- Stickers or rubber stamps (such as “tracer,” “corrected billing,” provider name and address, etc.);
- NHIC’s address at top of the form;
- Special characters (i.e., hyphens, periods, parentheses, dollar signs and ditto marks).
- Handwritten descriptions;
- Attachments smaller than 8 1/2 x 11.

The claim form must be:
- An original CMS-1500 printed in red “drop out “ ink with the printed information on back (photocopies are not acceptable);
- Size - 8½” x 11” with the printer pin-feed edges removed at the perforations;
- Free from crumples, tears, or excessive creases (to avoid this, submit claims in an envelope that is full letter size or larger);
- Thick enough (20-22 lbs.) to keep information on the back from showing through;
- Clean and free from stains, tear-off pad glue, notations, circles or scribbles, strike-overs, crossed-out information or white out.

Handwritten claims will not be accepted. If printed items are not correctly positioned within the corresponding boxes the claims will be processed incorrectly or rejected and sent back to the provider.

**CM S-1500 Required Fields:**

**Basic Information:**
BOX 1: Check the appropriate box “Medicaid” for CCC+ or Medallion 4.0 and Medicare for MAPD and DSNP.

BOX 1A: Enter the member’s Virginia Premier I.D. number.

BOX 2: Enter the member’s name (Last name, First Name, Middle Initial)

BOX 3: Enter member’s date of birth (mm/dd/yyyy) and select appropriate gender (M or F)

BOX 4: Enter the member’s name (Last name, First Name, Middle Initial) OR “SAME”

BOX 5: Enter the member’s name (Last name, First Name, Middle Initial) OR “SAME”

BOX 6: Required to check appropriate box

BOX 9: If 11d = yes, this field must be populated. Reject if blank

BOX 9A: If 11d = yes, this field must be populated. Reject if blank

BOX 9D: If 11d = yes, this field must be populated. Reject if blank

BOX 10: Must be populated, will reject if not populated

BOX 10A: Must be populated, will reject if not populated

BOX 10B: Must be populated, will reject if not populated. If "Yes" is selected, for auto accident or other accident, field 14 must be populated with accident date.

BOX 10C: Must be populated, will reject if not populated. If "Yes" is selected, for auto accident or other accident, field 14 must be populated with accident date.

BOX 11: If 10b is selected with a "YES", this must be populated. Reject if blank. If 11C is populated, 11 must be populated.

BOX 11A: Required if patient relationship is not "Self". If blank, reject.

BOX 11D: Required is 11D is Checked yes

BOX 11D: if 11D = "YES" then 9, 9a, and 9d must be populated, if “NO” 9, 9a and 9d must be blank

BOX 12: Not Required

BOX 13: Not Required

BOX 14: If 10a, b or c is populated with "YES", this is required. Reject if blank.

BOX 15: This is used if there is another date outside of what is in field 14.

BOX 16: Not Required

BOX 17: VPHP will allow blank values. If data is passed, then fields (17 & 17b) and segments must be populated. If not, reject claim as missing required information.

BOX 17A: Not Required

BOX 17B: Required if information entered in BOX 17- NPI # - Enter the 10-digit NPI

BOX 18: Not Required

BOX 19: Not Required

BOX 20: Not Required

BOX 21: Diagnosis Code - for transportation claims, use R68.89

BOX 22: Required for Corrected Claim Process. Use 7 in resubmission code and original claim number for Original Ref No.

BOX 23: 5 Digit Zip Code of Pickup Address for Medicare Claims

BOX 24A: Enter the date of service (mm/dd/yy)

BOX 24B: Enter the Place of Service Code - For Land Ambulance transports, use “41”, Air Ambulance use “42”

BOX 24D: Enter the appropriate CPT code for the transport. Please place appropriate procedure code modifier in corresponding box to denote Ambulance Modifier listed in appendix B

BOX 24E: Enter the Diagnosis Pointer. The diagnosis pointer is the letter in BOX 21 where you entered code R68.89 (i.e., A, B, C, etc.)

BOX 24F: Enter the total charge amount for each line
BOX 24G: Enter the number of units or miles for each line
BOX 24J: NPI # - Enter the 10-digit NPI.
BOX 25: Enter your Federal Tax ID number and check the box the “SSN” (Social Security Number) or “EIN” block
BOX 26: Required, your host system tracking number
BOX 27: Required
BOX 28: Total Charge - Enter the total charges for the services in 24F lines 1-6
BOX 29: Not Required
BOX 30: Not Required
BOX 31: Sign and date here
BOX 32: Enter the address where the member was dropped off. Do NOT use commas, periods or other punctuations in the address. Enter space between city and state. Include the hyphen for the 9-digit zip code.
BOX 33: Enter your billing address and phone number. Do NOT use commas, periods or other punctuations in the address. Enter space between city and state. Include the hyphen for the 9-digit zip code.
BOX 33A: Enter your 10-digit NPI number

- You are required to bill in a service charge then mileage charge order. For every instance that a Land Ambulance Service Charge is billed, A0426, A0427, A0428, A0429, a mileage line must also be billed A0425.
- If billing Air Ambulance claims A0430 must be billed with A0435 and A0431 must be billed with A0436.
- Always bill using your NPI number.
- Individual Consideration Service charges must be approved in advance (NEA Only). Service Charges should be billed using CPTT2003 at 1 unit per dollar authorized.
- One claim form per trip leg. For trips with multiple legs the individual legs need to be billed on separate claim forms.
- Failure to place procedure code modifiers on CMS-1500 will result in claim rejection.
- Place only the actual drop off address for the patient in box 32 must have 9-digit zip.

**ID CARDS AND ELIGIBILITY**

**New Member Information**

Virginia Premier members are sent a New Member Packet that includes helpful guidelines and instructions on how to access their health benefits. This packet includes:

- Welcome Letter
- Summary of Benefits
- Multi-Language Insert
- Notice of Non-Discrimination
- Information on how to request a Member Handbook, Provider Directory or formulary or how to access these member materials are located on the Virginia Premier website.

All Virginia Premier members are sent the New Member Packet and Member Identification Card prior to their effective date of coverage.
Eligibility Verification

Each new member enrolled in Virginia Premier will receive an individual member identification card. It is important to remember that a member's eligibility could change on a month-to-month basis. Consequently, you should verify your patient's eligibility each time they present the identification card for services. Physician offices can verify member eligibility through the monthly PCP enrollment and panel listing, online through Virginia Premier's Provider Portal [www.virginiapremier.com](http://www.virginiapremier.com) or by calling Virginia Premier directly.

Virginia Premier has an IVR (interactive voice response) system that allows providers to check member eligibility by entering in the member data utilizing your phone's keypad.

Member Identification Card

Members should be asked to present their member ID card at each visit. Members that have both Medicaid and Medicare should present both their Virginia Premier Medicaid and Virginia Premier Elite Plus ID card when receiving services. Remember that possession of an ID card does not guarantee eligibility for benefits, coverage or payment. The back of the member identification card contains helpful reminders to our member along with instructions on how to reach us. The ID card includes valuable information as displayed below.
ID CARD SAMPLES

Virginia PremierElite Plus

Front of Sample Member Identification Card

Back of Sample Member Identification Card

For urgent or emergency care, dial 911 or go to the nearest urgent/emergency facility. If you are not sure if you need emergency care, call your PCP or the 24-hour Nurse Advice line.

Member Services: <X.XXX.XXX.XXX, TTY:711>
Behavioral Health Crisis: <X.XXX.XXX.XXX>
24-hour Nurse Advice Line: <X.XXX.XXX.XXX>
Smiles for Children: <X.XXX.XXX.XXX>
Adult Dental: <X.XXX.XXX.XXX>
Vision: <X.XXX.XXX.XXX>
Pharmacy Help Desk: Envision: <X.XXX.XXX.XXX>

Website: <VirginiaPremier.com>
Send Claims To: <Virginia Premier Claims
PO Box 4259
Richmond, VA 23220>
Virginia Premier Elite Family

Front of Sample Member Identification Card

Back of Sample Member Identification Card

For urgent or emergency care, dial 911 or go to the nearest urgent/emergency facility. If you are not sure if you need emergency care, call your PCP or the 24-hour Nurse Advice line.

Member Services: <X.XXX.XXX.XXX, TTY:711>
24-hour Nurse Line: <X.XXX.XXX.XXX>
Behavioral Health: <X.XXX.XXX.XXX>
Pharmacy Help Desk: <X.XXX.XXX.XXX>
Smiles for Children: <X.XXX.XXX.XXX>
Adult Dental: <X.XXX.XXX.XXX>
Vision: <X.XXX.XXX.XXX>
ARTS: <X.XXX.XXX.XXX>
Website: <VirginiaPremier.com>
Send Claims To: <Virginia Premier Claims
PO Box 4250
Richmond, VA 23220>
Virginia Premier Elite Individual

Front of Sample Member Identification Card

Back of Sample Member Identification Card

For urgent or emergency care, dial 911 or go to the nearest urgent/emergency facility. If you are not sure if you need emergency care, call your PCP or the 24-hour Nurse Advice line.

Member Services: <XXX XXXX XXXX, TTY 711>
24-hour Nurse Line: <XXX XXXX XXXX>
Behavioral Health: <XXX XXXX XXXX>
Pharmacy Help Desk: <XXX XXXX XXXX>
Benefits: <XXX XXXX XXXX>
Adult Dental: <XXX XXXX XXXX>
Vision: <XXX XXXX XXXX>
ARTS: <XXX XXXX XXXX>
Website: <VirginiaPremier.com>
Send Claims To: <Virginia Premier Claims
PO Box 4250
Richmond, VA 23220>
Co-payments and Co-insurance

Virginia Premier members have no co-payments or co-insurance.

Note: Co-payments are applicable for FAMIS members which are indicated on the membership ID card.

Enrollment Broker

The state has hired an outside vendor, Maximus, to process enrollments for members. The Health Plan will not be able to use agents and/or brokers to enroll members. The Health Plan will also not be able to enroll members directly.

PRIMARY CARE PHYSICIANS

Role of the Primary Care Physician

Primary Care Physicians (PCPs) in the Virginia Premier network include Board Certified or Board Eligible practitioners in the fields of Internal Medicine, General Practice, Family Practice, Pediatrics and Geriatrics. Each Virginia Premier member chooses a PCP who assumes responsibility for the management of our member’s health care needs.

The Primary Care Physician is the key to managing the member’s overall health and well-being. Among the PCP’s role are to:

- Develop, maintain and monitor Individualized Care Plan (ICP) for the member;
- Actively participate as a member of the Interdisciplinary Care Team (ICT); Provide information to member regarding Virginia Premier services;
- Maintain and provide to Virginia Premier medical and other such records and information to the extent permitted by state and federal law;
- Maintain the confidentiality of member information and records;
- Freely communicate with patients about their treatment, regardless of benefit coverage limitations;
- Perform an initial health assessment for new members assigned to their panel to begin establishing the physician-patient relationship;
- Direct provision or coordination of all health care services for the member to include 24-hour coverage;
- Generate referrals to in-network specialists when services cannot be performed by the PCP;
- Contact Virginia Premier to obtain necessary prior authorization for designated services (e.g., out of network referrals, specified diagnostic tests); and
- Comply with all established Virginia Premier policies and procedures as documented in this provider manual.

Availability

The PCP must have an after-hours telephone number for members to call twenty-four (24) hours a day, seven (7) days a week. This number must be published. The member must
be able to reach someone after hours. A voicemail alone after hours is not acceptable.

**Nurse Advice Line**

The Primary Care Physician is the primary source of medical care for our members and acts as the care coordinator for 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 Virginia Premier’s care coordinator, the member’s PCP, and the LTSS provider 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 coordinator, including a physician if necessary. We ensure that if care management needs are identified for a member, the Virginia Premier staff person following up on the member’s issue has access to, and is familiar with, the enrollee’s Individualized Care Plan. After hours, in non-emergent situations, members may contact the Nurse Advice Line at: 800-256-1982. The same number is used for Care Management Support.

**PCP Assignment**

New members are asked to select a Primary Care Physician (PCP) at the time of enrollment. Members may select any Virginia Premier participating PCP whose panel is open to accepting new members. If the member does not select a PCP, Virginia Premier will select one on their behalf. We will consider all available information related to any prior relationship the patient may have had with a PCP, special clinical needs, language requirements, as well as geographic proximity to the provider. Virginia Premier will notify the member of their PCP assignment and will issue a Member Identification Card with the PCP’s name, address and phone number. The PCP will be responsible for getting the Virginia Premier members panel from our Web Portal at [www.virginiapremier.com](http://www.virginiapremier.com).

Members may request a change to their PCP assignment at any time. PCP’s will still receive reimbursement for services rendered to eligible Virginia Premier members regardless if the PCP’s name is printed on the member’s card or not.

**Member Panels**

Virginia Premier now offers a Web Portal for ease of the Primary Care Physicians to access a Member List of all patients paneled to that provider. Please visit [www.virginiapremier.com](http://www.virginiapremier.com). This listing provides important information and should be reviewed at least monthly by your officestaff. Please continue to check eligibility through the
portal as this listing does not necessarily reflect eligibility. Please refer to these resources before providing services or referring members to specialists.

Example of Member Panel

<table>
<thead>
<tr>
<th>Medical Practice ID</th>
<th>Medical Practice Address</th>
<th>Provider Name</th>
<th>Member Name</th>
<th>Member Gender</th>
<th>Member Ph</th>
<th>Member Address</th>
<th>Effective Date</th>
<th>Member Status</th>
<th>Benefit Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>VPPROV 0 Dr Drive</td>
<td>Dr Med ABC Patient xxxxx</td>
<td>F (757) 000-0000 x Milky Wa</td>
<td>10/1/2015</td>
<td>ACTIVE</td>
<td>VA PREMIE</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Member/Provider Incompatibility

Virginia Premier recognizes that the physician-patient relationship is a personal one and may become unsatisfactory to either party. Virginia Premier has established procedures that allow for the smooth and orderly transfer and re-assignment of members and PCPs.

- All member transfer requests, whether from the member or the PCP, will be reviewed by Virginia Premier to determine the appropriateness of the request. Member transfer requests that involve quality of care issues will be forwarded to our Quality Team and Medical Director for review.
- Decisions regarding member transfer requests will be made effective the 1st day of the following month. Both the member and the provider will receive written notification of PCP transfers. The notification will include the effective date of the transfer.
- The new PCP is responsible for contacting the member’s former PCP to arrange for the transfer of any medical records in order to ensure continuity of care. Member listings will appear in the following month’s statement.

At Member’s Request:

Members have the right to change their PCP with or without cause. Members must contact Virginia Premier’s Member Services Department to initiate the change. Member Services staff will identify and document the reason for a Primary Care Physician change. We will monitor changes to identify possible trends to be addressed through our Quality Program.

At the PCP’s Request:

Primary Care Physicians have the right to request that a member be transferred to another participating PCP. Requests for member transfers may be initiated by telephone, but must also be submitted in writing to Virginia Premier’s Provider Service’s Department and should include the reason(s) for the request. All decisions regarding such transfers shall be made and become effective as soon as administratively feasible, but in any event decisions shall be made within (60) days from the date of the request. In the event that a PCP wishes to dismiss a patient from their panel the provider is still responsible for providing that member with Primary Care Services, participating in the ICT and facilitating the ICP until the transfer to another PCP has taken place. In addition, the Primary Care Physician is required to share with the new Primary Care Physician or other provider any and all medical records related to the member’s care.

Mail or fax your request to:
Change in Member Status

Virginia Premier members can be disenrolled from Virginia Premier by the Department of Medical Assistance Services (DMAS) if the member no longer meets DMAS’ eligibility requirements. PCPs are responsible for notifying Virginia Premier’s Member Services Department, Virginia Premier’s care coordinator and the ICT if they know of a member’s change in eligibility status.

Immunizations

Primary Care Physicians are responsible for administering appropriate immunizations to Virginia Premier members. Virginia Premier recommends administration of immunizations according to the Advisory Committee on Immunization Practices (ACIP). PCP compliance with immunization standards will be monitored through Virginia Premier’s provider office and medical record review.

Note: CPT codes are subject to change annually. Providers are advised to review the immunization schedule developed by the Advisory Committee on Immunization Practice (ACIP) or go to www.vdh.state.va.us.

- Providers are encouraged to enroll in the Vaccines for Children (VFC) program. Enrollment documentation can be found at the following link: www.vdh.virginia.gov/content/uploads/sites/11/2016/04/VirginiaProviderAgreementProfile.pdf
- Providers should not routinely refer members to local health departments for vaccines.
UTILIZATION MANAGEMENT

Utilization Management Program

Virginia Premier’s Medical Payment Policy (MPP) Committee determines procedures that are considered investigational, not medically necessary, are medically necessary if they meet medical criteria (including InterQual©), and those procedures requiring authorization. Practitioners are urged to review our website for operational updates. These updates will be posted to our website under the “Provider Services Tab” at www.virginiapremier.com. Specific questions relating to the MPP can be obtained by contacting our Medical Management Department.

Virginia Premier is prohibited from providing incentives for denying, limiting, or discontinuing medical services for its members inclusive of practitioners and Virginia Premier staff. UM decisions are based on appropriateness of care and service, member’s wishes or as communicated by the caregivers, and existence of coverage for the member. Virginia Premier does not discriminate against particular practitioners, LTSS providers that serve high-risk populations, or providers that specialize in conditions that require costly treatment. Additional information pertaining to Virginia Premier Utilization Management Program can be accessed at www.virginiapremier.com.

Authorizations

Primary Care Physicians (PCPs) in the Virginia Premier network include Board Certified or Board Eligible practitioners in the fields of Internal Medicine, General Practice, Family Practice, and Pediatrics. Each Virginia Premier member chooses a PCP who assumes responsibility for the management of our member’s health care needs. An Obstetrician may assume care for members during pregnancy, but generally will refer back to the PCP for health care issues unrelated to the pregnancy. If a PCP determines that a member requires the services of a specialist or other treatment that they are unable to provide, then the PCP must make a recommendation to the appropriate specialist for the services, however Virginia Premier does not require a referral from the PCP in order for the member to obtain specialist services. The PCP shall request and ensure receipt of copies of medical records of the services provided by the specialist. The PCP will evaluate the outcome of the specialist services and coordinate further care for the member. If a member requires specialist services and a participating specialist is not available, the PCP shall obtain authorization from Virginia Premier to refer to a non-participating specialist. Any approval by Virginia Premier for a course of treatment or referral services does not release the PCP from his/her obligation to verify member eligibility at the time covered services are rendered.

Members may be referred to an out of network specialist with prior authorization from Virginia Premier in the following circumstances:

- Virginia Premier’s contracted providers are unable to provide the specialty service required for the member’s medical care.
- Virginia Premier does not have a provider in the network with appropriate training or experience.
- Services are prior authorized by another HMO or Medallion prior to enrollment with Virginia Premier to avoid interruption of care.
<table>
<thead>
<tr>
<th>Region</th>
<th>Address</th>
<th>Phone</th>
<th>Fax</th>
<th>Admissions Only: 877-739-1365</th>
</tr>
</thead>
</table>
| **Tidewater**                 | Virginia Premier Referral and Authorizations 825 Greenbrier Circle Suite 200  
Chesapeake, VA 23320         | 888-251-3063    | 800-827-7192                 |                               |
| **Central Virginia / Fredericksburg / Western** | Virginia Premier Referral and Authorizations  
P.O. BOX 5307  
Richmond, Virginia 23220 | 888-251-3063    | 800-827-7192                 |                               |
| **Roanoke / Southwest Virginia** | Virginia Premier Referral and Authorizations  
5060 Valley View Blvd. NW  
Roanoke, Virginia 24012      | 888-251-3063    | 800-827-7192                 |                               |
Out-of-Plan Authorizations

Referrals to non-participating specialists are permitted only if the required specialty service is not available through the Virginia Premier network and the service is pre-authorized by the Plan.

- All out-of-plan referrals must receive advance approval by the UM Department representative or the Medical Director as indicated with the exception of emergent services and family planning. Authorization must be obtained before a claim is submitted or the claim will be denied.
- The PCP or rendering provider should call the UM department to request approval for out-of-plan services. The Medical Director will review the request if the request does not meet continuity of care guidelines or if the service cannot be provided in network.
- If approved, the PCP or the Medical Director will recommend the appropriate out-of-plan specialist to be utilized. The PCP will obtain an authorization number from the UM Department.
- The specialist must complete the evaluation and document the findings and send a report back to the PCP. If the referral is not approved by Virginia Premier, the Rendering provider will be notified and provided with alternative recommendations. The PCP has the right to appeal the denial and may discuss medical indications with the Medical Director.

Pre-Authorization

The PCP is responsible for providing and/or managing all health care services for the Virginia Premier member. However, some services also require pre-authorization from us. The pre-authorization process allows Virginia Premier to:

- Verify the member’s eligibility
- Determine whether or not the service is a covered benefit
- Make sure that the chosen provider is in the Virginia Premier network
- Evaluate the medical necessity criteria for the service
- Enter the member into Virginia Premier’s Case or Disease Management program if appropriate

To pre-authorize services, contact Virginia Premier’s UM Department at the number listed for the service area. Failure to pre-authorize services will result in denial of payment and the provider may be held responsible for the services.

Please see Mental Health Services for clarification of authorization requirements.

Procedures Requiring Pre-Authorization

The full listing of services can be found at www.virginiapremier.com, Goto Providers, Utilization Management, and then PAL Search Tool, or to this link:

www.virginiapremier.com/npa/NPA_Search.html

Pre-authorization is required for services including, but not limited to, the following:
• All inpatient hospitalizations (and extensions beyond original LOS)
• Observation admission (Most in or out of network facilities do not require an authorization).
• Chemotherapy
• Chiropractic (this is a FAMIS benefit only)
• Cosmetic Surgery (e.g., Keloid and Scar Revisions, Varicose Veins, Mammoplasty, Reduction and Augmentation)
• Durable Medical Equipment (DME) (Includes Orthotics and Prosthetics when applicable*)
• Enteral Nutrition* and Total Parenteral Nutrition
• Health Education and Training Services
• Home Health Services
• Hyperbaric Therapy
• Infusion Services
• Organ Transplant
• Outpatient Surgical Procedures done in a Hospital / Ambulatory Surgical Setting
• Out of Network Referrals
• Pain Management (e.g., joint injection, spinal cord stimulator)
• Rehab Therapy (e.g., Physical Therapy, Occupational Therapy)
• Radiological – (Non routine imaging for example: CT, CTA, MRI, MRA, Nuclear Scan, PET Scans, etc.). This is prior authorized through NIA: www.RadMD.com, or (800) 642-7578
• Radiation Therapy
• Specialty Drugs

*Age requirements apply.

Note: If a provider has any questions pertaining to prior authorization, please contact Virginia Premier’s Utilization Management Department or check our PAL list on our website prior to performing the procedure.

Authorization Decision Time Frames

The following timeframe for decision requirements applies to service authorization requests:

Standard Authorization Decisions

For standard authorization decisions, Virginia Premier shall provide the decision notice as expeditiously as the member’s health condition requires and within State-established timeframes described in the table below, with a possible extension of up to fourteen (14) additional calendar days, if:

• The member or the provider requests extension; or
• Virginia Premier justifies to the State agency upon request that the need for the additional information is in the member’s interest.
**Expedited Authorization Decisions**

For cases in which a provider indicates, or Virginia Premier determines, that following the standard timeframe could seriously jeopardize the member’s life or health or ability to attain, maintain, or regain maximum function, Virginia Premier will make an expedited authorization decision and provide notice as expeditiously as the member’s health condition requires and no later than 72 hours after receipt of the request for service.

Virginia Premier may extend the 72-hour turnaround time frame by up to fourteen (14) calendar days if the member requests an extension or Virginia Premier justifies (to the State agency upon request) a need for additional information and how the extension is in the member’s interest.

<table>
<thead>
<tr>
<th>Service Authorization Decision Timeframes for MLTSS (See above description for extensions.)</th>
<th>Turnaround Times</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Physical Health</strong></td>
<td></td>
</tr>
<tr>
<td>Inpatient (Standard or Expedited) and Concurrent inpatient</td>
<td>1 business day if all clinical information is available or up to 3 business days if additional clinical information is required as expeditiously as the member’s condition requires</td>
</tr>
<tr>
<td>Outpatient / EPSDT Outpatient (Standard)</td>
<td>3 business days if all clinical information is available or up to 5 business days if additional clinical information is required.</td>
</tr>
<tr>
<td>Outpatient (Expedited)</td>
<td>No later than 72 hours from receipt of request; or, as expeditiously as the member’s condition requires</td>
</tr>
<tr>
<td>Long Term Services and Supports to include - CCC Plus Waiver (including waiver services through EPSDT), Nursing Facility, Respite, Personal Care, Long Stay Hospital, etc. (Standard)</td>
<td>5 Business Days</td>
</tr>
<tr>
<td>Long Term Services and Supports to include - CCC Plus Waiver (including waiver services through EPSDT), Nursing Facility, Respite, Personal Care, Long Stay Hospital, etc. (Expedited)</td>
<td>No later than 72 hours from receipt of request; or, as expeditiously as the member’s condition requires</td>
</tr>
</tbody>
</table>
Behavioral Health

<table>
<thead>
<tr>
<th>Standard UM Review</th>
<th>14 days if all clinical information is available, or as expeditiously as the member’s condition requires.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient (Standard or Expedited) and Concurrent inpatient</td>
<td>1 business day if all clinical information is available or up to 3 business days if additional clinical information is required as expeditiously as the member’s condition requires</td>
</tr>
<tr>
<td>Expedited Urgent reviews for other urgent service</td>
<td>24 Hours</td>
</tr>
</tbody>
</table>

Utilization Management Staff Availability

UM personnel are available to assist you in expediting care for your Virginia Premier patient. UM Offices are open from 8:00 am to 6:00 pm daily. If you call after hours or on a weekend, a confidential answering machine will receive your call. Please leave detailed information and a Virginia Premier representative will respond to your call on the next business day.

Hospital Admissions: Elective Admissions

All hospital admissions, some observation admissions (excluding OB observation), and outpatient ambulatory surgical procedures must be pre-authorized using the following guidelines (also referred to as “pre-admission certification”).

- The admitting physician or his/her designee will notify Virginia Premier’s UM nurse of the planned admission. If this is an emergency admission, Virginia Premier must be notified within 24 hours of admission, or the next business day.
- The UM nurse will verify eligibility, then obtain baseline information:
  - Demographic profile
  - Requested admission date
  - Requested procedure date, if applicable and/or different from admission date
  - Hospital or outpatient facility
  - Admitting physician
  - Diagnosis
  - Procedure, if applicable
  - Expected length of stay (LOS)
The UM Nurse will review the request based upon clinical information obtained.

1. Appropriate ICD-10 codes are determined using ICD-10 referral sources.
2. If authorized, an authorization number will be given to the physician. All hospital stay extensions beyond the originally authorized length of stay will require additional review.
3. If the reported information is not consistent with Virginia Premier policy, the Medical Director will review the request for further consideration. If the admission is imminent, the Medical Director will make a determination within 24 hours unless additional clinical information is needed and then a determination will be made within 3 business days.
4. Notification to the requesting provider will be made no later than one (1) business day before the scheduled admission. Hospitals not receiving pre-authorization must contact Virginia Premier to verify status of authorization.

Admission / Concurrent Review

All inpatient hospital stays require an authorization. At the time of the review for emergency admission, Virginia Premier will determine if the admission was medically necessary. Pending availability of clinical data, determinations will be made within 24 hours of Virginia Premier’s notification with subsequent notification to providers within 24 hours of making the decision. When applicable, the admission will be documented in the member’s ICP.

Concurrent or continued stay reviews are performed on all non-DRG hospitalized patients and DRG admissions that exceed expected length of stay (LOS). Medical Records review will determine if the assigned LOS remains appropriate or if it should be modified given significant changes in the patient’s condition. Continued stay decisions will be communicated by telephone to the appropriate contact in the facility’s UM Department and to the attending physician’s office. Letters are generated for approvals and non-certification which include instructions on submitting an appeal. The facility, attending physician and member are notified in writing of the decision within 3 business days of making the decision or sooner if this is an expedited request.

Care Management Services

As part of the concurrent review process, Virginia Premier’s Utilization Management team will partner with the Care Coordination team to screen each patient for discharge planning and ongoing care coordination needs, as well as collaborate with the Regional Transition Coordinator to facilitate a smooth transfer back to the assigned care coordinator. The transition coordinator will facilitate communication between discharging and receiving providers and/or family members to minimize the risk of re-admission due to preventable causes.

Once the member is settled and the new treatment plan has been successful, the responsibility for Care Coordination will return to the Regional Care Team. Providers are encouraged to engage with the transition coordinator and the RCT during both ad hoc and regular Interdisciplinary Care team meetings to assess the member’s status and update the ICP.
Continuity of Care

Virginia Premier will honor all existing ICPs and prior authorizations (PAs) as provided by DMAS, DMAS’ contracted managed care entities, and Medicare until the authorizations ends or 90 days from enrollment, whichever is sooner, for MLTSS recipients. For EDCD Waiver members, Virginia Premier will develop and implement the ICP no later than the end date of any existing PA. If the existing PA end-date is within thirty (30) days of enrollment into the health plan, Virginia Premier may elect to automatically extend the authorization (unchanged) for up to thirty (30) days from the date of enrollment to allow time for the HRA and ICP to be developed.

Virginia Premier will allow members to maintain their current providers (including out-of-network providers) for 90 days from enrollment. Virginia Premier will also allow members to maintain their preauthorized services as provided from DMAS or DMAS’ contracted managed care entities for the duration of the PA or for the 90 days from enrollment, whichever is sooner, except for individuals residing in a NF at the date of enrollment into the health plan. Individuals in NFs at time of enrollment may remain in the NF as long as they continue to meet DMAS criteria for nursing home care, unless they or their families prefer to move to a different NF or return to the community.

Virginia Premier will transfer PA, assessment, ICP, and other pertinent information necessary to assure continuity of care to another MMP for members that choose to transfer. The information will be provided no later than three (3) calendar days from receipt of the notice of dis-enrollment to the Virginia Premier and no later than the effective date of transfer in the method and format specified by DMAS.

Virginia Premier will ensure that members in NFs who wish to move to the community have the appropriate services and resources in place to support their safe transition back to the community. The care coordinator will collaborate with the member, caregiver/family, ICT, facility, and transition provider to coordinate all aspects of the member’s transition. If appropriate, members will be given the choice of receiving transitional service and coordination through the plan or referral to the Money Follows the Person (MFP) Program. If the individual enrolls in the MFP Program, he/she will be dis-enrolled from Virginia Premier.

If, as a result of the development of the ICP or the HRA, Virginia Premier proposes modifications to the member’s prior authorized services after the continuity of care period, Virginia Premier will provide written notification to the member about an opportunity to Appeal the proposed modifications.

Non-Certification / Denial of Certification

Virginia Premier’s UM staff will make a referral to the Medical Director whenever the admission review or concurrent review information fails to meet medical necessity guidelines. The Medical Director will make a decision to approve or deny the certification. If denied, the decision of the Medical Director will be communicated by telephone and in writing, citing the reason for the decision (e.g., lack of medical necessity, lack of information, failure to notify).

The decision will also be documented in the member’s ICP. A provider and/or member may request a copy of the criteria that was used to make a non-certification decision. The Medical Director will discuss the denial with the attending physician should there be any questions.
For currently certified admissions, notification of a non-certification decision will be given on the day prior to or the same day of the non-certified day. The physician, hospital UR department and any other hospital department requesting notification will be called with the name of the member, date of non-certification. In addition, non-certification letters will be sent to the physician, member and the hospital-admitting / UR department, along with instructions on submitting an appeal.

**Inpatient Denials**

If an attending physician continues to hospitalize a member who does not meet Virginia Premier’s medical necessity criteria, all claims for the hospital and physician will be denied from that day forward.

Note: The member cannot be billed for covered services that Virginia Premier has denied. If the patient / family member insists upon continued hospitalization (even though both the attending physician and Virginia Premier agree that the stay is no longer medically necessary) or if the services are non-covered benefits, the member will be financially responsible for those services if notified prior to receiving services and gives consent. The Virginia Premier UM nurse will notify the member or the member’s family of the determination of non-certification. The hospital must notify the member of their financial responsibility.

**Medical Necessity Appeals**

The Medical Necessity Appeals process is a mechanism through which a member, member’s representative, attending physician / provider or facility can request a review of a decision by Virginia Premier. Appeals will be considered if received within thirty (30) days of the decision.

Note: A decision made by Virginia Premier may be due to the failure to demonstrate medical necessity for admissions, continued length of stays, services, procedures, and diagnostic tests. Medical necessity is based on Virginia Premier approved medical policy, Interqual© criteria, and state and national clinical guidelines. A provider and/or member may request a copy of the criteria that was used to make a non-certification decision.

**Medical Necessity Criteria**

Virginia Premier uses McKesson Interqual© criteria, nationally recognized clinical practice guidelines / standards and approved Virginia Premier peer-review guidelines for determinations of medical necessity for medical and behavioral health services. The following factors are considered when applying criteria to a given individual:

- Age
- Co-morbidities
- Complications
- Progress of treatment
• Psychosocial situation
  • Home environment, if applicable
• Benefit coverage

Upon request, individual criteria used in a medical necessity determination will be mailed to a member, practitioner and/or facility.

There are two types of Medical Necessity Appeals, Expedited and Standard.

**Expedited Medical Necessity Appeal**

Expedited appeals may be requested when a non-certification decision is made by Virginia Premier prior to, or during the course of treatment. If the member or physician / provider believes that Virginia Premier’s decision is not acceptable, a request to appeal should be faxed to Virginia Premier’s Medical Management Department. Once the appeal is received, Virginia Premier will select a physician of the same or related specialty to review the case. This physician will be responsible for returning a decision within seventy-two (72) hours of receiving the information required for the expedited appeal. A member may appeal to Virginia Premier and/or DMAS. A member / provider must exhaust the plan level appeal process before appealing to DMAS.

**Standard Medical Necessity Appeal**

Standard appeals are generally made after the services have been rendered. Copies of medical or hospital records may be required before the process can begin. All documentation should be faxed or mailed to Virginia Premier's Medical Management Department. Once the related information is received, the appeal will be reviewed by a physician of the same or related specialty, and a decision rendered in thirty (30) days. A member may appeal to Virginia Premier and/or DMAS.

Virginia Premier will provide in writing, clinical rationale for the non-certification decision to the member, physician / provider, or the facility. A member / provider must exhaust the plan level appeal process before appealing to DMAS.

All medical information and appeals for reconsideration of prior authorization / notification or appeals of medical necessity should be sent to:

  Virginia Premier
  Medical Management Grievances and Appeals
  P.O. Box 5244
  Richmond, Virginia 23220

Providers must exhaust appeals with Virginia Premier before appealing to Department of Medical Assistance Services (DMAS).

  Department of Medical Assistance Services (DMAS) Appeals Division
  600 E Broad Street
  Richmond, VA 23219

  **Phone:** (804) 371-8488
Emergency Services / Urgently Needed Care / ESRD Out of the Service Area

In the case of sudden onset of an unexpected medical condition and time permits, Virginia Premier members are instructed to contact their PCP for medical advice. If the member is unable to reach their PCP or the situation arises after business hours, members are instructed to call the Nurse Advice Line at 1-800-256-1982. The PCP or Nurse Advice Line staff will assess the member's medical condition and instruct the member on how to obtain appropriate medical services.

URGENT CARE

Virginia Premier members may utilize participating Urgent Care Centers for unexpected medical conditions and no referral is required.

If the member presents to the ER without authorization from their PCP or Nurse Advice Line, and the situation does not appear to pose an immediate threat to the member's health, emergency room staff should encourage the member to contact the member's PCP.

Remember: In the event of a true emergency, Virginia Premier members should seek immediate medical treatment from the nearest emergency room. Members should notify their PCP or Virginia Premier within 24 hours (or the next business day) of receiving services.

In the absence of authorization of non-emergent / urgent care, visits may be retrospectively reviewed to determine coverage. Only true emergencies based on the prudent layperson standard will be approved for payment. Facility / Emergency Room services that do not meet the Prudent Layperson standard will be reimbursed for a medical screening or “triage fee” only when applicable. Members should be referred back to their primary care physician for any follow-up.

APPEALS

There are two types of Medical Necessity Appeals, Expedited and Standard.

Expedited Medical Necessity Appeals

Expedited appeals may be requested when an adverse benefit determination is made by Virginia Premier prior to, or during the course of treatment. If the member or physician / provider believes that Virginia Premier's decision is not acceptable, a request to appeal should be sent to Virginia Premier Medical Management's Grievances and Appeals Department. Once the appeal is received, Virginia Premier will select a physician of the same or related specialty to review the case. This physician will be responsible for returning a decision within seventy-two (72) hours of receiving the information required for the expedited appeal, but is not the same physician who rendered the initial denial. A member or physician / provider must exhaust all Virginia Premier appeals BEFORE appealing to DMAS. A member / provider must exhaust the plan level appeal process before appealing to DMAS.
Standard Medical Necessity Appeals

Standard appeals are generally made up to sixty (60) calendar days after the services have been rendered. Copies of medical or hospital records may be required before the process can begin. All documentation should be faxed or mailed to Virginia Premier Medical Management’s Grievances and Appeals Department. Once the related information is received, the appeal will be reviewed by a physician of the same or related specialty, and a decision rendered in thirty (30) calendar days, but is not the same physician who rendered the initial denial. A member or physician / provider must exhaust all Virginia Premier appeals before appealing to DMAS. Virginia Premier will provide in writing, clinical rationale for the adverse benefit determination to the member or physician / provider. A member / provider must exhaust the plan level appeal process before appealing to DMAS.

All medical information and appeals of prior authorization / notification or appeals of medical necessity should be sent to:

Virginia Premier
Medical Management Grievances and Appeals
P.O. Box 5244
Richmond, VA 23220

Members or physicians / providers must exhaust appeals with Virginia Premier before appealing to DMAS.

To contact DMAS regarding appeals, use the following information:

Department of Medical Assistance Services (DMAS) Appeals Division
600 E Broad Street
Richmond, VA 23219
Phone: (804) 371-8488

EMERGENCY SERVICES

In the event of a true emergency, Virginia Premier members should seek immediate medical treatment from the nearest emergency room. Members should notify their PCP or Virginia Premier within 24 hours (or the next business day) of receiving services to assist with any care needs.

In the case of sudden onset of an unexpected medical condition and time permits, Virginia Premier members are instructed to contact their PCP for medical advice. If the member is unable to reach their PCP or the situation arises after business hours, members are instructed to call the Nurse Advice Line at 1-800-256-1982. The PCP or Nurse Advice Line staff will assess the member’s medical condition and instruct the member on how to obtain appropriate medical services.

Gynecology and Obstetrical Services

All female Virginia Premier members have direct access to in-network OB/GYN’s for
annual and routine visits and all necessary follow-up care without a referral. If the Virginia Premier member requires continuous follow-up care, the OB/GYN can provide such care without authorization or a referral, but should consult with the member’s PCP either before or after the care is provided. Consultations may be made by telephone.

When a Virginia Premier MLTSS member has selected their OB/GYN, the OB/GYN must become part of the Interdisciplinary Care Team (ICT).

Outpatient surgical procedures or hospitalizations require pre-authorization from Virginia Premier. Services can be coordinated through Virginia Premier’s Medical Management Department for obstetric patients that require additional specialist visits. OB/GYN services include:

- Prenatal, labor and delivery, and post-partum care
- Specialty gynecological care
- Family planning services in or out of network
- Annual routine pelvic exams under the Women’s Wellness Program
- Counseling for HIV testing
- Maternal and newborn home health assessment (home health visits within 48 hours)
- Elective abortions are authorized and reimbursed through DMAS

When a pregnant member’s estimated date of delivery (EDD) is determined, the obstetrician must:

- Complete the OB Registration Form (Exhibit A) which can be accessed at www.virginiapremier.com.
  - This form is used to identify pregnant members early and to assist with care coordination. Virginia Premier seeks to partner with the provider to ensure consistent prenatal care by the member.
- Return the request form to the Medical Management Department by faxing to the number found on the form.
- OB ultrasounds and non-stress test do not require prior authorization.

OB/GYN’s are responsible for coordinating services with participating hospitals and specialists for OB related care. The participating OB/GYN is responsible for notifying Virginia Premier’s Case Management Department for assistance with prenatal care and enrollment in the Healthy Heartbeats™ program.

**Length of Stay Policy**

For routine vaginal delivery, Virginia Premier authorizes a length of stay of three days, or less, based on the decision of the member and their physician. Cesarean section deliveries are authorized for a five-day length of stay, or less, based upon the decision of the member and their physician.
Post-Delivery Services and Home Health

On July 1, 1996, the Virginia legislature passed a bill that requires all plans to provide postpartum services in accordance with medical criteria as outlined in “Guidelines for Perinatal Care” prepared by American Academy of Pediatrics (AAP) and the American College of Obstetrics and Gynecology (ACOG). These services include appropriate postpartum inpatient care including home visits for early discharges. All Virginia Premier postpartum patients will receive a home visit from an RN within 48 hours of discharge unless refused by the member or attending OB/GYN physician. For MLTSS recipients, the home visit will be documented in the ICP.

Gynecology Services: Direct Access Legislation

The Virginia Legislature passed a bill effective July 1, 1996, allowing women to self-refer to their OB/GYN physician for services related to the female reproductive system / breasts. Any Virginia Premier member may self-refer for the following services:

- Annual Exam and PAP smear
- Any OB/GYN Problem
- Family Planning
- Prenatal Care
- Breast Exams
- Screening Mammogram

Upon self-referral, the OB/GYN must notify Virginia Premier and assume an active role within the Interdisciplinary Care Team. The OB/GYN will be responsible for communicating with the ICT and ensuring the ICP is updated accordingly.

Family Planning

Family planning services are covered benefits for Virginia Premier members. Family planning can be provided in or out of network, do not require prior authorization and services include the following:

- Counseling services and patient education regarding HIV, sexually transmitted infections, and risk reduction practices
- Preventive exam and treatments
- Medically necessary lab tests, including testing and counseling for HIV
- Medically approved methods, procedures, drugs, supplies and devices to prevent an unplanned pregnancy. These include the use of birth control pills, diaphragms, Depo Provera injections, IUD and Norplant implants (insertion and removal) and other contraceptive methods. (This does not include services to treat infertility or to promote fertility)
- Treatment for sexually transmitted diseases

Sterilization Services

Sterilization services (tubal ligation, contraceptive implants and vasectomy) are covered services
for Virginia Premier members. Virginia Premier follows the State and Federal regulations regarding sterilization procedures. All requests for pre-authorization for sterilization procedures must have the completed “Consent to Sterilization” form which can be found at www.virginiapremier.com. The patient must be 21 years of age, mentally competent and must wait a minimum of 30 days (no more than 180 days) after signing the consent form to have the procedure.

Healthy Heartbeats™

To meet the needs of routine and high-risk pregnant women, Virginia Premier implemented the Healthy Heartbeats™ (HHB) Program. The HHB prenatal care program combines extensive outreach and home visits with high-risk OB case managers, prenatal care, education classes, and support services such as transportation to improve birth outcomes. Members enrolled in Healthy Heartbeats™ are cared for by their physician and the Interdisciplinary Care Team that includes a medical outreach worker, a case manager, and a health educator.

This team arranges for personalized telephonic or in-home assessments and follow-up services that allow the plan to develop care coordination and supportive services tailored to the needs of each member. Ancillary services such as nutritional counseling and peer support groups for breastfeeding mothers may also be provided through a unique partnership with the Women, Infants and Children Program (WIC). Virginia Premier has also collaborated with local hospitals throughout all regions on the delivery of prenatal education classes. Virginia Premier partners with internal and external resources to offer baby showers for members across all regions, where they receive gifts, prenatal, postpartum, and baby care education and connect with other members.

Members receive incentives for joining Healthy Heartbeats, accessing timely prenatal and postpartum care appointments, and earn points for completing screenings, enrolling in WIC, finding a pediatrician for their baby, reviewing safe sleep and breastfeeding education, attending prenatal and parenting classes and participating in case management and home outreach services. After delivery, the member may receive a home health nurse visit that supports new mothers in the first 48 to 72 hours after discharge when necessary.

Eligible program participants will be identified through completed OB Registration forms submitted by the Obstetrician, Primary Care Physician encounters with a pregnancy related diagnosis, emergency room visits, specialty referrals to OB physicians, inpatient care reports, Makenna and NAS reports, DMAS, self-referrals, updated plans of care, ICT members and community referrals. Program goals include:

- Creating a partnership between the member, OB or Midwife, and Virginia Premier
- Increasing early, consistent and timely prenatal and postpartum care
- Identifying and addressing any medical/social problems that may adversely impact the pregnancy outcome
- Developing partnerships with providers and members to improve outcomes and compliance with the Individualized Care Plan through high-risk OB services
- Screening members for risk and connecting them with needed services
- Transitioning each newborn into Virginia Premier’s educational Watch Me Grow EPSDT Program
WIC (Women, Infants and Children)

Virginia Premier works closely with Primary Care and OB/GYN providers to identify any member who may benefit from the Special Supplemental Nutrition Program for Women, Infants and Children (WIC). This program is administered by the Virginia Department of Health and provides breastfeeding education, supplemental nutrition, formula and vouchers for other food products.

As part of the Healthy Heartbeats™ program, members receive assistance in enrolling into the WIC program. In addition, as part of the incentive program they receive bonus points for WIC enrollment that may later be rewarded with a gift card that the member can use for baby items and necessities.

Abortions

Virginia Premier does not cover services for abortion. Requests for abortions where the life of the mother is endangered shall be forwarded to the Department of Medical Assistance Services (DMAS) for review to ensure compliance with Federal Medicaid rules. DMAS will be responsible for payment of abortion services meeting Federal Medicaid requirements under the fee-for-service program.

Infertility Services

Infertility services are a non-covered benefit for Virginia Premier members.

Substance Use Services for Obstetric Patients

Medallion members must request inpatient residential or day treatment substance abuse services for pregnant women through DMAS. These services are available to Virginia Premier’s MLTSS members and are coordinated through the ICT team and in accordance with the ICP. Virginia Premier will coordinate access to these services for our members.

FAMIS Exception: Inpatient or day treatment substance abuse services for pregnant women will be covered by Virginia Premier for members enrolled through the FAMIS program. Members are restricted to 90 days of treatment in a lifetime. All inpatient services will be arranged through a participating acute care hospital. FAMIS enrollees may not be admitted to a freestanding psychiatric facility.

DIAGNOSTIC TESTING: LABORATORY SERVICES

Virginia Premier has contracted with Lab Corporation of America (LabCorp) and Solstas Labs to provide outpatient laboratory services for our members. Participating physicians should contact LabCorp or Solstas Labs to arrange for specimen pick-up, supplies, Laboratory Request Forms, results, and general information.

Physicians may elect to draw specimens in their office for courier pick-up by LabCorp or Solstas, or they may choose to send the patient with orders to one of our lab partners draw sites.

To find the nearest LabCorp site, visit www.labcorp.com
To find the nearest Solstas site, visit www.solstas.com
CLIA Waived Tests

All physicians performing Clinical Laboratory Improvement Amendment (CLIA) labs must have a Certification of Waiver or a Certificate of Registration and an Identification number. Those physicians with a Certificate of Waiver are limited to providing only the types of tests permitted under the terms of the waiver. Physicians with a Certificate of Registration may perform the full range of services for which they are certified.

Pre-Operative Lab Testing

Virginia Premier members who are scheduled for elective surgery at a participating hospital should have their pre-operative lab work sent to LabCorp, Solstas or lab station negotiated in our contract.

If this is not possible due to time constraints of the scheduled admission, the lab work can be done by the admitting hospital. In order for these labs to be reimbursed, the hospital must call the Virginia Premier UM department to obtain the appropriate authorization. The hospital should bill the pre-operative lab work separately from all other services and include this authorization number for payment.

Pathology Specimens

Pathology specimens obtained in the physician’s office must be sent to LabCorp or Solstas Labs for processing. If a provider deems it necessary to send a pathology specimen to a non-participating pathology lab (other than LabCorp or Solstas) then Virginia Premier must be notified and those services pre-authorized.

Exceptions: If Virginia Premier has authorized a procedure, the authorization includes all professional services associated with that procedure. Therefore, an additional authorization is not required for pathology services associated with that authorized procedure. The hospital may perform and bill for pathology services associated with the procedure.

Sperm analysis for infertility treatment is excluded since this is not a covered benefit.

RADIOLOGY SERVICES AND GUIDELINES

Routine Radiological Studies

Physicians may self-refer patients for routine diagnostic radiological testing. This testing must be done at a participating facility or the physician’s office if certified to perform radiological testing. Routine radiological testing does not require prior authorization from Virginia Premier. Routine diagnostic radiological testing performed in the PCP or specialist’s office will be billed and reimbursed fee-for-service.

Outpatient Studies

Virginia Premier partners with NIA (National Imaging Associates) to manage the outpatient imaging management services precertification process using nationally revered clinical guidelines for imaging/radiology services.

Prior authorization is required for the following outpatient radiology procedures through NIA:
• CT / CTA / CCTA
• MRI/MRA
• PET Scan
• Nuclear Cardiology

The ordering physician is responsible for obtaining authorization prior to rendering the above-listed services. To obtain authorization, the provider should go to the NIA website www.RadMD.com, or through the NIA dedicated toll-free phone number, 1-800-642-7578.

Providers rendering the services listed above should verify that the necessary authorization has been obtained by visiting www.RadMD.com, or by calling NIA at 1-800-642-7578. Failure to do so may result in nonpayment of your claim. A complete listing of CPT codes requiring preauthorization through NIA is available at www.RadMD.com.

Note: Emergency room, observation and inpatient imaging procedures do not require authorization.

Any requests to perform services out of plan must receive prior authorization through Virginia Premier’s Medical Management Department or will result in nonpayment of the claim.

Mammography Services

Virginia Premier encourages women over the age of 40 to have breast exams and yearly mammograms. Virginia Premier covers one baseline mammogram for women between ages 35 - 39. No referral or authorization is required for screening mammograms. Additionally, mammograms ordered as a result of breast abnormalities are covered regardless of age. These diagnostic mammograms require prior authorization. All breast exams for MLTSS recipients will be documented in the member’s ICP.

Preventive Services

The following preventive screening tests and examinations are covered:

• Annual Wellness Visit
• Initial Preventive Physical Examination
• Colorectal cancer screening
• Screening Pap tests
• Screening pelvic examinations
• Prostate cancer screening
• Cardiovascular disease screenings
• Diabetes screening tests
• Glaucoma screening
• Human Immunodeficiency Virus (HIV) screening
• Bone mass measurements
• Ultrasound screening for abdominal aortic aneurysm.
MENTAL HEALTH SERVICES

Virginia Premier has an expectation that all services provided to members are through Trauma-Informed Care treatment modality. Many individuals have experienced potentially traumatic events in their lifetime. It is important that everyone is aware of the potential impact of trauma on those they serve, prepare to recognize and offer trauma specific services when needed and be mindful of trauma-informed interventions.

The following core principles of a trauma-informed approach to care is necessary within the provider setting:

1. **Patient empowerment**: Using individuals’ strengths to empower them in the development of their treatment.

2. **Choice**: Informing patients regarding treatment options so they can choose the options they prefer.

3. **Collaboration**: Maximizing collaboration among health care staff, patients, and their families in organizational and treatment planning.

4. **Safety**: Developing health care settings and activities that ensure patients’ physical and emotional safety; and

5. **Trustworthiness**: Creating clear expectations with patients about what proposed treatments entail, who will provide services, and how care will be provided.

CCC Plus

Mental health providers a part of the CCC Plus program should contact Virginia Premier with clinical information to receive an initial authorization for services outlined in the DMAS Mental Health Services Manual, Addiction Recovery and Treatment Services (ARTS) Manual, and Inpatient Psychiatric Admissions. A prior authorization is needed for traditional outpatient services for out of network providers and electroconvulsive therapy. Authorization must be obtained before seeing patients or payment of services may be denied. Request for authorization can be submitted via fax, Inpatient/ARTS Fax: 804-799-5105, Outpatient Fax: 804-799-5104 or Virginia Premier's web portal.

Medallion 4.0

Mental health providers a part of the Medallion 4.0 program should contact Virginia Premier with clinical information to receive an initial authorization for all services outlined in the DMAS Mental Health Manual, Addiction Recovery and Treatment Services (ARTS) Manual, and Inpatient Psychiatric Admissions. A prior authorization is needed for traditional outpatient services for out of network providers and electroconvulsive therapy. Authorization must be obtained before seeing patients or payment of services may be denied. Request for authorization can be submitted via fax, Inpatient/ARTS Fax: 804-799-5105, Outpatient Fax: 804-343-0304 or Virginia Premier's web portal.
Registration of Services

Registration may be required for some services that do not require authorization. Registration is a key element to the success of a care coordination model. Registering a service with Virginia Premier as the service is being provided ensures that the care coordinator has a complete picture of all the services an individual is receiving. Registration also may assist with identifying gaps in services that may help an individual progress in their recovery. Registration is a means of notifying Virginia Premier that an individual will be receiving behavioral health services, avoiding duplication of services and ensuring informed care coordination. Providers rendering services that require registration rather than authorization should register the start of any new service within two (2) business days of the service start date.

Inpatient Mental Health Services and Inpatient Substance Use Services

Inpatient mental health and substance use services are available through Virginia Premier’s network of participating providers when medically necessary. All elective admissions require prior authorization. In the event of an emergency admission, Virginia Premier must be notified within 24 hours or the next business day. All inpatient admissions will be documented in the member’s Individualized Care Plan (ICP).

Services provided to patients in an inpatient psychiatric or substance use detoxification unit will be reviewed and authorized based on the severity of the presenting symptoms. When the admission meets condition-specific criteria, certification of days may be authorized to enable a physician to evaluate the patient and develop an appropriate treatment plan. At the end of the initially approved period, the treatment plan is reviewed for intensity of service and severity of illness according to the following components:

- Diagnosis including precipitating event and patient history treatment goal(s);
- Treatment modality appropriate to diagnosis; and
- Medication and prescribed therapy including dosage levels, frequency and expected duration of treatment(s).

Following the review of the treatment plan, the UR staff will assign an appropriate length of stay.

During concurrent review, the UR staff will continually evaluate the patient’s progress toward the treatment goal(s) and his/her ability to function in a non-acute inpatient environment. Continued hospital stay will only be approved under the following conditions:

- Continued presence of behavior which justify hospital admission
- Complications resulting from medication or prescribed therapy, which require continued medical observation.

Temporary Detention Orders (TDO)

TDO facility admissions may occur in acute care hospitals, private and state-run psychiatric hospitals and 23-hour crisis stabilization and residential crisis stabilization units (RCSU) providers who are identified as Department of Behavioral Health and Developmental Services (DBHDS) licensed
facilities of temporary detention. Limited TDO coverage is included in the contracts for the Program of All-Inclusive Care for the Elderly (PACE), Medallion 4.0 and Commonwealth Coordinated Care (CCC Plus) programs. Medicaid coverage for TDOs by the Fee For Service (FFS) contractor managing the behavioral health services benefit for individuals enrolled in FFS, currently Magellan of Virginia, the Medicaid Managed Care Organization (MCO) for individuals enrolled in managed care, or PACE for individuals enrolled in the PACE program is limited by the type of placement and age of the member. TDOs not covered by the FFS contractor, the Medicaid MCO or PACE are covered by the TDO Program. See the chart below for additional information.

<table>
<thead>
<tr>
<th>Type of TDO Placement</th>
<th>Non-Medicaid eligible</th>
<th>Medicaid and FAMIS FFS</th>
<th>Medallion 4.0CCC Plus (Medicaid and FAMIS)</th>
<th>PACE Program</th>
</tr>
</thead>
<tbody>
<tr>
<td>23-hour and Residential Crisis Stabilization Providers (effective 12/1/2021)</td>
<td>Covered by TDO Program</td>
<td>Covered by FFS contractor</td>
<td>Covered by MCO</td>
<td>Covered by PACE Program</td>
</tr>
<tr>
<td>Psychiatric Unit Of Acute Care Hospital</td>
<td>Covered by TDO Program</td>
<td>Covered by FFS contractor</td>
<td>Covered by MCO</td>
<td>Covered by PACE Program</td>
</tr>
<tr>
<td>Freestanding Psychiatric Hospital – private and state (ages 21 – 64)</td>
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<tr>
<td>Freestanding Psychiatric Hospital – private and state (under 21 and over 64)</td>
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<td>Covered by FFS contractor</td>
<td>Covered by MCO*</td>
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</tr>
</tbody>
</table>

TDO hospitalizations do not require an authorization from Virginia Premier until after the custody hearing.

Non-Medicaid Eligible Individuals

The TDO Program will cover TDO services during the duration of the TDO for individuals without insurance but will not cover services once the TDO has expired. Individuals uninsured at the time of the TDO placement must be determined eligible for Medicaid and enrolled to receive Medicaid coverage for services once the TDO has expired. TDO Program claims for non-Medicaid eligible individuals with a primary insurance may also be submitted for secondary coverage through the TDO Program. TDO Program claims are subject to DMAS Third Party Liability (TPL) criteria in accordance with § 37.2-809(G) of the Code of Virginia, see Claims Processing for Services Reimbursed by the TDO Program for additional information.
# TDO Claim Submission

<table>
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<tr>
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</table>

*If MCO does not cover individuals enrolled in FAMIS under enhanced benefit, submit claims to TDO program.

## Claims Processing for Services Reimbursed by the TDO Program

Charges must be submitted on a UB-04 (CMS 1450) claim form or CMS-1500 (08-05) claim form. DMAS will accept only the original claim forms.

Effective December 1, 2021, DMAS will reimburse for TDO services provided by 23-hour crisis stabilization and RSCU providers using the HCPCS codes for these services (see the Comprehensive Crisis Services Appendix of the Mental Health Services Manual). The HCPCS code H0018 with HK modifier will no longer be effective for Crisis Stabilization Unit TDO claims for dates of service after November 30, 2021. 23-hour crisis stabilization and RSCU providers shall submit claims for TDO services to DMAS using the CMS-1500 (08-05) claim form. The day of admission is covered as a full day of inpatient care, regardless of the time of admission. The day of discharge is not an authorized day of care by Medicaid and cannot be reimbursed.

Photocopies or laser-printed copies of claim forms will not be accepted because the
individual signing the forms is attesting to the statements made on the reverse side of the forms. These statements become part of the original billing invoice.

All TDO Program claims must have the TDO form attached to the claim with the pre-printed case identification number. Failure to provide the TDO form will result in claims being returned to the provider for incomplete information. The Execution section on the TDO form must be signed by the law enforcement officer and dated to be valid. Copies of the TDO form are acceptable.

Processing of TDO Program claims includes both Medicaid eligible and non-Medicaid eligible patients. The TDO Program is the payer of last resort:

- In settings covered by the FFS contractor, Medicaid MCO or PACE (see chart above), the provider must bill the FFS contractor, Medicaid MCO or PACE prior to billing the TDO Program. Any payment by the FFS contractor, Medicaid MCO or PACE must be considered payment in full and any balances cannot be billed to the TDO Program or to the member.

- All TDO claims for individuals with Third Party Liability (TPL) insurance coverage, including claims submitted by 23-hour crisis stabilization and RCSU providers, are subject to DMAS TPL criteria in accordance with § 37.2-809(G) of the Code of Virginia. Providers will need to submit documentation of amount of payment or non-payment by the primary carrier when TPL is listed on the Medicaid member’s file. Once the claim has been processed by the primary carrier, providers may submit claims to the TDO Program as a secondary payer source, however payment would be contingent on any amount issued by the primary payer and will not exceed the Medicaid reimbursement rate.

- The State and Local Hospital Program (SLH) does not have to be billed prior to submitting a TDO claim.

The actual processing of the TDO Program claim will be processed by the DMAS fiscal agent. Each claim will be researched for coverage by any other resource. If the individual has other resources, the claim will be returned to the provider. When claims are returned to the provider, there will be an attached letter advising the provider to bill the other available payment resource.

**Free-Standing Psychiatric Facility Admissions – CCC Plus**

Admission to a “free-standing” psychiatric facility under the CCC Plus program is permitted under the following circumstances:

A physician must certify for each individual that inpatient services in a freestanding psychiatric hospital are needed. The certification must be made at the time of admission.

A physician, physician’s assistant, or nurse practitioner, acting within the scope of practice and under the supervision of a physician, must recertify for each individual that inpatient psychiatric services are needed.

Prior to admission to a freestanding psychiatric hospital or before authorization for payment, the attending physician or staff physician must make a medical evaluation of each individual’s need for care in the hospital. In addition, appropriate professional
personnel must make a psychiatric and social evaluation. Each medical evaluation must include:

1. Diagnoses;
2. Summary of present medical findings;
3. Medical history;
4. Mental and physical functional capacity;
5. Prognosis; and
6. A recommendation by a physician concerning admission to the freestanding Psychiatric hospital

Free-Standing Psychiatric Facility Admissions – Medallion 4.0

Admission to a “free-standing” psychiatric facility under the Medallion 4.0 program is permitted under the following circumstances:

- The member is under 21 years of age or over 64 years of age.
- A screening is performed at the time of admission by an independent reviewer (such as a Community Services Board) for members under 21 years of age.
- The member is not enrolled in FAMIS.

Note: Under federal mandate, admission of a FAMIS member to a free-standing psychiatric hospital is not a covered service and will result in dis-enrollment of the child from the FAMIS program.

Traditional Outpatient Mental Health and Substance Use Services

Traditional Outpatient mental health and substance use services are available through Virginia Premier’s network of participating mental health providers. These services are billed using nationally recognized CPT codes and are not specific to Virginia Medicaid.

Outpatient mental health and substance use (SU) services are provided in a practitioner’s office, mental health clinic, individual’s home, or nursing facility. Services shall be medically prescribed treatment, which is documented in an active written treatment plan designed, signed, and dated by the professionally licensed, Virginia Premier enrolled or out of network qualified provider. Mental health and substance use medication management requires an Individualized Care Plan. A separate plan is required for outpatient psychiatric services and substance use services when service authorization is requested separately. The primary diagnosis should indicate the focus of treatment. If an individual has co-occurring mental health and substance use disorders, integrated treatment for both disorders is allowed with the expectation the clinician will bill for the primary presenting problem.

Each provider may only bill one psychiatric diagnostic interview examination (90791 or 90792) within a 12-month period. The examination must meet medical necessity criteria. No authorization is required. Medication management does not require service authorization and is not subject to the unit limit.

The mental health services units are separate from the substance use treatment units.
When medically necessary, there may be concurrent authorizations for mental health services and substance use services. For persons with co-occurring psychiatric and substance use conditions, providers are expected to integrate the treatment.

**DMAS Mental Health Services**

Mental health services covered in the DMAS Mental Health Services Manual include: Community Mental Health Rehabilitative Services (CMHRS), Enhanced Behavioral Health Services (EBH), and Mental Health Case Management (MHCM). CMHRS and MHCM medical necessity and program descriptions are located in Chapter IV of the DMAS Mental Health Services Manual. EBH medical necessity and program descriptions are located in the appendixes of the Mental Health Services Manual. Below are brief descriptions of each service covered by Virginia Premier including:

- Applied Behavior Analysis (97151-97158, 0362T, 0373T) (effective 12/1/21)
- Assertive Community Treatment (H0040)
- Mobile Crisis Response (H2011) (effective 12/1/21)
- Community Stabilization (S9482) (effective 12/1/21)
- 23-Hour Crisis Stabilization (S9485) (effective 12/1/21)
- Residential Crisis Stabilization Unit (H2018) (effective 12/1/21)
- Functional Family Therapy (H0036) (effective 12/1/21)
- Intensive In-Home Services (H2012)
- Mental Health Skill-building Services (MHSS)/Assessment (H0046/H0032 U8)
- Mental Health Case Management (H0023)
- Mental Health Intensive Outpatient (MH-IOP) (S9480)
- Mental Health Partial Hospitalization Program (MH-PHP) (H0035)
- Multisystemic Therapy (H2033) (effective 12/1/21)
- Psychosocial Rehab (H2017/H0032 U6)
- Therapeutic Day Treatment (TDT)/Assessment (H2016/H0032 U7)
- Mental Health Peer Support Services/Family Support Partners (H0024 & H0025)

**FAMIS and FAMIS MOMS**

FAMIS enrollees and FAMIS MOMS enrollees under age 21 who are covered by Medallion 4.0 have limited mental health services benefits that include:

- Mental Health Partial Hospitalization Program (MH-PHP)
- Mental Health Intensive Outpatient (MH-IOP)
• Assertive Community Treatment (ACT)
• Mobile Crisis Response (effective 12/1/2021)
• Community Stabilization (effective 12/1/2021)
• 23-Hour Crisis Stabilization (effective 12/1/2021)
• Residential Crisis Stabilization Unit (effective 12/1/2021)
• Multisystemic Therapy (effective 12/1/2021)
• Functional Family Therapy (effective 12/1/2021)
• Applied Behavior Analysis (effective 12/1/2021)
• Intensive In-Home Services
• Therapeutic Day Treatment
• Mental Health Case Management for Children at Risk of Serious Emotional Disturbance (effective 12/1/2021)
• Peer Recovery Support Services

Service Descriptions

Applied Behavior Analysis (CPT 97151-97158, 0362T, and 0373T) effective 12/1/21
The practice of behavior analysis as established by the Virginia Board of Medicine in §54.1-2900 as the design, implementation, and evaluation of environmental modifications using behavioral stimuli and consequences, to produce socially significant improvement in human behavior. This includes the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior.

Authorization is required for all non-assessment codes. All requested dates and units may be requested under a single CPT code 97155 which will allow for billing on any CPT code 97151-97158 for the NPI listed on the authorization.

1 unit = 15 minutes

Additional program description and medical necessity criteria located in Appendix D, Intensive Community Based Support – Youth, of the DMAS Mental Health Services Manual.

Assertive Community Treatment (H0040)
Assertive Community Treatment (ACT) is a highly coordinated set of services offered by a group of medical, behavioral health, peer support providers and rehabilitation professionals in the community who work as a team to meet the complex needs of individuals with severe and persistent mental illness. An individual who is appropriate for ACT requires this comprehensive, coordinated approach as opposed to participating in
services across multiple, disconnected providers, to minimize risk of hospitalization, homelessness, substance use, victimization, and incarceration. An ACT team provides person-centered services addressing the breadth of individuals’ needs, and is oriented around individuals’ personal goals. A fundamental charge of ACT is to be the first-line (and generally sole provider) of all the services that an individual receiving ACT needs. Being the single point of responsibility necessitates a higher frequency and intensity of community-based contacts between the team and individual, and a very low individual-to-staff ratio. ACT services are flexible; teams offer personalized levels of care for all individuals participating in ACT, adjusting service levels to reflect needs as they change over time.

Authorization is required.

1 unit = 1 day

Additional program description and medical necessity criteria located in Appendix E, Intensive Community Based Support, of the DMAS Mental Health Services Manual.

**Mobile Crisis Response (H2011) effective 12/1/21**

Mobile crisis provides rapid response, assessment and early intervention to individuals experiencing a behavioral health crisis. It is provided 24 hours a day, seven days a week. This service includes prevention of acute exacerbation of symptoms, prevention of harm to the individual or others, provision of quality intervention in the least restrictive setting, and development of an immediate plan to maintain safety in order to prevent the need for a higher level of care. Mobile crisis is the mechanism by which pre-admission screening for hospitalization may be performed by DBHDS pre-admission screening clinicians.

Mobile crisis is designed to:

- Provide rapid response to a member experiencing a mental health crisis;
- Meet the member in an environment where they are comfortable to engage in order to facilitate quick resolution of that crisis;
- Provide appropriate care/support/supervision in order to maintain safety while avoiding unnecessary law enforcement involvement, emergency room utilization, and/or hospitalization;
- Refer and link to all medically necessary behavioral health services and supports;
- Coordinate with behavioral health providers; and
- Deploy in real time to the location of an individual in crisis ideally utilizing a two-person team for safety.

Registration/Authorization is required.

1 unit = 15 minutes
Community Stabilization (S9482) effective 12/1/21
Short-term services designed to support a member in their natural environment following contact with an initial crisis response service. Services provide referral and linkage to other community-based services at the appropriate level of care. Interventions include brief therapeutic and skill building, engagement of natural supports to de-escalate and stabilize the crisis, and coordination of follow-up services.

The goal of Community Stabilization is to continue to stabilize the member within their community and support both them and their support system during the period between either 1) an initial Mobile Crisis Response and entry into an established follow-up service OR 2) transitional step-down from a higher level of care if the next level of care identified as needed is not immediately available for access.

Registration/Authorization is required

1 Unit = 15 minutes

Additional program description and medical necessity criteria located in Appendix G, Comprehensive Crisis Services, of the DMAS Mental Health Services Manual.

23-Hour Crisis Stabilization (S9485) effective 12/1/21

23-Hour Crisis Stabilization provides a period of up to 23 hours in a community-based facility that provides assessment and stabilization to members experiencing an acute behavioral health crisis. This service is for members who require a safe environment for observation and assessment prior to determination of whether admission to an inpatient or residential crisis stabilization unit is necessary. This service is appropriate for individual who have immediate significant emotional dysregulation, disordered thought processes, substance use and intoxication and environmentally de-stabilizing events that require a multi-disciplinary crisis intervention team to observe and stabilize the immediate crisis and determine the next appropriate step in the plan of care.

This service is provided in a community-based facility that has referral relationships with both outpatient and inpatient level of care as next level of care options.

Registration is required.

1 Unit = Per Diem Rate
Additional program description and medical necessity criteria located in Appendix G, Comprehensive Crisis Services, of the DMAS Mental Health Services Manual.

**Residential Crisis stabilization Unit (H2018) effective 12/1/21**

Residential Crisis Stabilization Unit (RCSU) are a diversion from inpatient hospitalization. They provide short-term, 24/7, facility based psychiatric and substance related crisis evaluation and brief intervention.

Registration/Authorization is required

1 Unit = Per Diem rate

Additional program description and medical necessity criteria located in Appendix G, Comprehensive Crisis Services, of the DMAS Mental Health Services Manual.

**Functional Family Therapy (H0036) effective 12/1/21**

Functional Family Therapy (FFT) is a short-term, evidenced-based treatment program for youth (ages 11-18) who have received referral for treatment of behavioral or emotional problems by the juvenile justice, behavioral health, school, or child welfare systems. FFT is primarily home-based and addresses both symptoms of emotional disturbance in the youth as well as parenting/caregiving practices and/or caregiver challenges that affect the family. FFT is rehabilitative in nature and services as a step-down and diversion from higher levels of care. It seeks to understand and intervene with the youth within their network of systems including family, peers, school, and neighborhood/community.

Authorization is required.

1 Unit = 15 Minutes

Additional program description and medical necessity criteria located in Appendix D, Intensive Community Base Support - Youth, of the DMAS Mental Health Services Manual.

**Intensive In-Home Services for Children/Adolescents (H2012)**

Intensive In-Home Services for Children / Adolescents under age 21 are time-limited interventions provided typically but not solely in the residence of a child who is at risk of being moved into an out-of-home placement or who is being transitioned to home from out-of-home placement due to a documented medical need of the child. Providers must be licensed as a provider of Intensive In-Home Services through DBHDS. Authorization for this service is required.
One unit = 1 hour

The assessment must document the eligibility and medical necessity for the service. Assessment code H0031 or H0032 must be billed before the service code H2012 is billed.

Additional program description and medical necessity criteria located in Chapter IV, Covered Services and Limitations, of the DMAS Mental Health Services Manual.

**Mental Health Skill-Building Services (MHSS)(H0046)**

Mental Health Skill-building Services are goal-directed training and supports to enable restoration of an individual to the highest level of baseline functioning and achieve and maintain community stability and independence in the most appropriate, least restrictive environment. MHSS provides face-to-face activities, instruction, and interventions in the following areas: (i) functional skills and appropriate behavior related to the individual’s health and safety; instrumental activities of daily living, and use of community resources; (ii) assistance with medication management; and (iii) monitoring health, nutrition, and physical condition with goals towards self-monitoring and self-regulation of all of these activities.

Authorization is required for reimbursement. The member must have a prior history of qualifying mental health treatment such as a psychiatric hospitalization, comprehensive crisis services, PACT, ICT/ACT services, RTC-level C placement or a TDO evaluation due to mental health decompensation.

**Service Units**

- One unit = 1 to 2.99 hours per day
- Two units = 3 to 4.99 hours per day

Additional program description and medical necessity criteria located in Chapter IV, Covered Services and Limitations, of the DMAS Mental Health Services Manual.

**Mental Health Case Management (MHCM)(H0023)**

Mental health case management is defined as a service to assist individuals, eligible under the State Plan who reside in a community setting, in gaining access to needed medical, social, educational, and other services.

Case management does not include the provision of direct clinical or treatment services. If an individual has co-occurring mental health and substance use disorders, the case manager may include activities to address both the mental health and substance use disorders, as long as the treatment for the substance use disorder is intended to positively impact the mental health condition. The impact of the substance use disorder on the mental health condition must be documented in the assessment, the ISP, and the progress notes.

Mental health case management services assist individual children and adults in accessing needed medical, psychiatric, social, educational, vocational, and other
supports essential to meeting basic needs.

One unit of service per calendar month will be reimbursed.

Providers must be credentialed with a Community Services Board (CSB) and licensed by DBHDS.

Registration required for this service.

Additional program description and medical necessity criteria located in Chapter IV, Covered Services and Limitations, of the DMAS Mental Health Services Manual.

**Mental Health Intensive Outpatient Services (MH-IOP) (S9480)**

Mental Health Intensive Outpatient Services (MH-IOP) are highly structured clinical programs designed to provide a combination of interventions that are less intensive than Partial Hospitalization Programs, though more intensive than traditional outpatient psychiatric services. MH-IOP are focused, time-limited treatment programs that integrate evidence-based practices for youth (ages 6-17 years) and adults (18 years +). MH-IOP can serve as a transition program, such as a step-down option following treatment in a Partial Hospitalization Program. MH-IOP focuses on maintaining and improving functional abilities through an interdisciplinary approach to treatment. This approach is based on a comprehensive, coordinated and individualized service plan that involves the use of multiple, concurrent interventions and treatment modalities. Treatment focuses on symptom and functional impairment improvement, crisis and safety planning, promoting stability and developmentally appropriate living in the community, recovery/relapse prevention and reducing the need for a more acute level of care.

MH-IOP services are appropriate when an individual requires at least six hours of clinical services a week (for youth ages 6-17), or nine hours of clinical services as week (for adults 18 years and older) over several days a week and totaling a maximum of 19 hours per week. A MH-IOP requires psychiatric oversight with at least weekly medication management included in the coordinated structure of the treatment program schedule.

Authorization is required

1 unit = 1 day

Additional program description and medical necessity criteria located in Appendix F, Intensive Clinic Based Support, of the DMAS Mental Health Services Manual.

**Mental Health Partial Hospitalization Program (MH-PHP) (H0035)**

Mental Health Partial Hospitalization Program (MH-PHP) is a highly structured clinical program designed to provide an intensive combination of interventions and services similar to an inpatient program, but available on a less than 24-hour basis. MH-PHP is active, focused and time-limited treatment intended to stabilize acute symptoms. The average length of stay may be four to six weeks, though length of stay should reflect individual symptoms severity, needs, goals, and medical necessity. MH-PHP can serve as a step-down program from inpatient psychiatric admission or a diversion from an inpatient admission. Members would likely require inpatient psychiatric hospitalization...
MH-PHP requires at least four hours of clinical services per day over several days a week and totaling a minimum of 20 hours per week.

Authorization is required.

1 unit = 1 day

Additional program description and medical necessity criteria located in Appendix F, Intensive Clinic Based Support, of the DMAS Mental Health Services Manual.

**Multisystemic Therapy (H2033) effective 12/1/21**

Multisystemic Therapy (MST) is an intensive, evidence-based treatment program provided in the home and/or community settings for youth (11-17 years old) who have been referred by the juvenile justice, behavioral health, school, or child welfare systems. MST is appropriate for members with significant clinical impairment. It emphasizes engagement with the family, caregivers, and natural supports. MST is a short-term and rehabilitative services that serves as a step-down and diversion from higher levels of care.

Authorization is required.

1 Unit = 15 Minutes

Additional program description and medical necessity criteria located in Appendix D, Intensive Community Based Support - Youth, of the DMAS Mental Health Services Manual.

**Psychosocial Rehabilitation (H2017)**

Psychosocial rehabilitation is provided in sessions of two (2) or more consecutive hours per day to groups of individuals in a Non-residential setting. These services include assessment, education about the diagnosed mental illness and appropriate medications to avoid complication and relapse, opportunities to learn and use independent living skills and to enhance social and interpersonal skills within a supportive and normalizing program structure and environment. The primary interventions are rehabilitative in nature.

An authorization is required for this service.

Units of service are calculated as follows: 1 unit = 2 to 3.99 hours per day

2 units = 4 to 6.99 hours per day

3 units = 7 + hours per day

Additional program description and medical necessity criteria located in Chapter IV, Covered Services and Limitations, of the DMAS Mental Health Services Manual.

**Therapeutic Day Treatment Services (TDT) (H2016)**
Therapeutic Day Treatment (TDT) provides medically necessary, individualized, and structured therapeutic interventions to youth with mental, emotional, or behavioral illnesses that support and are consistent with the TDT service and whose symptoms are causing significant functional impairments in major life activities. TDT is provided during the school day or to supplement the school day or year. The service includes assessment, assistance with medication management, interventions to build daily living skills or enhance social skills, and individual, group, and/or family counseling and care coordination. These services are provided for two or more hours per day. Youth receiving TDT must have the functional capacity to understand and benefit from the required activities and counseling of the service. TDT is rehabilitative and intended to improve the youth’s functioning.

Service authorization is required.

Assessment code H0031 or H0032 must be billed before the service code H2016 will pay.

Units of service are calculated as follows:

unit = 2 to 2.99 hours per day
units = 3 to 4.99 hours per day 3 units = 5 plus hours per day
No more than 3 units may be billed per day.

Additional program description and medical necessity criteria located in Chapter IV, Covered Services and Limitations, of the DMAS Mental Health Services Manual.

Mental Health Peer Support Services or Family Support Partners – Individual (H0024), Group Mental Health Peer Support (H0025)

Services that are non-clinical, peer to peer activities that empower individuals to improve their health, recovery, resiliency, and wellness. Services are person centered and provided by a Registered Peer Recovery Specialist who has lived experience with mental health, substance use disorders, or co-occurring mental health and substance use disorders and have been trained to offer support and assistance in helping others in their recovery. Peer support is designed to promote empowerment, self-determination, upstanding, and coping skills through mentoring and service coordination support, as well as to assist members in achieving positive coping mechanisms for the stressors and barriers encountered when recovering from their illness or disorder.

Registration/Authorization required.

1 Unit = 15 minutes

Additional program description and medical necessity criteria located in the Peer Recovery Support Services Supplement of the DMAS Mental Health Services Manual.

Addiction Recovery Treatment Services (ARTS) CCC Plus and Medallion 4.0
Addiction and Recovery Treatment Services are a delivery system for substance use disorder treatment based on the American Society of Addiction Medicine (ASAM) standards. ARTS covers the full spectrum of the ASAM levels of care for substance use disorders. Medical necessity and program descriptions for ASAM levels listed below are outlined in the DMAS ARTS manual. The following ASAM levels are covered as ARTS services and may require authorization or registration.

Residential Substance Use Treatment (H2034, H0010, H2036)

ASAM Levels 3.1-3.7

Services are for members with serious substance use problems who require a residential level of care for the purposes of improving the member’s overall health, treating the substance use disorder, strengthening supportive relationships and achieving and maintaining a sober and substance-free lifestyle.

The enrollee must agree to actively participate in care. Services provided are development education, symptom and behavior management, and personal health care training.

Authorization for this service is required.

1 Unit = Per Diem Rate

Substance Use Partial Hospitalization Services (S0201)

ASAM Level 2.5

Services of two (2) or more consecutive hours per day, which may be scheduled multiple times per week and provided to groups of individuals in a non-residential setting. The minimum number of service hours per week is twenty (20) hours with a maximum of thirty (30) hours per week. Substance use day treatment may not be provided concurrently with intensive outpatient or opioid treatment services.

Authorization is Required.

1 Unit = 1 Day

ARTS Intensive Outpatient (H0015) ASAM Level 2.1

Intensive outpatient services (ASAM level 2.1) is a structured program of skilled treatment service for adults, children and adolescents delivering a minimum of 3 service hours per service day to achieve 9 to 19 hours of services per week for adults and 6 to 19 hours of services per week for children and adolescents. Intensive outpatient services require a service authorization.

Services two (2) or more consecutive hours per day, which may be scheduled multiple times per week and provided to groups of individuals in a non-residential setting. The maximum number of service hours per week is nineteen (19) hours per week. This service should be provided to those members who do not require the intensive level of care of inpatient, residential, or day treatment services, but require more intensive services than outpatient services. Intensive outpatient services may not be provided concurrently with day treatment services or opioid treatment services.

Authorization is Required.
1 Unit = 1 Day

**Substance Use Traditional Outpatient Therapy ASAM Level 1.0 and 0.5**

ASAM Level 1.0 and 0.5 are traditional outpatient therapy or Screening Brief Intervention and Referral (SBIRT) where the primary diagnosis and focus of treatment is on the substance use disorder. Providers practice within the scope of their license and bill appropriate outpatient CPT codes.

No authorization required for in-network providers.

**Substance Abuse Case Management (H0006)**

Services to assist members and their family members in accessing needed medical, psychiatric, psychological, social, educational, vocational, recovery, and other supports essential to meeting the member’s basic needs.

Registration is Required.

1 Unit = 1 Month

**Peer Support Specialist T 1012 ARTS Individual; S 9445 ARTS Group**

Services that are non-clinical, peer to peer activities that empower individuals to improve their health, recovery, resiliency, and wellness. Services are person centered and provided by a Registered Peer Recovery Specialist who has lived experience with mental health, substance use disorders, or co-occurring mental health and substance use disorders and have been trained to offer support and assistance in helping others in their recovery. Peer support is designed to promote empowerment, self-determination, upstanding, and coping skills through mentoring and service coordination support, as well as to assist members in achieving positive coping mechanisms for the stressors and barriers encountered when recovering from their illness or disorder.

Registration of the initial service is required and all subsequent services require authorization.

1 Unit = 15 minutes

Additional program description and medical necessity criteria located in the Peer Recovery Support Services Supplement of the DMAS Mental Health Services Manual.

**Opioid Treatment (H0020)**

Services that are similar to substance use day treatment, but it is provided to persons with opioid dependence and who need medication to prevent withdrawal.

A unit of service is 15 minutes. Billing rates are based on type of service provider and degree/credentials of the service provider. Opioid medications may be billed separately as a Pharmacy Point of Service claim or by using the appropriate HCPCS code. No authorization is required.

**MCO Billing Requirements for Preferred Office Based Opioid Treatment (OBOT) and**
**Opioid Treatment Program (OTP)**

Only buprenorphine-waivered practitioners can bill MAT induction (H0014) - Buprenorphine waivered practitioners OR licensed behavioral health professionals can bill opioid counseling (H0004 or H0005). Buprenorphine waivered practitioners OR licensed behavioral health professionals can bill substance use care coordination (G9012).

The buprenorphine waivered practitioner shall not bill for physician services (MAT induction H0014 or E&M physician visits) and psychotherapy or opioid counseling (H0004 or H0005) if provided by the same practitioner on the same date of service. A different credentialed addiction treatment professional can provide opioid counseling and bill for H0004 or H0005 on the same date of service that the physician services are delivered by the buprenorphine waivered practitioner.

<table>
<thead>
<tr>
<th>Codes</th>
<th>What provider types allowed to bill?</th>
<th>Billing NPIs</th>
<th>Servicing NPI</th>
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<tr>
<td>H0014 – MAT Induction</td>
<td>▪ Buprenorphine-waivered practitioner (MD, DO, NP, PA) ▪ Licensed behavioral health providers</td>
<td>▪ OBOT Group ID ▪ Buprenorphine-waiver practitioner (MD, DO, NP, PA)</td>
<td>▪ Buprenorphine-waivered practitioner (MD, DO, NP, PA)</td>
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<td>H0004 – Individual Opioid Counseling</td>
<td>▪ Buprenorphine-waivered practitioner (MD, DO, NP, PA) ▪ Licensed behavioral health providers</td>
<td>▪ OBOT Group ID ▪ Buprenorphine-waiver practitioner (MD, DO, NP, PA) ▪ Licensed behavioral health providers</td>
<td>▪ Buprenorphine-waivered practitioner (MD, DO, NP, PA) ▪ Licensed behavioral health providers</td>
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<tr>
<td>H0005 – Group Opioid Counseling</td>
<td>▪ Buprenorphine-waivered practitioner (MD, DO, NP, PA) ▪ Licensed behavioral health providers</td>
<td>▪ OBOT Group ID ▪ Buprenorphine-waiver practitioner (MD, DO, NP, PA) ▪ Licensed behavioral health providers</td>
<td>▪ Buprenorphine-waivered practitioner (MD, DO, NP, PA) ▪ Licensed behavioral health providers</td>
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<tr>
<td>G9012 – Substance Use Care Coordination</td>
<td>▪ Buprenorphine-waivered practitioner (MD, DO, NP, PA) ▪ Licensed behavioral health providers</td>
<td>▪ OBOT Group ID ▪ Buprenorphine-waiver practitioner (MD, DO, NP, PA) ▪ Licensed behavioral health providers</td>
<td>▪ Buprenorphine-waivered practitioner (MD, DO, NP, PA) ▪ Licensed behavioral health providers</td>
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Substance use care coordination G9012 should not be billed in the same month as substance use case management (H0006).

**LONG TERM SERVICES AND SUPPORTS**

Long Term Services and Supports (LTSS) offer a variety of services and supports that help elderly individuals and/or individuals with disabilities meet their daily needs for assistance and improve the quality of their lives. LTSS services are provided over an extended period, predominantly in homes and communities but can also be provided in facility-based settings such as nursing facilities. LTSS services include assistance with Daily Activities of Living (ADL) which consist of bathing, dressing, and other activities of self-care as well as support for everyday tasks such as housekeeping and laundry. Referrals to the Pre-Admission Screening (PAS) team are made through the local Department of Social Services for members in the community or the hospital (inpatient) to evaluate the need for services.

The PAS team will complete the UAI, DMAS-97 and DMAS-96 to determine if the member meets nursing facility level of care criteria or EDCD enrollment. Once the PAS and member identify needed services, the member, family, caregivers or authorized representative will possibly choose the desired delivery model such as agency directed, or consumer directed care for long-term support services.

**LTSS Providers**

LTSS providers include:

- Adult Day Health Care (ADHC) Personal Care (agency directed and consumer directed)
- Respite Care (agency directed and consumer directed)
- Personal Emergency Response Systems (PERS) and Medication Monitoring
- Service Facilitation
- Early Intervention
- Skilled Nursing Facilities
- Custodial Care (Nursing Facility)
- Congregate Care
- Transition Coordination / Skilled Private Duty Nursing
- Assistive Technology
- Environmental Modifications

All LTSS services should be outlined in the Individualized Care Plan (ICP) for the member. The ICP is developed in conjunction with the member after the Health Risk Assessment (HRA) is completed and input from their identified Interdisciplinary Care Team (ICT). They will meet at regular intervals to review and update the ICP as the member’s status changes.
LTSS Authorizations

All LTSS services shall require prior authorization and approval of services based on the DMAS screening tools and LOC assessment and score if applicable. The PAS team or service provider should send all screening documents (UAI, DMAS-95, DMAS-97, DMAS-96, and DMAS-225) to Virginia Premier within 2 business days of completion and member selection of a provider. Providers may submit the DMAS-98 form or the Outpatient Authorization Service form located on the website to request LTSS authorization. The authorization process allows Virginia Premier to:

- Verify the member’s eligibility.
- Determine whether or not the service is a covered benefit.
- Contact the member to review their chosen model of care delivery and agency preference if they have selected to have agency directed care or adult day health care.
- Make sure that the chosen provider is in the Virginia Premier network or facilitate them joining the network.
- Evaluate the medical necessity criteria for the service.
- Refer the member to Virginia Premier’s Chronic Care Management and/or Health Education program; if appropriate coordinate care and additional services as needed.
- Update the member’s ICP.

Elderly or Disabled with Consumer Direction Waiver (EDCD) Agency Directed Care (AD)

Once selected, the AD personal care provider schedules an in-home comprehensive assessment with the member and family. The assessment is documented on the DMAS-99 form. To avoid duplication, Virginia Premier’s care coordinator will collaborate with the agency RN to attend this face-to-face assessment and incorporate information into Virginia Premier’s initial individualized care plan (ICP). The service plan for LTSS services is developed by the agency RN with the member and care coordinator and is documented on the DMAS-97 A/B form. On the DMAS-97 A/B, the agency provider completes the composite ADL score section to determine the composite LOC score. All documents inclusive of additional requested services are submitted to Virginia Premier within 2 business days of completion. The agency may initiate care up to 40 hours based on the composite score without prior authorization from Virginia Premier.

The authorization given by Virginia Premier will indicate the approved service, level of care and hours approved. All services must be initiated within 30 days or sooner of the screening. The care coordinator will incorporate the DMAS-97 A/B into the member’s overall plan of care. The personal care provider will be included in the member’s ICT.

The agency RN must make a supervisory visit at least every 30 days for members with cognitive impairment(s), but no less than every 90 days for members without cognitive impairments (as outlined in the EDCD manual). A reassessment of the member by the agency RN is done every 90 days and documented on the DMAS-99. This information is submitted to the Virginia Premier care coordinator to be incorporated in the plan of care and discussed in the ICT. The DMAS-97 A/B must be completed annually and when there is a significant change in the needs of the member. This will be done as collaboration between
the agency RN and the care coordinator. The care coordinator will complete the annual level of care assessment (also known as DMAS 99 C) and send a copy to the agency for their records.

If supervision is requested, the agency will complete the DMAS-100 (request for supervision) and submit to the care coordinator for review and authorization.

**Consumer Directed Care (CD)**

Members who are enrolling in the EDCD Waiver and want to utilize the CD model of care will undergo the same screening process as those who elect agency-directed services. The PAS team will complete the UAI, DMAS- 97 and DMAS-96 to determine if the member meets the criteria for EDCD enrollment.

Once the PAS and member identify needed services, the member, family, caregivers, or authorized representative will choose the desired delivery model such as consumer directed care for long-term support services.

If consumer directed care is selected, the PAS must complete the DMAS-95 Addendum (DMAS-95A) and submit that to Virginia Premier along with the other screening tools within 2 business days of completion. If the PAS does not complete the DMAS-95A at the time of screening and Virginia Premier’s care manager determines that the member desires to have consumer direction, the service facilitator will complete the DMAS 95A. Virginia Premier’s care coordinator will contact one of its network service facilitators to schedule an in-home comprehensive assessment with the member which is documented on the DMAS-99. To avoid duplication, the care coordinator will collaborate with the service facilitator to attend this face-to-face assessment and incorporate information into Virginia Premier’s initial member face-to-face assessment.

The service facilitator will assist the member in completing their required forms for PPL and all information associated with employing their attendant. The member will have follow-up visits from the service facilitator and Virginia Premier at 30, 60 and 90 days after the initial assessment to monitor the member’s ability to hire and maintain attendants and monitor the plan of care and level of services that are being given. The member will have at least quarterly face-to-face visits with a reassessment every 6 months that is done by the service facilitator in collaboration with Virginia Premier’s care manager. The service facilitator will be part of the member’s ICT. The DMAS 97 A/B must be completed annually and when there is a significant change in the needs of the member. This will be done as collaboration between the service facilitator and the care coordinator. The care coordinator will complete the annual level of care assessment (also known as the DMAS 99 C) and send a copy to the service facilitator for their records.

**Respite Services**

Respite services can be provided in conjunction with personal care or as the sole EDCD waiver service. The member may receive skilled (only available through AD care) or unskilled respite services. The same assessment requirements outlined above for agency directed or consumer directed personal care apply to respite services. A plan of care must be developed and sent to Virginia Premier’s care coordinator on the DMAS 97 A/B to be incorporated in their overall plan of care. Virginia Premier will render an authorization within 14 business days of receiving the request for respite services. There is a maximum of 480 hours per year (July
to June) for all types of respite combined.

**Respite Care Follow-Up Services**

When respite services are received on a routine basis and are provided by an agency, the minimum frequency of supervisory visits is every 30 to 90 days depending on their cognitive status. When respite care services are more episodic, a RN nurse supervisor must conduct the initial home assessment visit with the aide or LPN on or before the start of care and make a second home visit during the second respite care visit. All information must be documented and sent to Virginia Premier’s care coordinator within 2 business days of completing the visit. This information will be used to update the Individualized Care Plan and discussion in the member’s ICT.

If respite services are needed and the member has consumer directed personal care, the Individualized Care Plan goals, objectives and activities will be reviewed by the service facilitator annually and every six months or whenever 240 service hours have been used. All information must be documented and sent to the care coordinator within 2 business days of completing the visit. This information will be used to update the Individualized Care Plan and discussion in the member’s ICT.

**Adult Day Health Care**

Referrals to the Pre-Admission Screening (PAS) team are made to the local Department of Social Services for members in the community or the hospital (inpatient) to evaluate the need for services. The PAS team will complete the UAI, DMAS-97 and DMAS-96 to determine if the member meets nursing facility level of care criteria or EDCD enrollment. Once the PAS and member identify needed services, the member, family, caregivers or authorized representative will possibly choose the desired delivery model such as Adult Day Health Care (ADHC).

Once Virginia Premier contacts the member and family and assist in selecting an Adult Day Health Care provider, Virginia Premier will issue an authorization to the selected provider. The provider will complete the DMAS-301 (Adult Day Health Care Interdisciplinary Service Plan) and submit to Virginia Premier-Goal oriented progress notes are required to be documented at least every 30 days. The care coordinator will use the information to update the overall Individualized Care Plan and collaborate with the site to be a part of the member’s ADHC Interdisciplinary Team meetings. The care coordinator may attend these meetings in person or via telephone. The care coordinator will complete the annual DMAS 99 C (Level of Care Assessment).

For the purpose of calculating patient pay collection obligation, each day of ADHC is considered equivalent to 6 hours of care (regardless of actual time spent at the center).

**Personal Emergency Response System (PERS)**

The PERS is not a stand-alone service and the member must be receiving another EDCD service in conjunction with PERS. The DMAS-100 (Request for PERS) form is used to determine if the member meets criteria for PERS and the provider of the other EDCD services can complete the form and send to Virginia Premier’s care coordinator for authorization of services. In addition, the care coordinator may complete this assessment as part of the Individualized Care Plan, if services are warranted.
Medication Monitoring

Medication monitoring units must be physician ordered and are not considered a standalone service. In cases where medication monitoring units must be filled by the provider, the person filling the unit must be a RN, LPN or a licensed pharmacist. The units may be refilled every 14 days. This service is authorized by Virginia Premier’s care coordinator and must be reauthorized every 6 months.

Early Intervention

Under Virginia Premier, Early Intervention services will be billed to Virginia Premier using the same CPT / HCPC codes that have been historically billed to DMAS. To be a provider with Virginia Premier there are some key points that need to be met before credentialing can begin:

- All Early Intervention (EI) providers are required to be contracted with a Local Lead Agency. You will not be paid for services without this affiliation.
- EI Providers are required to have certifications.
- Groups are required to be listed on the DBHDS site as an EI provider.
- EI services do not require authorization.

Credentialing

There are two different scenarios for Virginia Premier credentialing of an Early Intervention (EI) provider:

1. Local Lead Agency (LLA) submits claims for all services rendered by the EI provider:
   - EI provider is not required to submit an application and credentialing occurs through the Local Lead Agency.
2. EI provider is contracted with Local Lead Agency but submits their own claims:
   - Individual applications and licenses will need to be submitted to Virginia Premier for all providers servicing members that submit claims independently of the LLA.

EI Authorizations

Participating providers are not required to obtain authorization for EI services. Non-participating providers will be required to obtain authorization before treating a Virginia Premier member.

Practice Changes: Psychological Testing

Please notify Virginia Premier within 30 days of any providers that have been hired or have left the practice. Virginia Premier requires the provider to complete a “Provider Update Request Form”, located on our website at www.virginiapremier.com.

Technology-Assisted Waiver
As with other waiver services, members must undergo the UAI assessment performed by the PAS team while the member is in the hospital, facility, or the community. Members qualify for this waiver service when:

- The provision of home and community-based care must be determined to be a medically appropriate and cost-effective alternative to facility placement
- Individuals under the age of 21 must be determined to otherwise require acute care hospitalization and score at least 50 points on the designated assessment tool
- Individuals over 21 years of age must be eligible for adult specialized care placement prior to waiver admission
- The health, safety, welfare of the individual must be safely maintained in the home with the nurse or personal care aide are absent
- Services cannot be provided to any individuals residing outside Virginia

Once members meet criteria for the Tech Waiver, the PAS documents must be submitted to Virginia Premier (UAI, DMAS-96, DMAS-97, DMAS-225). The care coordinator will collaborate with the member and their caregiver to select an appropriate provider (if they do not already have one) to coordinate additional care needs. The provider must submit the authorization request for waiver services to Virginia Premier along with supporting documentation such as DMAS-108 (adult), DMAS-109 (child), CMS 485, DMAS-116, DMAS-97T, DMAS-102, DMAS-103, DMAS-259, DMAS 62 and Tech Waiver and EPSDT assessment. The services available under the Tech Waiver include:

- Assistive Technology
- Environmental Modifications
- Personal Care (Adults Only)
- Skilled Private Duty Nursing
- Skilled Private Duty Nursing-Respite
- Transition Services

Once all appropriate documentation is received, the care coordinator will integrate elements from the service plan into the member’s ICP. The service provider will also become part of the member’s ICT and participate in regular meetings regarding the member’s care and services. Providers may submit authorization requests to Virginia Premier on the DMAS-98 or Outpatient authorization request form. The care coordinator will also collaborate with the provider to perform the required DMAS 99 C (Level of Care Assessment).

Intermediate or Custodial Nursing Facility Care

The PAS or inpatient facility completes the UAI, DMAS 97 and DMAS 96 and submits to Virginia Premier’s care coordinator. Once received, the care coordinator will authorize admission to the nursing facility for care. Services will require reauthorization at least every 12 months.

The Virginia Premier care coordinator will perform a face-to-face assessment with the member incorporating the information from the MDS. A plan of care will be developed in
collaboration with the nursing facility and the care coordinator will be a part of the facility’s care planning / MDS meetings for the member. Virginia Premier’s care coordinator will actively assist the member and family in conjunction with the nursing facility to prepare members for return to the community if the member has a desire to return to the community (as indicated in MDS Section Q) or no longer meets criteria for nursing facility care.

TELEHEALTH SERVICES

Definitions

Provider
For purposes of this manual supplement, the term “Provider” refers to the billing provider—either a qualified, licensed practitioner of the healing arts or a facility—who is enrolled with DMAS.

Telehealth
Telehealth means the use of telecommunications and information technology to provide access to medical and behavioral health assessment, diagnosis, intervention, consultation, supervision, and information across distance. Telehealth encompasses telemedicine as well as a broader umbrella of services that includes the use of such technologies as telephones, interactive and secure medical tablets, remote patient monitoring devices, and store-and-forward devices.

Reimbursable Telehealth Services

Services delivered via telehealth will be eligible for reimbursement when all of the following conditions are met:

• The Provider at the distant site deems that the service being provided is clinically appropriate to be delivered via telehealth;

• The service delivered via telehealth meets the procedural definition and components of the CPT or HCPCS code, as defined by the American Medical Association (AMA);

• The service provided via telehealth meets all state and federal laws regarding confidentiality of health care information and a patient’s right to his or her medical information; and

• Services delivered via telehealth meet all applicable state laws, regulations and licensure requirements on the practice of telehealth; and

• DMAS deems the service eligible for delivery via telehealth.

In order to be reimbursed for services using telehealth that are provided to MCO-enrolled individuals, Providers must follow their respective contract with the MCO.

Reimbursement and Billing for Telehealth Services
**Telemedicine**
Distant site Providers must include the modifier GT on claims for services delivered via telemedicine.

Place of Service (POS), the two-digit code placed on claims used to indicate the setting, should reflect the location in which a telehealth service would have normally been provided, had interactions occurred in-person. For example, if the member would have come to a private office to receive the service outside of a telehealth modality, a POS 11 would be applied. Providers should not use POS 02 on telehealth claims, even though this POS is referred to as “telehealth” for other payers. Place of service codes can be found at [https://www.cms.gov/Medicare/Coding/place-of-service_codes/Place_of_Service_Code_Set](https://www.cms.gov/Medicare/Coding/place-of-service_codes/Place_of_Service_Code_Set).

**Store-and-Forward**
Distant site Providers must include the modifier GQ.

Place of Service (POS), the two-digit code placed on claims used to indicate the setting, should reflect the location where the distant site provider is located at the time that the service is rendered.

**All telehealth modalities**
The only procedure code an originating site Provider may bill is Q3014.

Originating site Providers, such as hospitals and nursing homes, submitting UB-04/CMS-1450 claim forms, must include the appropriate telemedicine revenue code of 0780 (“Telemedicine-General”) or 0789 (“Telemedicine-Other”). The use of these codes is currently not applicable for services administered by Magellan.

Telehealth services may be included in a Federally Qualified Health Center (FQHC), Rural Health Clinic (RHC), or Indian Health Center (IHC) scope of practice, as approved by HRSA and the Commonwealth. If approved, these facilities may serve as the Provider site and bill under the encounter rate. When an FQHC or RHC serves as the originating site, the originating site fee is paid separately from the center or clinic all-inclusive rate.

**Provider Requirements**
All coverage requirements for a particular covered service described in the DMAS Provider Manuals apply regardless of whether the service is delivered via telehealth or in-person.

Providers must maintain a practice at a physical location in the Commonwealth or be able to make appropriate referral of patients to a Provider located in the Commonwealth in order to ensure an in-person examination of the patient when required by the standard of care.

Providers must meet state licensure, registration or certification requirements per their regulatory board with the Virginia Department of Health Professions to provide services to Virginia residents via telemedicine. Providers shall contact DMAS Provider Enrollment
Documentation Requirements
Providers delivering services via telehealth must maintain appropriate documentation to substantiate the corresponding technical and professional components of billed CPT or HCPCS codes. Documentation for benefits or services delivered via telehealth should be the same as for a comparable in-person service. The distant site Provider can bill for covered benefits or services delivered via telehealth using the appropriate CPT or HCPCS codes with the corresponding modifier and is responsible for maintaining appropriate supporting documentation. This documentation should be maintained in the patient’s medical record.

When billing for an originating site, the originating site and distant site Providers must maintain documentation at the originating Provider site and the distant Provider site respectively to substantiate the services provided by each. When the originating site is the member’s residence or other location that cannot bill for an originating site fee, this requirement only applies to documentation at the distant site.

Utilization reviews of enrolled Providers are conducted by DMAS, the designated contractor or the Medicaid Managed Care Organizations (MCOs). These reviews may be on-site and unannounced or in the form of desk reviews. During each review, a sample of the Provider's Medicaid billing will be selected for review. An expanded review shall be conducted if an excessive number of exceptions or problems are identified. Providers should be aware that findings during a utilization review that support failure to appropriately bill for telemedicine services as defined in this policy manual, including use of the GT/GQ modifier, appropriate POS or accurate procedure codes are subject to retractions.

Member Choice and Education
Before providing a telehealth service to a member, the Provider shall inform the patient about the use of telehealth and document verbal, electronic or written consent from the patient or legally-authorized representative, for the use of telehealth as an acceptable mode of delivering health care services. This documented consent shall be maintained in the medical record. When obtaining consent, the Provider must provide at least the following information:

- A description of the telehealth service(s);
- That the use of telehealth services is voluntary and that the member may refuse the telehealth service(s) at any time without affecting the right to future care or treatment and without risking the loss or withdrawal of the member’s benefits;
- That dissemination, storage, or retention of an identifiable member image or other information from the telehealth service(s) shall comply with federal laws and regulations and Virginia state laws and regulations requiring individual health care data confidentiality;
- That the member has the right to be informed of the parties who will be present at the distant (Provider) site and the originating (member) site during any telemedicine
service and has the right to exclude anyone from either site; and

- That the member has the right to object to the videotaping or other recording of a telehealth consultation.

If a Provider, whether at the originating site or distant site, maintains a consent agreement that specifically mentions use of telehealth as an acceptable modality for delivery of services including the information noted above, this shall meet DMAS’s required documentation of patient consent.

**Telehealth Equipment and Technology**

Equipment utilized for telemedicine must be of sufficient audio quality and visual clarity as to be functionally equivalent to an in-person encounter for professional medical services.

Providers must be proficient in the operation and use of any telehealth equipment.

Telehealth encounters must be conducted in a confidential manner, and any information sharing must be consistent with applicable federal and state laws and regulations and DMAS policy.

Health Information Portability and Accountability Act of 1996 (HIPAA) confidentiality requirements are applicable to telemedicine encounters.

The Office for Civil Rights (OCR) at the Department of Health and Human Services (HHS) is responsible for enforcing certain regulations issued under HIPAA. Providers shall follow OCR HIPAA rules with the member, including services provided via telehealth. Providers are responsible for ensuring distant communication technologies meet the requirements of the HIPAA rules.

Clinicians shall use their clinical judgment to determine the appropriateness of service delivery via telehealth considering the needs and presentation of each individual.

**Medicaid-covered mental health and substance use disorder services authorized for delivery by telemedicine**

<table>
<thead>
<tr>
<th>Service(s)</th>
<th>Telemedicine-specific Service Limitations</th>
<th>Code(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>circumstances, including to prevent a delay in timely intake, eligibility determination, assessment for service planning, IFSP development/review, or service delivery.</td>
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</tr>
<tr>
<td>Service(s)</td>
<td>Teledicine-specific Service Limitations</td>
<td>Code(s)</td>
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<tr>
<td>------------------------------------------------</td>
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<tr>
<td>Diagnostic Evaluations</td>
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<td>90791-90792</td>
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<tr>
<td>Psychotherapy</td>
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<td>90832-90837</td>
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<tr>
<td>Pharmacologic counseling</td>
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<td>Psychotherapy w/E&amp;M svc</td>
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<td>90833-90838</td>
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<tr>
<td>Family/Couples Psychotherapy</td>
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<td>90845-90847</td>
</tr>
<tr>
<td>Group Therapy</td>
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<td>90853</td>
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<tr>
<td>Prolonged Service, in office or outpatient setting</td>
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<td>99354-99357</td>
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<tr>
<td>Psychological testing evaluation</td>
<td></td>
<td>96130, 96131</td>
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<tr>
<td>Neuropsychological testing evaluation</td>
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<td>96132, 96133</td>
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<tr>
<td>Psychological or neuropsychologic test administration &amp; scoring</td>
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<td>96136, 96137, 96138, 96139, 96146</td>
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<tr>
<td>Neurobehavioral Status Exam</td>
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<td>96116, 96121</td>
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<tr>
<td>Add-on Interactive Complexity</td>
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<tr>
<td>Health Behavior Assessment</td>
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<tr>
<td>Health Behavior Intervention (Individual, group, family)</td>
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<td>96158-96159, 96164-96165, 96167-96168, 96170-96171</td>
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<tr>
<td>Evaluation &amp; Management (Outpatient)</td>
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<td>99202-99205, 99211-99215</td>
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<tr>
<td>Evaluation &amp; Management (Inpatient)</td>
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<td>99221-99223, 99231 99233</td>
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<tr>
<td>Smoking and tobacco cessation counseling</td>
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<td>99406-99407</td>
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<tr>
<td>Alcohol/SA structured screening and brief intervention</td>
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<tr>
<td>OTP/OBOT Specific Services</td>
<td></td>
<td>H0004, H0005, H0014*, G9012</td>
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<td>SUD Cae Mnage mnt</td>
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<td>Service(s)</td>
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<tr>
<td>Mental Health Case Management Services</td>
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<td>IACCT Initial Assessment</td>
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<td>Mental Health Skill Building</td>
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<tr>
<td>Crisis Stabilization</td>
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<tr>
<td>Crisis Intervention</td>
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<tr>
<td>Mobile Crisis Response</td>
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<tr>
<td>Community Stabilization</td>
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<tr>
<td>Assertive Community Treatment</td>
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<tr>
<td>Psychosocial Rehabilitation</td>
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<tr>
<td>Intensive In-Home Services</td>
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<td>H2012</td>
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<tr>
<td>Therapeutic Day/Treatment</td>
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<tr>
<td>Behavioral Therapy Program</td>
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<tr>
<td>Applied Behavior Analysis (ABA)</td>
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<td>97131 – 97158, 0362T, 0373T (effective 12/1/2021)</td>
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<tr>
<td>Multisystemic Therapy (MST)</td>
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<td>Functional Family Therapy (FFT)</td>
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<tr>
<td>Foster Care Case Management</td>
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<td>T1016</td>
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<tr>
<td>Peer Recovery Support Services (PRSS)</td>
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<td>H0024, H0025, S9445, T1012</td>
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<td>Mental Health Partial Hospitalization Program</td>
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<tr>
<td>Mental Health Intensive Outpatient Program</td>
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<tr>
<td>SUD Partial Hospitalization</td>
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<tr>
<td>SUD Intensive Outpatient</td>
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**Radiology-Related Procedures for Physician Billing Included under Telehealth Coverage**

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<thead>
<tr>
<th>Procedure Title (Reduced Length)</th>
<th>CPT Code</th>
</tr>
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<tbody>
<tr>
<td>Fine needle aspiration; with imaging guidance</td>
<td>10022</td>
</tr>
<tr>
<td>Biopsy of breast; percutaneous, needle core, using imaging guidance</td>
<td>19102</td>
</tr>
<tr>
<td>Biopsy of breast; percutaneous, automated vacuumassisted or rotating biopsy device</td>
<td>19103</td>
</tr>
<tr>
<td>Preoperative placement of needle localization wire, breast</td>
<td>19290</td>
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<tr>
<td>Image guided placement, metallic localization clip, percutaneous, breast biopsy/aspiration</td>
<td>19295</td>
</tr>
<tr>
<td>Arthrocentesis, aspiration, and/or injection; major joint or bursa</td>
<td>20610</td>
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<tr>
<td>Transcatheter occlusion or embolization (e.g., for tumor destruction, other)</td>
<td>37204</td>
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<tr>
<td>Hepatotomy; for percutaneous drainage of abscess or cyst, one or two stage</td>
<td>47011</td>
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<tr>
<td>Abdominal paracentesis (diagnostic or therapeutic); with imaging guidance</td>
<td>49083</td>
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<tr>
<td>Electrocardiogram, routine ecg with at least 12 leads; with interpretation</td>
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<tr>
<td>Electrocardiogram, routine ecg with at least 12 leads; interpretation and</td>
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<tr>
<td>report only</td>
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<td>---------------------------------------------------------------------------</td>
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<tr>
<td>Echocardiography, transthoracic, real-time with image documentation (2d)</td>
<td>93306</td>
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<tr>
<td>Duplex scan of extremity veins including responses to compression and</td>
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<td>other</td>
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<td>Duplex scan of extremity veins including responses to compression and</td>
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<td>Duplex scan of arterial inflow and venous outflow of abdominal, pelvic,</td>
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<td>Duplex scan of arterial inflow and venous outflow of abdominal, pelvic,</td>
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<td>other organs</td>
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</tbody>
</table>

**Service Limitations**

Unless otherwise noted in Attachment A, limitations for services delivered via telehealth are the same as for those delivered in-person.

**PHARMACY SERVICES**

**Pharmacy Benefits**

Virginia Premier covered prescription and over-the-counter (OTC) drugs are administered through EnvisionRx, [www.envisionrx.com](http://www.envisionrx.com). All prescriptions and OTC drugs must be filled at a participating pharmacy, unless a medical or FEMA declared emergency or an out-of-area situation exists. Prescriptions or OTC drugs that require special authorization procedures shall have a response within 24 hours, in most circumstances.

*Note: On March 19, 2020 - 2021, EnvisionRxOptions, a wholly owned subsidiary of Rite Aid Corporation, announced it will further integrate its pharmacy benefits, services and technology companies, rebranding under the new name, Elixir. At this time, it remains EnvisionRx.*

Our Virginia Premier Elite Plus members who are eligible for Medicare will have a [Medicaid Wrap Formulary](#), which will only consist of certain Non-Part D covered and OTC drugs. All other Virginia Premier Elite Plus and Virginia Premier Medallion members will have access to drugs outlined in the [Common Core Formulary](#); the Common Core Formulary is dictated by the Department of Medical Assistance Services (DMAS) and will include certain prescription and OTC drugs taken from the Medicaid Fee-for-Service and Virginia Premier's formulary. There will be no cost share or copayment for drugs covered under the Core or Medicaid Wrap formulary. However, all Medicaid FAMIS members will have access to the [Medallion 4 FAMIS Formulary](#). The FAMIS formulary requires use of generic use for prescription and OTC medications.

*Note: These members are subjected to cost share and or copayments.*

The formularies can be downloaded on Virginia Premier's website at [www.virginiapremier.com](http://www.virginiapremier.com). For pharmacy and prescription related questions, please call EnvisionRx at 1-855-872-0005 (TTY users call 711), 24 hours a day, 7 days a week.
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. Our network includes:

- Retail Pharmacies
- Specialty Pharmacies

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 judgment.

Once prior authorization is obtained, providers will be informed about the available options on the specialty drugs, such as: using the preferred specialty vendor, using office stock or when appropriate, home health nursing services. All specialty pharmacy order forms can be located on the Virginia Premier website.

Non-Covered Drugs

There are specific drug classes that, by law, are not covered under the Virginia Premier program. The drug classes not covered for members include:

- Drugs used for Anorexia or Weight Gain;
- Drugs used to promote fertility;
- Agents used for cosmetic purposes or hair growth;
- Agents used for the treatment of sexual or erectile dysfunction;
- DESI (Drug Efficacy Study Implementation) drugs considered by the FDA to be less than effective. Compound prescriptions, which include a DESI drug, are not covered;
- Drugs which have been recalled;
- Experimental drugs or non-FDA-approved drugs; and
- Drugs marketed by a manufacturer who does not participate in the Medicaid Drug Rebate Program.
Over-the-Counter Drugs

Virginia Premier covers the following over-the-counter drugs and supplies with a prescription from a participating provider:

<table>
<thead>
<tr>
<th>Covered Over the Counter Medications by TherapyClass</th>
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<tbody>
<tr>
<td>Antacids</td>
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<tr>
<td>Laxatives and Cathartics</td>
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<tr>
<td>Antidiarrheal</td>
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<tr>
<td>Niacin</td>
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<tr>
<td>Antifungals – tropical and vaginal</td>
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<tr>
<td>Nicotine gum and lozenge</td>
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<tr>
<td>Antihistamine / Decongestant</td>
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<td>Nicotine patch</td>
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<td>Antihistamines</td>
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<tr>
<td>NSAID</td>
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<tr>
<td>Antiulcer</td>
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<tr>
<td>Oral Analgesics / Antipyretics</td>
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<tr>
<td>Calcium supplements</td>
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<tr>
<td>Prenatal Vitamins</td>
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<tr>
<td>Cough and Cold products</td>
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<tr>
<td>Proton Pump Inhibitors</td>
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<tr>
<td>Decongestants</td>
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<tr>
<td>Salicylates and related drugs</td>
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<tr>
<td>Ferrous Sulfate</td>
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<tr>
<td>Scabicides and Pediculicides</td>
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<tr>
<td>Glucosamine / Chondroitin</td>
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<tr>
<td>Topical Corticosteroid</td>
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<tr>
<td>Ketotifen</td>
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<tr>
<td>Vitamins and Minerals</td>
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</table>

IUD Distribution

To obtain IUDs or implantable contraceptive devices for Virginia Premier members you may use the order forms found on our website [www.virginiapremier.com](http://www.virginiapremier.com) under pharmacy forms.

Providers may also choose to utilize office stock and may bill Virginia Premier directly for the device as well as for the insertion of the device using the appropriate CPT codes. Should you have questions regarding this change please contact your local Provider Services Representative or Utilization Review at 1-877-719-7358.

Emergency Supply

The member may also be eligible to receive up to a 72-hour supply of a drug, until a pre-authorization 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 of a prescription drug. Virginia Premier will grant a temporary supply on a case-by-case basis, to ensure continuity of care. If you have questions about whether a member is entitled to a temporary supply of a drug in a particular situation, please call Envision Rx at 1-855-872-0005 (TTY: 711), 24 hours a day, 7 days a week.

Pharmacy Prior Authorization Guidelines

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

- **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 prior authorization. The provider can help determine if there is a different drug on the formulary 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 (prior authorization) to receive coverage for the drug.

- **If the drug is subject to a utilization management requirement:** A team of prescribers and pharmacists developed these special requirements to help our members use drugs safely and in a cost effective manner. The provider can help if the prescription drug is subject to quantity limits, step therapy or prior authorization. A team of doctors and pharmacists to help our members use drugs safely and in a cost effective manner develops these special requirements.

- **Prior Authorization:** For certain medications, the provider is required to provide Virginia Premier with information so we can confirm the medication’s medical necessity. The prior authorization criteria are based on current medical findings, manufacturer labeling information, and Food and Drug Administration guidelines. Prior authorization applies to medications that are more likely than others to be taken incorrectly, used inappropriately, or taken in amounts that exceed recommendations for dosage or length of treatment.

- **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 medication 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 applies to medications that are more likely to be taken in amounts that exceed recommendations for dosage or length of treatment.

If the member and the provider believe these restrictions should not apply, the member and/or the provider can make the request for a quantity limit exception by contacting Envision Rx. We will need the doctor to give us a written statement with the medical reasons for the formulary exception requesting.

**How to Contact Virginia Premier to request a Coverage Determination (Prior Authorization)**

The member and/or provider can make the request for a formulary exception by contacting Envision Rx. A prior authorization may be requested either:
• Orally by calling 1-855-872-0005 (TTY: 711); OR

• Electronically by visiting our website www.virginiapremier.com, Cover My Meds, or Sure Scripts; OR

• Written by either faxing1-866-250-5178 or mailing to: Envision Pharmaceutical Services, LLC Attn: Coverage Determinations Dept., 2181 East Aurora Road, Twinsburg, OH 44087

Once we receive the physician's statement, we must notify the member of our decision no later than 24 hours in most circumstances. The request will be expedited if we determine, or the provider informs us, that the member’s life, health, or ability to regain maximum function may be seriously jeopardized by waiting for a standard request.

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 must request this appeal within 30 calendar days from the date of our decision. The member or provider may request the appeal to be standard or expedited.

Standard Requests. Once we receive a written consent to start the appeals process, we must notify the member of our decision no later than 30-days for a standard request.

Expedited Requests. Once we receive a written or oral consent to start the appeals process, we must notify the member of our decision no later than 72 hours for an expedited request.

An appeal can be requested either:

• Orally by calling 855-813-0349 (TTY: 711), Monday through Friday from 8:00 am to 8:00 pm; OR

• Electronically by visiting our website www.virginiapremier.com; OR

• Written by either faxing 877-307-1649 or mailing to: Virginia Premier Attn: Grievances and Appeals P.O. Box 5244 Richmond, VA 23220

Addiction and Recovery Treatment Services (ARTS)

As part of the Centers for Disease Control and Prevention (CDC) opioid prescribing guidelines and DMAS initiatives to deter inappropriate use of narcotic medications, Virginia Premier formulary will include non-opioid pharmacologic therapies for pain without utilization management edits (i.e., Step Therapy or Prior Authorization).

Based on the CDC Guidelines for Prescribing Opioids for Chronic Pain, opioids are not recommended as first-line treatment for chronic pain. For additional information please see: www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm.

For a list of preferred non-opioid pharmacologic therapies visit our website.

Virginia Premier will cover naloxone injection and nasal spray for all members.
Without restrictions.

In addition, Virginia Premier will require prior authorizations on methadone, short-acting and long-acting opioids, and buprenorphine containing products.

Virginia Premier will utilize and follow the DMAS approved service authorizations and criteria:

- **All short-acting opioids** are limited to two (2) 14-day supply per fill and not to exceed 28 days in 60 days. The quantity limit will apply to each short-acting opioid drug exceeding a 14-day supply per fill or exceeding a 28-day supply in 60 days. Authorization will be required for approval.

- **All long-acting opioids** are indicated for patients with chronic, moderate to severe pain who require daily, around-the-clock, chronic opioid treatment.

- Patients with a history of substance use disorder should be considered for Buprenorphine analgesic treatment with either topical patch or buccal film (authorization required). These products have a ceiling effect with less risk of respiratory depression than others.

- The FDA has issued a black box warning on concurrent utilization of opioids and benzodiazepines. A prior authorization will be required for concurrent utilization of opioids and benzodiazepines with greater than or equal to 14-day supply. For more information about the black box warning visit the FDA website at [www.fda.gov/drugs/drugsafety/ucm518473.htm](http://www.fda.gov/drugs/drugsafety/ucm518473.htm).

### Patient Utilization Management and Safety (PUMS) Program

Virginia Premier has a Patient Utilization Management & Safety (PUMS) program in place. The program makes sure that members are getting appropriate health care, especially when it comes to patient safety.

**PUMS Program Goal**

PUMS deals with prescription drugs as well as other kinds of health care, making certain the member is getting treatment that is appropriate and safe. Virginia Premier’s clinical staff reviews our members’ use of health care services to see whether they should be in the PUMS program. For members in the PUMS program, Virginia Premier takes extra steps to make sure they use services safely.

**Being considered for PUMS does NOT mean a member has done anything wrong.** For any member who may be at risk for unsafe services, Virginia Premier must review whether the member should be in the PUMS program. In cases involving oral buprenorphine use, the member will be automatically enrolled in the PUMS program.

**How Might PUMS Change a Member’s Care?**

Virginia Premier may offer case management services. Virginia Premier could set a single doctor for controlled substances to see the member, or a single pharmacy to provide controlled substance prescription drugs.

**PUMS Member Rights**
Virginia Premier will send every PUMS member a letter about the program. The letter will make clear how the member can get emergency care. The letter will also tell them how they can appeal being placed in the PUMS program.

Note: Virginia Premier’s doctors and pharmacists now use the Prescription Monitoring Program (PMP). The PMP helps them make sure that prescription drugs are used safely. Among other Patient Utilization Management & Safety (PUMS) triggers, we review patients who have:

- **High Average Daily Dose**: > 120 cumulative morphine milligram equivalents (MME) per day over the past 90 days. And/or
- **Concurrent use of Opioids and Benzodiazepines**: at least 1 Opioid claim and 14-day supply of Benzo (in any order)

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

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

We greatly appreciate your collaboration and health care services to our members. As part of our PUMS safety review we hope to collaborate with you for complete patient information with the goal of validating safe and appropriate controlled substance use and coordinated patient care.

**ADDITIONAL ANCILLARY SERVICES**

**Hearing Aid Services**

All Medicaid members will be eligible for hearing aid services administered by NationsBenefits, LLC, beginning March 1, 2022. The benefit includes a $2,000 annual allowance that includes a complete routine hearing exam and evaluation, hearing aid fittings, a three (3) year supply of batteries, up to sixty (60) batteries per hearing aid per year, and a three (3) year manufacturer’s warranty on all hearing instruments. In addition, members will be able to access NationsBenefits, LLC’s network of hearing aid providers.

Members can access their benefits information by visiting NationsHearing.com/Virginia Premier Medicaid or by calling NationsBenefits, LLC at 844-376-8637. Member Experience Advisors are available 24 hours per day, 7 days per week, 365 days per year. Language support services available free of charge.
Physical and Occupational Therapy

Home Therapies are rehabilitative services available to Virginia Premier members. Evaluations do not require an authorization. Therapy services require prior authorization and medical necessity must be demonstrated based on InterQual® criteria. Virginia Premier will authorize 12 treatment visits until the therapist submits the treatment plan to Virginia Premier. The therapist must then submit a treatment plan to Virginia Premier for prior authorization of additional services beyond the evaluation and 12 treatment visits. Extensions may be approved based on medical necessity.

Inpatient Rehab Services

Inpatient rehabilitation may be provided through a participating rehabilitative hospital or other specialized facility. Services include rehabilitative nursing, physical therapy, occupational therapy and other forms of approved therapy. Services require prior authorization before admission for inpatient rehabilitation and are subject to medical necessity criteria.

Audiology and Speech Pathology Services

Inpatient and outpatient services for speech, language and hearing disorders are covered services. All services require prior authorization from Virginia Premier and are subject to medical necessity criteria.

Vision Services

Virginia Premier has contracted with Vision Service Plan (VSP) to provide routine vision care for eligible members.

Vision Benefits (age 21 and over):

Non-diabetic eye exams will be covered every 24 months. Diabetic eye exams will be covered delivery 12 months. Lenses and frames will be covered every 24 months with a $100 allowance towards the purchase of lenses and frames.

Medically necessary services associated with eye surgeries are also covered under Virginia Premier. Members may select a provider of their choice from Virginia Premier's Provider Directory or they may call the Member Services Department for assistance in selecting a provider. Members may also contact VSP Customer Service at 1-800-877-7195.

Dental Services

Virginia Premier covers one oral exam, one cleaning and one set of bitewing x-rays per year.

Home Health Services

Home health services are available to Virginia Premier members. These services must be provided by a participating home health agency and provided to a Virginia Premier member in their home. Home health services must be authorized by the Primary Care Physician or by the Obstetrician when acting as the PCP for a pregnant member. Home health services are intended to provide skilled, short-term services to aid in the member's recovery and/or to provide assistance with the activities of daily living. Evaluations do not require an
authorization. Contact Virginia Premier’s Utilization Review (UR) nurse to authorize home health services. Virginia Premier will authorize 12 treatment visits upon request until the provider submits the treatment plan to Virginia Premier for additional visits.

**Durable Medical Equipment (DME), Prosthetic Devices and Supplies**

Virginia Premier will cover all medically necessary equipment and supplies for rental or purchase when ordered by a contracted Virginia Premier participating provider. DME services must be pre-authorized by Virginia Premier. Please refer to DMAS Appendix B (Medicaid) for items covered under the Medicaid Plan and [www.medicare.gov/publications](http://www.medicare.gov/publications) to view the booklet “Medicare Coverage of Durable Medical Equipment and Other Devices” for items covered under the Medicare Plan. The Certificate of Medical Necessity (CMN) form can be found on the DMAS and CMS Websites. Examples of covered items include (but not limited to):

- Ostomy supplies
- Respiratory / oxygen equipment and supplies
- Diabetic monitors and test strips for insulin dependent diabetics
- Syringes and needles
- Glucose monitors
- Equipment and supplies for asthma-related conditions
- Wheelchairs and walkers
- Artificial arms, legs and their necessary supportive devices when medically necessary to include orthotics when part of an approved rehabilitative program

**Nutrition Services**

Virginia Premier will cover all medically necessary visits to dieticians or nutrition clinics with a recommendation by the member’s PCP. Nutritional assessment and counseling are covered for all pregnant women and coordinated through the Virginia Premier Case Manager. These services do require authorization from Virginia Premier.

**WIC (Women, Infants and Children)**

Virginia Premier works closely with Primary Care and OB/GYN providers to identify any member who may benefit from the Special Supplemental Nutrition Program for Women, Infants and Children (WIC). This program is administered by the Virginia Department of Health and provides supplemental nutrition, formula, and vouchers for other food products.

As part of the Healthy Heartbeats™ program, members receive assistance in enrolling into the WIC program. In addition, as part of the incentive program they receive bonus points for WIC enrollment that may later be rewarded with a gift card that the member can use for baby items and necessities.

**GENERAL LIMITATIONS AND EXCLUSIONS**

**Non-Covered Services**

Virginia Premier is pleased to offer its members a comprehensive array of health benefits. However, there are a few services that are not covered by our plan. If you have any
questions about covered benefits, please contact our Member Services Department. Non-covered services include:

- Chiropractic Services are not covered by Virginia Premier;
- Private duty nursing services are not covered for members over 21 years old;
- Experimental or investigational procedures are not covered by Virginia Premier but will be evaluated on an individual basis for medical necessity and exhaustion of other viable treatments;
- Services and supplies that are not medically reasonable and necessary;
- Excluded items and services and services subject to limitations;
- Services and supplies that have been denied as bundled or included in the basic allowance of another service; and
- Items and services reimbursable by other organizations or furnished without charge.

**Carved-Out Services**

- Waiver services for the following waivers:
  - Alzheimer’s Assisted Living (AAL)
  - Day Support (DS)
  - Developmental Disabilities (DD)
  - Intellectual Disabilities (ID)
- Developmental Disability Support Coordination
- Pre-admission screening services
- School-Health Services
- Residential Treatment Facility Services - Level C for children under the age of 21
- Community Intellectual Disability Case Management

**Exclusions from Virginia Premier Enrollment**

The following individuals are excluded from enrollment in the CCC+ program:

- Individuals enrolled in the Alzheimer’s Assisted Living (AAL) Waiver
- Individuals enrolled in the Commonwealth’s Medallion 3.0 and Title XXICHIP Programs
- Individuals enrolled in a PACE program
- Individuals enrolled in Money Follows the Person (MFP)
- Newborns whose mothers are CCC+ enrollees on their date of birth, unless the newborns qualify for CCC+ as outlined in the CCC+ Contract
- Dual eligible members without full Medicaid benefits, such as:
  - Qualified Medicare Beneficiaries (QMBs)
  - Special Low-Income Medicare Beneficiaries (SLMBs)
  - Qualified Disabled Working Individuals (QDWIs)
  - Qualifying Individuals (QIs)
• Individuals enrolled in a Medicaid-approved hospice program at the time of enrollment. However, if an individual enters a hospice program while enrolled in CCC+, the member will remain enrolled in CCC+.

• Individuals who live on Tangier Island

• Individuals under age 21 who are approved for DMAS Psychiatric RTC Level C programs as defined in 12VAC 30-130-860

• Individuals with end stage renal disease (ESRD) at the time of enrollment into CCC+. However, an individual who develops ESRD while enrolled in CCC+ will remain in CCC+

• Individuals who are institutionalized in state and private ICF/ID and state mental health nursing facilities

• Individuals who reside at Piedmont, Catawba, and Hancock State facilities operated by DBHDS

• Individuals who reside in nursing facilities operated by the Veterans Administration

• Individuals participating in the CMS Independence at Home (IAH) demonstration

• Individuals enrolled in Plan First (DMAS' family planning program for coverage of limited benefits surrounding pregnancy prevention)

• Individuals who have any insurance purchased through the Health Insurance Premium Payment (HIPP) program

• Individuals enrolled in the Governor’s Access Plan (GAP), which provides basic medical and targeted behavioral health care to some uninsured Virginians with severe mental illness, or other limited benefit aid categories

• Certain individuals receiving treatment in facilities located outside of Virginia as authorized by DMAS

• Individuals who are incarcerated (individuals on house arrest are not considered incarcerated)

• Individuals who reside in the Virginia Home Nursing Facility will be temporarily excluded from CCC Plus. DMAS will transition the enrollment for Virginia Home residents to CCC Plus during a later implementation phase and through a transition plan that addresses the unique needs of the Virginia Home population and its system of care. DMAS will develop the transition plan in collaboration with the Virginia Home and the CCC Plus health plans

• Pregnant individuals who are within their first ninety (90) days of initial managed care enrollment, in their 3rd trimester of pregnancy, and their provider (including midwife) is not participating with the contractor, upon request of the member

• Individuals enrolled in the Birth Injury Fund (refer to Section 23.1)

Non-Participating Providers

Out-of-network providers are required to obtain authorization prior to providing services
(excluding emergency services).

Out-of-network providers are prohibited from causing the cost to the member to be greater than it would be if the services were furnished within the network. If an out-of-network provider delivers services to a member, Virginia Premier will coordinate with the provider to ensure the cost to the member is appropriate.

**MEDICAL MANAGEMENT PROGRAMS**

**Medical Outreach**

Medical Outreach reaches out to members telephonically or in the home depending on the services needed. While visiting with the member, the Medical Outreach Representative assesses the home environment and elicits from the member specific health and social service needs. A Health Risk Assessment (HRA) may be completed with the member. As a result, our outreach team will also play a “case-finding” role referring members to the appropriate Care Management team for ongoing follow-up, as well as to other community resources as necessary.

All pregnant members who are enrolled in the Healthy Heartbeats™ program receive regular contact and home follow-up visits. This program offers personalized supportive services and education from conception to delivery to ensure the best pregnancy and delivery experience for our members. Members are screened for risk and appropriately referred and followed through 60 days postpartum. Members are encouraged through the HHB program to receive their timely prenatal visit within 21-56 days of enrolling with Virginia Premier. Members are also encouraged to receive their timely postpartum visit within 7-60 days of giving birth to their baby. Our members receive incentives for completing these timely visits and receive education and follow up through the program and at baby showers.

All providers are encouraged to participate in our OB Registration Program. Through this program providers can identify expectant mothers and provide medical outreach with basic and important information about the pregnancy so that we are able to engage them in our prenatal care program. Through this program providers receive a $25 incentive if they complete and return the OB Registration Form.

After delivery, the Medical Outreach Representative contacts the member to offer postpartum services to provide postpartum screening and assessment and to promote the Watch Me Grow (WMG) child wellness and EPDST reminder and education program. Through the WMG program members are screened and receive reminders to get their scheduled well child visits and immunizations.

**Chronic Care Management**

Virginia Premier’s Chronic Care Management programs are designed to help members manage their chronic conditions. Our programs are based on nationally accepted guidelines, support the physician-patient relationship, and are available at no additional cost to the member.

Virginia Premier provides Chronic Care Management programs for the following chronic conditions: Asthma, Heart Disease / Heart Failure, Hypertension, Chronic Obstructive Pulmonary Disease (COPD), Bipolar Disorder / Schizophrenia, Childhood Weight and Nutrition Management, Diabetes, Cancer (breast, lung, colorectal, hematological), and
Chronic Kidney Disease (Stage 3-Dialysis).

For members under the MLTSS Virginia Premier Elite Plus program, the member’s care will be coordinated between the Virginia Premier MLTSS care coordinator and the Chronic Care Management Nurse in conjunction with the interdisciplinary care team. In addition, the Chronic Care Management Nurse will notify the member’s primary care provider (PCP) of the member’s participation in the Chronic Care Management program.

Program components include:
- Educational materials / education on chronic conditions and benefits
- Referralsto community classes and resources
- Referralsto Case Management as needed
- 24-hour Nurse Adviseline
- Special monitoring equipment (peak flows, glucose meters, and weight scale)

We are staffed by registered nurses Monday-Friday, 8:00 am to 5:00 pm (except holidays). Please encourage your patients to participate in the programs by calling us directly at 1-866-243-0937. Providers can also utilize our online Care Management Request Form which can be located at www.virginiapremier.com under the Medical Management tab.

Care Management

Virginia Premier uses a holistic, person-centered, and collaborative approach to care which is based on a comprehensive assessment strategy. The first step in the process is the administration of a Health Risk Assessment (HRA) that was created to evaluate the medical, psychosocial, cognitive and functional status of the member to better determine their medical, behavioral health, long term supports and services, and social needs.

This assessment serves as a foundation in the development of an individualized care plan (ICP) which is updated at regular intervals to address the member’s completion of goals, preferences, and changes in condition. Members who have service plans in place with other providers will have those elements incorporated into their overarching ICP to ensure their ongoing needs are addressed and met with targeted interventions.

Another component central to the care management program is the Interdisciplinary Care Team (ICT) which is comprised of the member, caregiver / family, primary care provider, care coordinator, and other internal / external participants of the member’s choosing including but not limited to:
- Targeted Case Manager
- Specialist Physicians
- Behavioral Health Providers
- Service Providers (LTSS)
- MedicarePlan Representative (if a dual-eligible member)
- Pharmacy
- Chronic Care Management
- Health Education
Social Worker

Virginia Premier’s care coordinators utilize strategies such as motivational interviewing and coaching to assist members in realizing their health goals and adoption of health-conscious behaviors to promote a better quality of life and health outcomes.

Preventive Health and Wellness Programs

Virginia Premier understands the important role of health education in prevention of illnesses.

We are proactive in our approach to health education and actively seek to identify members who may benefit from our programs. Virginia Premier Health Education Department works closely with all other departments in Medical Management to assist with identification of members for health education services. Medical Outreach, Case Managers and Chronic Care Managers perform assessments which include questions on health status and interest in health education classes or information. These surveys are then shared with health education to develop an individualized approach to presenting information to the member.

Virginia Premier values the importance of health education as a tool to stay healthy and empower the member. Virginia Premier offers health education classes that include:

- At home exercise (chair and walking DVDs, exercise bands, pedometers, etc.)
- Prenatal / parenting Skills
- Nutrition and weight Loss Smoking cessation
- One-on-one counseling sessions are provided if the member is not able to access a class at one of our locations, or if a barrier to learning is identified.

For more information about Virginia Premier’s health education services, call our Health Education Department.

Health education classes are taught at a variety of locations in the community to allow the member flexibility and greater access. Transportation is provided to all health education classes. One-on-one counseling sessions are provided if the member is not able to access a class at one of our locations, or if a barrier to learning is identified.

For more information about Virginia Premier’s health education services, call our Health Education Department.

QUALITY PROGRAM

Quality Program Description

All practitioners are required to cooperate with Virginia Premier Quality Activities.

The goal of the Quality Program is to ensure the delivery of high-quality medical and behavioral health care. The Quality Program concentrates on evaluating both the quality of care offered and the appropriateness of care provided.

The goal of continuously improving the quality of care provided is to improve the overall health status of our members. The measurement of improvement of health status can be demonstrated by health outcomes. Virginia Premier is committed to improving the
communities where our members livethrough participation in public health initiatives on the national, state, and local levels and the achievement of public health goals.

This continual assessment uses quality improvement concepts such as Six Sigma, root cause analysis, and Plan, Do, Study, Act (PDSA). The Quality program is a population-based plan that acts as a road map in addressing common medical problems identified within our population.

The Virginia Premier Quality Program activities include the elements of:

- identification of performance goals
- internal and external benchmarks
- data collection and establishment of baseline measurements
- barrier analyses, trending, measuring, analyzing, and
- development and implementation of corrective interventions as needed.

The Virginia Premier Quality Program is designed to monitor, assess and continually advance care and the quality of services delivered. The scope of the Quality Program is integrated within clinical and non-clinical services provided for the Virginia Premier members. The program is designed to monitor, evaluate and continually improve the care and services delivered by contracted practitioners and affiliated providers, across the full spectrum of services and sites of care. The program encompasses services rendered in ambulatory, inpatient and transitional settings and is designed to resolve identified areas of concern on an individual and system-wide basis.

The Quality Program will reflect the population served in terms of age groups, disease categories and special risk statuses and diversity. The Quality Program includes monitoring of community-focused programs, practitioner availability and accessibility; coordination and continuity of care; and other programs or standards impacting health outcomes and quality of life. The scope of the Quality Program includes oversight of all aspects of clinical and
administrative services provided to our members, to include:

- Program design and structure
- Quality improvement activities that comply with CMS, NCQA, DMAS and other regulatory requirements
- Care management (to include complex case management, behavioral health, care transitions and end of life planning) and disease management programs that are member-centric focused and address the health care needs of members with complex medical, physical and mental health condition; assessments of drug utilization for appropriateness and cost-effectiveness
- Utilization management, focus on providing the appropriate level of service to members. Member appeals and grievances
- Implementation of high-quality customer service standards and processes
- Benchmarks for preventive, chronic and quality of care measures. Credentialing and re-credentialing of physicians, practitioners, and facilities. Compliance with NCQA accreditation standards
- Audits and evaluations of clinical services and processes. Development and implementation of clinical standards and guidelines. Measuring effectiveness
- Evidenced-based care delivery
- Potential quality of care and safety concerns

Quality Management Program Goals

The ultimate goal of the Virginia Premier Medallion (Medicaid) Quality Program is to achieve a 5-Star rating from NCQA by ensuring the delivery of high quality culturally competent health care, particularly to members with identified health care disparities. Our health care modalities will emphasize medical, behavioral health, and pharmaceutical services. The Quality Program concentrates on evaluating both the quality of care offered and the appropriateness of the care provided. These goals allow Virginia Premier to:

- Continuously meet organization’s mission
- Continuously meet regulatory and accreditation requirements
- Create a system of improved health outcomes for the populations served
- Improvethenumber of members through the continuous enhancement of comprehensive health management programs including Performance Improvement Projects
- Make care safer by reducing variation in practice and enhancing communication across the continuum
- Strengthen member and caregiver engagement in achieving improved health outcomes. Ensure culturally competent care delivery through practitioner cultural education including provision of information, training and tools to staff and practitioners to support culturally competent communication.
Quality Management Program Objectives

The primary objective of Virginia Premier’s Medallion Quality Program is to continuously improve the quality of care provided to members to enhance the overall health status of the members. Improvement in health status is measured through Healthcare Effectiveness Data and Information Set (HEDIS®) information, internal quality studies, and health outcomes data with defined areas of focus. Virginia Premier has defined objectives to support each goal in the pursuit of improved outcomes.

Quality Management Program Functions

The following are identified functions of the Quality Management Program:

- Provide the organization with an annual Quality Program Description, Quality Work Plan, and Quality Annual Evaluation
- Coordinate the collection, analysis, and reporting of data used in monitoring and evaluating care and service, including quality, utilization, member service, credentialing and other related functions managed at the plan level or delegated to vendor organizations
- Identify and develop opportunities and interventions to improve care and services
  Identify and address instances of substandard care including patient safety
  Track and monitor the implementation and outcomes of quality interventions
  Evaluate effectiveness of improving care and services
- Oversee organizational compliance with regulatory and accreditation standards
- Improve health outcomes for all members by incorporating health promotion programs and preventive medicine services into the primary care practices

Accessibility Standards

In order to ensure that all of our members receive culturally-, linguistically-, and disability-competent care, Virginia Premier makes resources available to our provider community like language lines and training modules. Please visit www.virginiapremier.com for more information.

Quality of Care Concerns

Quality of Care Issue

Defined by Virginia Premier as any "confirmed"(confirmed quality issue by Medical Director) occurrence impacting, or potentially impacting, the quality of care of a member. It is mandatory that all quality-of-care issues are reported to Virginia Premier.

Quality of Care issues may be generated from multiple sources. These sources include but are not limited to:

- Quality of Care Event
- Sentinel / Never-Prevention Event
- Health Risk Assessment (HRA) and/or Comprehensive Assessment (CA) Triggers
Social Work / Specialized Behavioral Health Assessment Triggers

- Referral/Request from Medical Management (Medical Director (MD), Care Manager (CM), Utilization Review (UR) nurse, Social Worker (SW), etc.) or any other source

Quality of Care Event

Examples of quality-of-care events that are routinely monitored will include, but are not limited to the following:

- Treatment in the Emergency Department (ED) within 7 days of discharge of an inpatient facility for the same diagnosis
- Re-admission to the hospital within 7 days of discharge
- Unplanned return to the operating room during an inpatient stay
- Post-surgical infections
- Unplanned admission to the hospital after outpatient test or procedure
- Ketoacidosis
- Admissions (exclude if new onset of Diabetes)
- ED treatment or inpatient admission for hypertensive crisis / malignant hypertension
- Any other occurrence that would impede care or access to care
- Inappropriate Level of Care (LOC) determinations
- Member safety such as abuse, neglect or exploitation

Sentinel / Never-Prevent Event

As defined by The Joint Commission, a Sentinel/Never Prevent Event is an unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof. Examples can include but are not limited to:

- Trauma suffered while in a health care facility or provider's office
- Surgery on wrong body part
- Surgery on wrong patient
- Loss of function not related to illness or condition
- Rape in 24-hour care facility
- Suicide in 24-hour care facility
- Death

Critical Incident

Critical incidents are defined by Virginia Premier as any incident that is "validated" as a critical incident in accordance with DMAS' CCC Plus Contract Section 17.3. A critical incident is any incident that threatens or impacts the well-being of the member. Critical incidents shall include, but are not limited to, the following:

- Medication errors
- Severe injury or fall
- Theft
- Suspected physical or mental abuse or neglect, financial exploitation
- Death of a member
- Serious Reportable Events
• Serious reportable events include, but are not limited to:
  • Death (unexpected, suicide or homicide)
  • Falls (resulting in death, injury requiring hospitalization, injury that will result in permanent loss of function)
  • Infectious disease outbreaks
  • Pressure ulcers that are unstageable or Stated III or IV
  • Traumatic Injuries (including third degree burns over more than 10 percent of the body) that result in death, require hospitalization, or result in loss of function
  • Restraint use that results in death, require hospitalization or result in loss of function
  • All elopement in which a member with a documented cognitive deficit is missing for 24 hours or more
  • Media-related event, any reporting of which the contractor is aware that presents a potentially harmful characterization of the Virginia Premier Program

Virginia legal code defines mandatory reporters as:

• Any person licensed, certified, or registered by health regulatory boards listed in 54.12503 of the Code of Virginia, except persons licensed by the Board of Veterinary Medicine.
• Any mental health services provider as defined in § 54.1-2400.1.
• Any emergency medical services personnel certified by the Board of Health pursuant to § 32.1-111.5.
• Any guardian or conservator of an adult. Any person employed by or contracted with a public or private agency or facility and working with adults in an administrative, supportive or direct care capacity.

Procedures / Guidelines

Provider or external source identifies critical incident

Verbal reporting to Virginia Premier to occur within 24 hours with written documentation within 48 hours.

If the critical incident includes notifying APS/CPS, the following numbers may be used for either child or adult protective services:

1-888-832-3858 or 1-800-552-7096

Notify Virginia Premier either by phone, fax, or email within 24 hours:

Phone: 1-877-719-7358 (Member Services, Medical Management, Care Coordination, Member Care Specialist hunt group)

Critical Incident Fax Line: 804-200-1962 Email: criticalincident@virginiapremier.com

Inform the Member Care Specialist the following information for any alleged abuse, neglect, exploitation reported to APS or CPS:
• Member name Date of birth
• Member ID or Medicaid ID
• Provider name and NPI and contact number Nature of incident
• Name of agency notified and reference or report number Contact person
• Date and time reported

Virginia Premier email will notify Regional Care Coordination Managers, Manager of Population Health Outcomes, and Compliance. The Regional Care Coordination Manager will identify the care coordinator assigned to the member.

The assigned care coordinator will supply member assessment and follow up. The care coordinator will send a request to have the Social Worker follow-up with the member and APS / CPS / Department of Health.

The care coordinator will send a request to Quality for review.

**Examples of the Virginia Premier Quality Program at Work Prenatal Care**

Virginia Premier is committed to increasing the percentage of pregnant members receiving appropriate prenatal care. A number of strategies have been implemented to accomplish this objective. These strategies include modified physician reimbursement to encourage Obstetric providers to increase the number of early and periodic prenatal examinations. Our Healthy Heartbeats™ program emphasizes outreach activities, prenatal visits and patient education. We support our pregnant members throughout their pregnancy to deliver a healthy baby. This program has reduced neonatal intensive care unit admissions by 50%. Correspondingly, the number of comorbid conditions associated with this high-risk group has also been significantly reduced.

**Immunizations**

A major objective of Virginia Premier is to increase the percentage of children who are adequately immunized against preventable illnesses. Virginia Premier’s Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program addresses member’s preventive health screenings and immunizations from birth through age twenty (20).

The objectives of the program are consistent with the Center for Disease Control and Prevention’s Healthy People 2000’s goals which include:

• Increase the number of immunizations to 80% of preschool children by their 2nd birthday
• Encourage members to comply with infant / child EPSDT screenings and health education classes
• Develop early intervention processes to assess developmental delays
• Ensure that 80% of Virginia Premier children will receive EPSDT screenings according to the periodicity schedule.

Using an integrated care management approach, Virginia Premier implements the program with oversight provided by the Chief Medical Officer and Vice President of Health Services. The care management team is comprised of case managers, health educators, outreach workers and social workers. This team will work closely with the pediatrician and parent / member in developing a plan of care and monitoring outcomes.
Virginia Premier monitors immunizations through its encounter/claims system and through medical record review. Care Gap Reports are generated to ensure screenings and immunizations for children are occurring according to the EPSDT periodicity schedule. This information is provided to the primary care physician (PCP) so that appropriate medical care can be arranged. The case manager, in conjunction with health education and medical outreach, contacts members by phone, mail or home visit if they have not accessed care within the first sixty days of enrollment. The Virginia Premier outreach worker will identify members who are out of compliance and will assist the member with obtaining the next available appointment with their PCP. Follow up occurs to ensure the child is seen and that they receive immunizations as scheduled.

In addition to the above programs, Virginia Premier provides education to participating pediatricians on immunizations and encourages participation in the Vaccine for Children’s Program for Medicaid/FAMIS Plus patients. Providers will be reimbursed fee-for-service for members enrolled under FAMIS. Pediatricians may also complete the infant risk screening and send it to the Virginia Premier Case Manager to refer for Case Management Services.

**Bereavement Program**

The Bereavement Program supports the behavioral health needs of members who have lost loved ones who were also members on the plan. Please contact the Quality Department, if you need assistance with accessing the program for one of your patients.

**Access to Care**

Virginia Premier will make a good faith effort to provide written notice of a termination of a contracted provider at least 30 calendar days before the termination effective date to all members who are patients seen on a regular basis by the provider whose contract is terminating. Virginia Premier will assist the member in selecting a new practitioner. In cases where there are acute or chronic conditions, the member may be allowed to continue to see the non-par practitioner on an interim, transitional basis, in order to maintain continuity of care needs of the affected members. If the member is in the second or third trimester of pregnancy, Virginia Premier will allow the member to continue to see the non-par practitioner through the postpartum period.

Standards for access and availability of care are monitored by Virginia Premier’s Quality department. Provider performance compared against the standards is monitored by the Quality Department to include provider on-site surveys, evaluation of appointment availability, provider audits, random telephone calls, member satisfaction surveys, reviews related to member complaints/grievances, and encounter reports which identify members’ access patterns and identify members who have not received a health assessment within 90 days of enrollment.

Virginia Premier is committed to high member satisfaction. We encourage our members to report any issues, including access to providers, to our Member Services Department. Results of these monitoring activities are analyzed and presented to the Quality Improvement Committee and the Healthcare Quality Utilization Management Committee (HQUM) for the development of Quality Initiatives. Through our Quality Program, this information is incorporated into corrective action plans that are implemented and monitored for effectiveness.

**Questions to Ask Your Physician**
"Questions to Ask Your Physician" is designed to encourage members to become proactive in their health care team. Members should engage in meaningful communication with their doctor (and vice versa), to ask questions regarding treatment / procedure (type of treatment; less invasive etc.), medications (dosage, selection), and medical tests (how test is performed, benefits / risks) so that our members can get a full understanding of any operations, procedures, medications etc.

The goal is also to foster supportive relationships between members and their treating physicians to ensure compliance and safe clinical practice. This information can be downloaded at www.virginiapremier.com.

20 Tips to Prevent Medical Errors:

The “20 Tips to Prevent Medical Errors” handout is intended to provide awareness and prevention of medical errors. Virginia Premier takes pride in preventive measures to provide positive outcomes. Members are encouraged to ask questions regarding:

- Medications (be sure pharmacist fills what the doctor prescribes)
- Hospital Stays (be sure health care workers wash hands, explanation of treatment plan upon discharge)
- Operation (be sure that all parties agree on procedure and site of procedure) This information can be accessed at: www.virginiapremier.com.

Medical Record-Keeping Policies

Participating physicians are required to maintain adequate medical records and documentation relating to the care and services provided to Virginia Premier 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 in the case of a minor child, their legal guardian. The medical record provides the mechanism that creates, 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 DMAS 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
Virginia Premier has 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.

Medical record-keeping practices may be assessed for:

- Member grievances
- Quality of Care (QOC) indicators
- Sentinel events
- Practice specific member surveys
- Reports from Virginia Premier employees
- Credentialing Department ongoing monitoring process
- Other Quality initiatives

**The Virginia Premier medical record standards are as follows:**

**Medical record-keeping requirements:**

- Confidentiality of medical records must be maintained by:
- Medical records being stored securely (i.e., confidential filing system, etc.) If records are electronic, appropriate security measures in place for access Only authorized personnel having access to medical records
- Conducting training on confidentiality related to member information periodically, and as needed Medical record documentation standards will be utilized.
- Each medical record must include the following:
  - History and physical
  - Allergies and adverse reactions
  - Problem list
  - Medications
  - Documentation of clinical findings and evaluation for each visit Preventive services/risk screening
  - Medical records must be organized and stored in a manner that allows for easy retrieval. Each member must have a record and not combined with another member’s information.

**Office Site Reviews**

Site visit assessments may be conducted, as the result of one or more of the following quality concerns:

- Member grievances
• Quality of Care (QOC) indicators
• Sentinel events
• Practice-specific member surveys
• Reports from Virginia Premier employees
• Credentialing Department ongoing monitoring process
• Other Quality-related initiatives

The purpose of the review is to ensure practitioners meet Virginia Premier, regulatory and accreditation site standards for quality, safety, and accessibility. Virginia Premier Quality staff will assess the following during an office site visit:

• Facility accessibility, appearance and adequacy
• Safety
• Adequacy of medical supplies and practices
• Medical record-keeping practices
• Availability of appointments

Practitioners who do not meet Virginia Premier’s site visit assessment performance threshold will be expected to document and implement a corrective action plan within a specified timeframe. At least every six months after the initial review, each deficiency will be monitored for progress and/or until the performance standards are met. If deficiencies are not resolved within a six-month time frame, they will be presented to the Chief Medical Officer and/or the Credentialing Committee to begin a review process with the practitioner.

Waiver Audit Site Visits (CCC Plus only)

Waiver audit site visits will be conducted to assess operational and medical management aspects for organizations delivering interventions to members receiving waivered services. Audits focus on the following domains as issued by the Department of Medical Assistance Services:

• Level of Care
• Service Plans
• Qualified Providers
• Health and Welfare
• Financial Accountability
• Administrative Authority

Practitioners Golden Globe Award (PGA)

The Practitioner Golden Globe Award is designed to recognize and promote outstanding participating practitioners who promote safe clinical practice, delivery of quality care and who voluntarily broaden their skill set and scope of practice through education and community involvement. Virginia Premier annually announces the outstanding practitioner through the
provider and member newsletters. Practitioners as well as members are encouraged to nominate a practitioner to be recognized by Virginia Premier. The nomination form can be accessed at: www.virginiapremier.com/assets/PGGABrochure.pdf.

**Culturally and Linguistically Appropriate Services**

Virginia Premier is committed to ensuring participating providers have training and resources needed to deliver culturally and linguistically appropriate services (CLAS) to our members. The organization strives to meet the needs of the underserved and vulnerable populations by delivering quality-driven, culturally sensitive and financially viable health care. It is the organization’s belief that all its members should receive equitable and effective treatment which is non-discriminatory. Virginia Premier follows the National Standards for Culturally and Linguistically Appropriate Services in Health Care.

According to the Institute of Medicine's Unequal Treatment Report, social and cultural differences influence practitioner-patient communication and health care decision-making. Evidence suggests that practitioner-patient communication is directly linked to patient satisfaction, adherence, and health outcomes. NCQA also addresses cultural needs, preferences and standards which say, “The organization assesses the cultural, ethnic, racial and linguistic needs of its members and adjusts the availability of practitioners within its network, if necessary.” Virginia Premier meets the intent of this standard through the Cultural Competency Program.

**Goals of the Program**

- Provide educational opportunities for participating practitioners to on how to deliver culturally competent care in an effective and respectful manner
- Strengthen the delivery of health care to culturally diverse populations
- Facilitate meeting members’ cultural, racial, ethnic, and linguistic needs and preferences by creating guides and tools to help practitioners and other providers better communicate in meaningful ways with their patients
- Promote safe and effective clinical practice by improving access for diverse populations Virginia Premier will ensure systems and processes are in place to address the goals for serving the culturally and linguistically diverse membership, through the following objectives:
- Analyze demographic data to identify significant culturally and linguistically diverse populations with plan’s membership. Revalidate data at least annually.
- Identify specific cultural and linguistic disparities found within the plan’s diverse populations.
- Analyze HEDIS® results for potential cultural and linguistic disparities that prevent members from obtaining the recommended key chronic and preventive services.
- Enhance current patient-focused quality improvement activities to address specific cultural and linguistic barriers using culturally targeted materials addressing identified barriers.
- Provide a more thorough organizational understanding of the specific reasons behind
identified cultural and linguistic barriers. This can be accomplished through varied forms of direct member input including focus group, member feedback forms or surveys, and complaint analyses.

- Conduct analysis of interpreter availability
- Develop educational materials to meet the cultural and linguistic needs of the population served addressing the top clinical conditions and others as requested.
- Provide staff with necessary information, training, and tools to address identified cultural barriers.

Virginia Premier offers a cultural competency quiz that can be downloaded and completed on paper. Search our website www.virginiapremier.com for “Cultural Competency” or contact us and we will fax or email you the quiz.

MODEL OF CARE (MOC)

Care Coordinator Overview

Virginia Premier serves a population requiring long term services and supports (LTSS). This includes children and adults with disabilities and complex needs, who may be living either in the community, group homes, or facilities. In addition to members designated as Emerging High Risk or Other High Risk, Virginia Premier coordinates care for recipients of waivered services in the following categories: technology assisted, elderly / disabled with consumer direction, intellectual disabilities, day support, and developmental disabilities.

Virginia Premier’s Care Coordination Program provides integration and coordination of medical and behavioral health to all members via the Regional Care Team (RCT). The RCT is comprised of Care Coordinators, Social Workers, Member Care Specialists, Community Outreach Workers, and a Regional Transition Coordinator. Supported by Disease Managers, Health Educators, Medical Directors, and Pharmacists, the RCT provides continuity for members as they move across and in between levels of care along the health care continuum.

Upon enrollment, Virginia Premier contacts all members to complete a Health Risk Assessment. This assessment covers social, functional, medical, behavioral, cognitive, LTSS, wellness, and preventive domains. A unique, member centric care plan is developed based upon the results of this assessment, in conjunction with the member and caregiver.

To ensure Care Plans are comprehensive, holistic, member-driven, and evolve over time, an Interdisciplinary Care Team (including the member, their caregiver(s), treating providers such as Specialist(s), PCP, Therapists, Care Coordinator and any other necessary members of the RCT) meets regularly to discuss progress and update the Care Plan. The ICT matches members and their caregivers with the expertise and resources needed to proactively identify issues, including caregiver burnout, and address barriers to attaining or maintaining optimal health status.

Virginia Premier’s Care Coordination Program goals include:

1. Improved quality of life, satisfaction, and health outcomes for our members. This will be accomplished by helping members navigate the health care delivery system and coordinating care to promote smooth, safe transitions between service / treatment settings.
2. Efficient stewardship of health care dollars. This will be accomplished through the timely transfer of information between treating providers, identifying and remediating barriers to treatment plan adherence, arranging services and supports to maximize opportunities for community living, reducing inappropriate utilization of services through timely and comprehensive discharge / transition planning, and promoting evidence-based Clinical Practice Guidelines, which are available to providers on our website.

3. Enhanced access to essential medical, behavioral, and social services. This will be accomplished through procuring a diverse network of providers in each region to meet the unique needs of our members, leveraging existing partnerships with external entities to provide innovative services, educating members and families on additional resources and programs available in the community, and providing timely referrals to both internal and external services to promote effective care coordination.

**PROVIDER REIMBURSEMENT AND CLAIMS**

Claim Filing Guidelines

Providers participating with Virginia Premier are required by their participation agreement to submit claims in the required format for all services rendered. If a claim is submitted with incomplete information for required fields, it will be rejected and returned to the submitter as unprocessed.

Claims for services provided to Virginia Premier members must be submitted on HIPAA-standard health care claim formats. Institutional claims submitted electronically must use the ASC X12 837 Institutional Claim guidelines; Institutional claims submitted on paper must use the CMS-1450 (UB04) form. Professional claims submitted electronically must use the ASC X12 837 Professional Claim guidelines; Professional claims submitted on paper must use the CMS-1500 form.

When submitting claims, refer to the most recent version of the following Professional resources for coding accuracy, including:

- International Classification of Diseases, Revised Edition
- Clinical Modification (ICD-10-CM)
- HCPCS Level II Medicare Codes manuals

All claims submitted must be computer generated or typed to ensure accurate processing. 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 and sent back to the provider.

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.

By following these claim submission guidelines and corporate claim submission policy Virginia Premier will be able to improve overall claims data and submission accuracy and enhance claims adjudication turn-around times.

**Paper Claim Submissions**

Paper claims should be submitted to the following addresses:

<table>
<thead>
<tr>
<th><strong>Primary Care Providers</strong></th>
<th><strong>Hospital Claims</strong></th>
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<tbody>
<tr>
<td>Virginia Premier</td>
<td>Virginia Premier</td>
</tr>
<tr>
<td>P.O. Box 5207</td>
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<td>Virginia Premier</td>
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<td>P.O. Box 5287</td>
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<tr>
<td>P.O. Box 4369</td>
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<td><strong>Primary Care Providers</strong></td>
<td><strong>Transportation Claims</strong></td>
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<tr>
<td>Virginia Premier Health Plan</td>
<td>Virginia Premier Health Plan</td>
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<td>P.O. Box 5550</td>
<td>P.O. Box 4250</td>
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<td>Richmond, VA 23220-0287</td>
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<th><strong>Claims Adjustments &amp; Appeals</strong></th>
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<td>Virginia Premier Health Plan</td>
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<tr>
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<td>Richmond, VA 23220-0286</td>
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</table>
**Coordination of Benefits (COB)**

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

For members with another primary carrier, all Explanations of Benefits (EOBs) from the primary carrier will be required with claims submission for Virginia Premier to process secondary claims.

This section provides guidance for coordination of benefits for Medicaid Managed Care members who also have Medicare Parts A and B or other Third-Party Liability (TPL) coverage.

Medicaid is considered the payer of last resort. For members that have other health insurance coverage, Virginia Premier will coordinate benefits with the primary insurance payer.

Please follow the guidelines below to assist in billing services for members who have dual coverage.

<table>
<thead>
<tr>
<th>Services Being Billed</th>
<th>Primary Insurance</th>
<th>Billing Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>MLTSS Waiver Service Only (Medicare Non-Covered Services)</strong></td>
<td>Virginia Premier D-SNP</td>
<td>Bill directly to Virginia Premier</td>
</tr>
<tr>
<td></td>
<td>Another D-SNP Payer</td>
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<tr>
<td></td>
<td>Medicare FFS</td>
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<tr>
<td></td>
<td>Other TPL Coverage</td>
<td></td>
</tr>
<tr>
<td><strong>All other Services</strong></td>
<td>Virginia Premier D-SNP</td>
<td>Submit one claim directly to Virginia Premier who will process both the Medicare and Medicaid portion of the claim.</td>
</tr>
<tr>
<td></td>
<td>Another D-SNP Payer / Other TP Coverage</td>
<td>Bill directly to the primary insurance. Upon receiving the final determination (Remit/EOB) from the primary payer, submit a secondary claim to Virginia Premier.</td>
</tr>
<tr>
<td></td>
<td>Medicare FFS</td>
<td>Bill directly to CMS. Under the Coordination of Benefit Agreement (COBA), CMS will submit the crossover claim directly to Virginia Premier.</td>
</tr>
</tbody>
</table>

While we will accept paper secondary claims, we encourage providers to submit
Coordination of Benefits (COB) claims electronically. Please ensure to follow the guidelines noted below when submitting secondary claims.

- For paper submissions
  - Include a copy of primary EOB.
- For EDI submissions
  - Create or forward claims in full HIPAA standard format (837) and include electronic payment information received from the primary payer's HIPAA standard electronic remittance advice (ERA).

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.

Reimbursement

Primary Care Reimbursement

Virginia Premier recognizes the important role that our primary care providers play in managing the health care of our members. Primary Care Physicians (PCP) are reimbursed according to the terms of their provider agreement with Virginia Premier. If the PCP's billed charges are less than the contracted rate, the PCP will be paid for the charges billed. All claims are to be filed on a CMA 1500 claim form or electronically.

Encounter Reporting

Encounters are defined as PCP services provided to a member that are covered under the PCP's monthly capitation payment. Even though these services are “pre-paid”, participating PCPs are required to complete a CMS 1500 form each time services are provided to a Virginia Premier member. Encounter reporting is used to determine levels of service and to assist in the coordination of benefits. Virginia Premier also uses encounter information to monitor, evaluate and report utilization.

Recoupment / Recovery Policy

In accordance with the Deficit Reduction Act of 2005 which established the Medicaid Program Integrity Plan which mandates Medicaid Managed Care Organizations (MCOs) to take measures to identify, recover and prevent inappropriate Medicaid payments. Virginia Premier will recoup/recover payments that are identified by our auditing and monitoring programs.

Member Hold Harmless Policy

Providers cannot bill a Medicaid / FAMIS Plus / FAMIS enrollees for medically necessary services covered under the Medicaid / FAMIS plus contract and provided during the enrollee’s period of enrollment. This provision shall continue to be in effect even if Virginia
Premier becomes insolvent. However, if an enrollee agrees in advance of receiving a non-covered service and this agreement is in writing, then the Provider can bill the member for those non-covered service.

**Denied Claims / Reconsiderations**

Reconsideration for denied claimsmust be sent to Virginia Premier within sixty (60) days of the original date of denial or the last appeal decision date. The Claim adjustment / reconsideration form can be accessed at [www.virginiapremier.com](http://www.virginiapremier.com).

Non-medicaldenials (e.g., timely filing, duplicate claim, cannot ID member triage payment etc.) should be sent to:

Virginia Premier  
Attention: Claim Reconsideration Department  
P.O.Box 5286 Richmond, Virginia 23220

Claims denied for medicalreasons (e.g., not medically necessary, etc.) must be appealed to Virginia Premier’s Medical Management Department with medical record documentation at:

Virginia Premier  
Attention Medical Management Department  
P.O.Box 5244  
Richmond, Virginia 23220-0244

**FILING OF SPECIFIC CLAIM TYPES**

**Inpatient Rounding**

Virginia Premier recognizes the need for PCPs to provide coverage for Inpatient Hospital Rounding. When providing inpatient coverage for another physician, please indicate the “referring physician” (e.g., the original PCP) in box 17 of the CMS 1500 claim form, “Name of Referring Physician or Other Source”, when submitting the claim for payment. This data is tracked and reported quarterly to Virginia Premier’s Medical Director. PCPs are reimbursed fee for service if they provide attending physician, “inpatient care” or discharge management services.

**Obstetric Services Reimbursement Schedule**

One of Virginia Premier’s ongoing initiatives is to increase the wellness of our membership through preventive medicine. One such initiative is Virginia Premier’s reimbursement design for obstetrical services. Virginia Premier allows for providers to select from either billing OB care globally or to unbundle those services as care is rendered to the member. Your Virginia Premier contract will stipulate which methodology you should follow; but providers can only select one method. In allowing the unbundling of OB services, which include antepartum and postpartum visits, the provider is not limited on the number of times that he/she can see the patient, thus increasing the wellness of the mother, her unborn child and increasing reimbursement to the physician for healthy outcomes.
OB Unbundled Method

Physicians following the unbundled design should bill their obstetrical services to Virginia Premier using the CPT codes listed below. Care rendered that is not related to the member’s pregnancy should be billed utilizing the appropriate CPT codes as defined by the AMA. In selecting the correct code for the level of care, please follow the guidelines established by the American Medical Association. All procedures from this schedule should be billed in conjunction with a primary pregnancy diagnosis code. Each visit should be billed individually for each service date and billed with the unit equal to 1. Antepartum visits should not be listed on one claim line with multiple units.

CPT codes to be utilized with unbundled method:

<table>
<thead>
<tr>
<th>Description of Service</th>
<th>CPT Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>New patient, OB visit</td>
<td>99201 – 99205</td>
</tr>
<tr>
<td>Established Patient, OB visit or antepartum</td>
<td>99211 – 99215</td>
</tr>
<tr>
<td>Antepartum care, visits 4, 5, and 6</td>
<td>59425</td>
</tr>
<tr>
<td>Antepartum care, visits 7 or more</td>
<td>59426</td>
</tr>
<tr>
<td>Delivery – Vaginal</td>
<td>59409, 59612</td>
</tr>
<tr>
<td>Delivery – Cesarean</td>
<td>59514, 59620</td>
</tr>
<tr>
<td>Postpartum visit</td>
<td>59430</td>
</tr>
</tbody>
</table>

Global OB Method

Providers who bill Virginia Premier for OB services globally should follow the AMA guidelines. The Global (bundled) delivery method includes: all antepartum visits, delivery (to include all services associated with the admission and discharge), and postpartum visits. If a provider provides prenatal services but does not perform the delivery then visits should be billed to Virginia Premier as follows: CPT 99201 – 99215 for 3 or less visits for each visit, CPT 59425 if member had 4-6 visits (unit should be 1) and CPT 59426 if member had 7 or more visits (unit should be 1).

Preventive E&M Services

Providers should bill preventive Evaluation and Management (E&M) services using the CPT code range of 99381 – 99397 to reflect preventive medicine. Preventive medicine services should be billed using the appropriate “V” diagnosis code from the ICD-9 diagnosis listing. Also, all services billed for preventive medicine must include any appropriate modifiers.

Injectables

When submitting claims for injections:

- Provide the name, dosage and strength of the injectable drug.
- Virginia Premier requires that prescription drug products using a drug-related Healthcare Common Procedure Coding System (HCPCS) J-code, to include the
National Drug Code (NDC) of the drug dispensed on all electronic (837P) and paper claims (CMS-1500) submissions. The quantity of each NDC submitted and the unit of measurement qualifier (F2, ML, GR or UN) will also be required.

- Providers participating in the 340B drug discount program must submit a UD modifier on each revenue line with the HCPCS / CPT code and NDC for revenue codes 0250 through 0259 and 0636 through 0639. All providers, including those not participating in the 340B discount program, must continue to submit NDC codes for revenue codes 0250 through 0259 and 0636 through 0639 and applicable HCPCS / CPT codes for each drug submitted.

Unlisted Procedure Codes

All procedure Codes ending in “99” must have additional documentation attached to the claim to sufficiently explain the services provided. This documentation may be an office note, operative note, invoice or other documentation. This information is used in determining the medical appropriateness of the service or supply as well as the level of reimbursement for these services. Lack of supporting documentation may result in a lower level of reimbursement or a denial.

Modifiers

Modifiers are important in determining the level of reimbursement for services rendered in different settings. Include modifiers when appropriate to avoid unnecessary delay or reduction in payment. Virginia Premier follows the use of modifiers as outlined in the CPT (Current Procedural Terminology). Virginia Premier accepts all AMA approved modifiers.

- Virginia Premier requires that bilateral procedures billed on one claim line with the modifier - 50 and 1 unit should be indicated for us to properly reimburse you to a bilateral procedure.

Collection of Charges from Third Parties

Virginia Premier providers should verify the member’s eligibility for each visit. Individuals enrolled in comprehensive health insurance, group health plans, and/or insurance provided to military dependents, are excluded from eligibility with Virginia Premier as set forth in the DMAS contract. If the recipient is enrolled in and receives service through Virginia Premier and is subsequently discovered to have another source of health insurance, Virginia Premier shall retract payments made for such services and deny them as coordination of benefits until primary carrier payment information is received.

Until the recipient is removed from Virginia Premier's enrollment, Virginia Premier will be responsible for providing Medicaid covered services as set forth in our contract with DMAS. Payment amounts will be determined by a review of the primary carriers EOB and Virginia Premier's allowable rate.

Reimbursement of Physician Assistants and Nurse Practitioners

Virginia Premier realizes that medical services may sometimes be provided by physician assistants (PA) and nurse practitioners (NP). Reimbursement for services provided by PAs and NPs under the supervision of a participating Virginia Premier provider shall be reimbursed to the credentialed provider.
If a nurse practitioner (pediatric, family or nurse midwife) wants to bill directly for their services, they must submit a Virginia Premier provider application, complete the credentialing process and be a participating practitioner with Medicaid.

Virginia Premier does not credential Physician Assistant’s. However, Virginia Premier does allow for PA’s to render care to our members. PA’s and NP’s are expected to follow the regulations as set forth by the Virginia Board of Medicine when rendering care to Virginia Premier members.

**Durable Medical Equipment Individual Consideration Request Submission**

DME Individual Consideration (IC) Item: HCPCS code that does not have a corresponding reimbursement rate.

The provider / DME supplier must submit Certification Medical Necessity (CMN) Form for DME requests to Medical Management Department for authorization. When submitting a claim for IC request, the vendor must attach to the claim the wholesale (cost) invoice and retail invoice including description for all items, and HCPCS codes. Without both the wholesale and retail invoices, the claims will be denied. Please refer to DMAS Appendix B (Medicaid) for item listed as IC or UCC. Items will be reimbursed in accordance with the Virginia Premier fee schedule.

**Electronic Filing Clearinghouses**

**Virginia Premier Elite Plus** electronic claims can be filed by utilizing one of the following Clearinghouses:

<table>
<thead>
<tr>
<th>Clearinghouse</th>
<th>Contact Information</th>
<th>Virginia Premier Payer ID</th>
</tr>
</thead>
<tbody>
<tr>
<td>Availity</td>
<td>800-282-4548</td>
<td>All Claim Types: VPEP1</td>
</tr>
<tr>
<td></td>
<td><a href="http://www.availity.com/about-us/contact-us">www.availity.com/about-us/contact-us</a></td>
<td></td>
</tr>
<tr>
<td>Relay Health</td>
<td>800-527-8133</td>
<td>837 Professional: 1244</td>
</tr>
<tr>
<td></td>
<td><a href="http://www.relayhealth.com/contact-us">www.relayhealth.com/contact-us</a></td>
<td>837 Institutional: 4573</td>
</tr>
</tbody>
</table>

**Virginia Premier Medallion 4.0** electronic claims can be filed by utilizing one of the following Clearing Houses:

<table>
<thead>
<tr>
<th>Clearinghouse</th>
<th>Contact Information</th>
<th>Virginia Premier Payer ID</th>
</tr>
</thead>
<tbody>
<tr>
<td>Availity</td>
<td>800-282-4548</td>
<td>All Claim Types: VAPRM</td>
</tr>
<tr>
<td></td>
<td><a href="http://www.availity.com/about-us/contact-us">www.availity.com/about-us/contact-us</a></td>
<td></td>
</tr>
<tr>
<td>Relay Health</td>
<td>800-527-8133</td>
<td>All Claim Types: VAPRM</td>
</tr>
<tr>
<td></td>
<td><a href="http://www.relayhealth.com/contact-us">www.relayhealth.com/contact-us</a></td>
<td></td>
</tr>
</tbody>
</table>
Virginia Premier strongly encourages providers to consider filing claims electronically for the following reasons:

- Reduces the amount of time and resources physician practices devote to manual administrative functions
- Claims submitted electronically are historically paid earlier than paper claims.
- Increases the account receivables payment for services rendered
- Electronically pre-audits claim fields for potential errors before submission to Virginia Premier
- Identifies claim issues and provides online claim resolution before processing by Virginia Premier
- Submits claims almost instantaneously to Virginia Premier
- Reduces postage, supplies and mailing expenditures incurred by providers
- Tracks claim's progress between intermediaries (e.g., a billing service or clearinghouse) and a payer through an electronic audit trail
- Confirms Virginia Premier's receipt of a claim through electronic reports
- Expedites Virginia Premier's claims processing turnaround and potential payment time frame
- Improves the practice's accounts receivable

Providers who wish to submit claims electronically must complete all necessary documents related to the process. Please allow at least thirty (30) business days to complete 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.

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

Providers participating with Virginia Premier who require the ability to create and submit claims through our direct data entry portal will need to do the following prior to submitting their first claim:

1. Go to www.virginiapremier.com/providers/medicaid/provider-portals and go to the “New Users” section
2. Sign up for a new account through HealthTrio Connect
3. You will receive a response within 3-5 business days with your username and
temporary password

4. Submit your claim submission via or portal

5. Primary insurance payer please follow the guidelines below to assist in billing
   services for members who have dual coverage.

Member Hold Harmless Policy

Providers may not charge members or Virginia Premier for any service that:

1. Is not a Medically Necessary Covered Service or non-covered service
2. For which there may be other Covered Services or non-covered services that
   are available to meet the member’s needs
3. Where the previous two items are not explained, the member will not be liable to
   pay the provider for the provision of any such services

Denied Claims / Reconsiderations

All denied claims, in whole or in part, must be appealed in writing to Virginia Premier. The
member cannot be charged or held liable for payment for which services have been denied. The
“appeal claim” must include any supporting documentation, which explains or satisfies
the reason for the original denial and why it should be paid accordingly.

Reconsiderations for denied claims must be sent to Virginia Premier within sixty (60) days
of the original date of denial. The Reconsideration claim form (Exhibit E) can be accessed

Claims denied for medical reasons (e.g., not medically necessary, etc.) must be appealed to
Virginia Premier Medical Management Department with medical record documentation at:

   Virginia Premier
   Medical Management Grievances and Appeals
   P.O. Box 5244 Richmond, Virginia 23220

Long Term Services and Supports (LTSS)

LTSS providers are required to have a National Provider Identifier (NPI) in order to submit
and have claims processed.

Patient Pay

Patient Pay is the amount of a Medicaid member’s income that must be contributed to the
cost of his or her care. The amount of patient pay is determined by the Department of Social
Services (DSS) based on the member’s income and medically related deductions.

MEMBER RIGHTS AND PROTECTIONS

Members of Virginia Premier are entitled to all the benefits outlined in their Member
Handbook Evidence of Coverage. With Virginia Premier’s support, each member must learn
the plan guidelines, follow proper procedures and seek services from our network of
participating providers. Members can exercise these rights without having their treatment adversely affected. Virginia Premier members have the right to:

- A right to a copy of the Privacy Notice annually or when requested.
- 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.
- Be treated with respect and with due consideration for his or her dignity and privacy.
- 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.
- Choose their personal Virginia Premier doctor/Primary Care Physician (PCP). You can find the Provider Directory online at virginiapremier.com. Contact Member Services for assistance.
- Change their personal Virginia Premier doctor and choose another one from Virginia Premier’s Provider Directory. The Provider Directory can be found online or call Member Services for assistance.
- 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.
- Have health care services twenty-four (24) hours a day, three hundred and sixty-five (365) days a year, including urgent, emergency and post stabilization services.
- 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.
- 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.
- Make suggestions regarding Virginia Premier’s Member Rights and Responsibilities statement, which is found in the member handbook.
- Make their own doctor/PCP appointments to be seen in their private office at their convenience.
- Not be balanced billed by any provider for covered services other than the Patient Pay established by DSS towards LTSS services.
- Not be discriminated against due to; medical conditions, including physical and mental illness, Claimsexperience, Receipt of health care and Medical history. Not to be treated against their will.
- 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.
• Provide language assistance services including but not limited to interpreter and translation services and effective communication assistance in alternative formats, such as, auxiliary aids, free of charge to members and/or the member’s representative.

• Receive information on available treatment options and alternatives presented in a manner appropriate to the member’s condition and ability to understand.

• Receive information in accordance with 42 CFR § 438.10.

• Receive information about Virginia Premier, its services, costs, providers, network pharmacies, drugs, and Members’ Rights and Responsibilities.

• Rights to reasonable accommodations
• Request and receive a copy of his or her medical records and request that they be amended or corrected, as specified in 45 CFR §§ 164.524 and 164.526.

• 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.

• To know the names and qualifications of the physicians and health care professionals involved in their medical treatment.

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

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

• To use Advance Directives (such as a Living Will or a Power of Attorney). Provide information to members about advance directives and any changes made in state law as soon as possible but no later than 90 days after the effective date of change.

• 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 your care.

**Supplemental Member Rights**

Virginia Premier members also have the right to:

• Confidentiality when coordinating care including medical records, member information and appointment records for the treatment of sexually transmitted diseases.

• File any type of grievance, including those related to advance directives, with Virginia Premier. Medallion members may call toll free at 1-800-727-7536. Virginia Premier Elite Plus members may call toll free at 1-877-719-7358, the Department of Medical Assistance Services, the Bureau of Insurance and the Department of Health.

• 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. 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.

- Have the doctor write in his or her medical record 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 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 other than the Patient Pay established by DSS for LTSS services.

- To contact Virginia Premier staff that has been trained on advance directives and asks questions, if needed.

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

- 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.

- To obtain information in different formats (i.e., large print, braille, etc.), if needed and in an easy form that takes into consideration the special needs of those who may have problems seeing or reading.

- 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 see an in-network doctor in a timely manner based on the access standards listed in this document under the section called: Access to Health Care Standards.

- 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.

**Member Responsibilities**

- 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.

- Carry their and/or their child's Virginia Premier Member ID Card with them at all times.

- Choose their and/or their child's Virginia Premier PCP from the list of our doctors from the provider directory. Work with their PCP to help establish a proper patient-physician relationship.

- Follow plans and instructions for care given by their physician.
• Get their health care from a participating PCP, hospital or other health care provider.

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

• Inform their PCP of visits to other doctors so that he can be kept informed about the care that they are receiving.

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

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

• Learn the difference between emergency and urgent care. Know: What is considered an emergency, what to do if an emergency happens and how to keep one from happening.

• 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 care managers and other health care professionals at Virginia Premier.

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

• Understand their health problems and discuss and/or agree upon a treatment plan with their physician.

Advance Directives (Patient Self-determination)

Living Will: This is a written document that specifies what medical treatment the patient wants, should they be unable to communicate their wishes.

Durable Power of Attorney for Health Care: A written document indicating that the individual has chosen someone to make health care decisions on their behalf, should they be unable to do so.

Information on Advance Directives is posted at www.virginiapremier.com to educate members, practitioners and providers. It is the expectation of practitioners and/or providers to actively engage members in discussions related to their expressed advanced directive wishes and document the details of the discussion in the member’s medical record. Virginia Premier will provide information to members about advance directives and any changes made in state law as soon as possible but no later than ninety (90) days after the effective date of the change.

Information about advance directives will be provided to members through our Member Handbook.
Grievances and Appeals Procedures
Virginia Premier is committed to providing high quality health care and service to its members. To ensure an open dialogue with our members, Virginia Premier has processes in place to fully investigate and address member complaints, grievances, and appeals and to incorporate this information into the continuous quality improvement process.

The complaint, grievances, and appeals system processes have been established with the following objectives:

- To promote member satisfaction with the care and services Virginia Premier provides
- To ensure timely and thorough investigation of a member's concerns
- To warrant and document effective resolution of member complaints
- To allow adequate opportunity for members to appeal a decision
- To ensure complete tracking and logging of all complaints, grievances and appeals
- To perform regular and periodic analysis of issues identified and to categorize opportunities for improvement related to services rendered to our members
- To develop an action plan for implementation of identified grievances and appeals quality improvements
- To ensure monitoring and oversight of activities for the effectiveness of such corrective measures

Virginia Premier provides information about the grievances and appeals process and procedures to all plan members at the time of enrollment, upon voluntary dis-enrollment, and at least annually thereafter. The Member Handbook explains how member complaints and grievances can be initiated.

A. The member's right to file grievances and appeals.
   i. There is no time limit for members to file a grievance following any dissatisfaction with Virginia Premier
   ii. All grievances, quality of care and non-quality of care, shall be responded to and resolved within 30 (thirty) calendar days from the date of initial receipt and/or as expeditiously as the enrollee’s health condition requires.
   iii. The health plan can extend the timeframe for processing a grievance by up to fourteen (14) calendar days if the member requests the extension, or, with the DMAS’s permission, if the plan shows that there is a need for additional information and that the delay is in the plan’s interest. If the plan extends the timeframe from a grievance not at the request of the member, the plan will give the member written notice, within two (2) calendar days, of the reason for the decision to extend the timeframe and inform the member of their right to file a grievance if he/she disagrees with that decision.
   iv. In the event Virginia Premier fails to adhere to the notice and timing requirements for extension of the grievance resolution timeframe, the
member may initiate a State Fair Hearing.

v. Members have sixty (60) days of an occurrence to file an appeal.

vi. Standard Appeals will be acknowledged by Virginia Premier within five (5) calendar days, and will be resolved within thirty (30) calendar days, unless extended.

vii. If Virginia Premier makes an extension not requested by the member, Virginia Premier will make reasonable efforts to give the member prompt oral notice of the delay, including giving the member written notice of the reason for the delay within two (2) calendar days and inform the member of the right to file an grievance if he or she disagrees with that decision.

viii. In the event Virginia Premier fails to adhere to the notice and timing requirements for extension of the appeal resolution time frame, the member may initiate a State Fair Hearing.

B. The right to a State Fair hearing:

i. Virginia Premier’s rights of appeals will inform members that they may appeal to DMAS at the same time of the appeal to Virginia Premier; or after they have exhausted their appeal rights with Virginia Premier; or instead of appealing to Virginia Premier. The member or their representative may appeal to DMAS for a fair hearing of any adverse action or appeal not resolved wholly in favor of the member by Virginia Premier. FAMIS members may file an appeal to DMAS for an external review with MPRO, DMAS’ external review organization once the FAMIS member has exercised his/her appeal rights through Virginia Premier.

ii. The member will be informed in writing that all appeals with DMAS must be filed within thirty (30) days of the member’s receipt of notice of any action to deny, delay, terminate, reduce a serve authorization request; or to deny payment for Medicaid / FAMIS Plus covered services unless there is good cause.

iii. Good cause reasons include:

- Appellant was seriously ill and was prevented from contacting Virginia Premier;
- Appellant did not receive notice of Virginia Premier’s decision;
- Appellant sent the request for appeal to another government agency in good faith within the time limit; or
- Unusual or unavoidable circumstances prevented a timely filing; or
- If Virginia Premier’s notice is found to be “defective,” i.e., does not contain the required elements, good cause may exist.

iv. When a member appeals to DMAS, Virginia Premier will provide DMAS and the member with an appeal summary describing the basis for the denial. The summary will include the following information.

- The action Virginia Premier intends to take;
- The reasons for the intended action;
• The specific regulations, medical criteria that supports Virginia Premier’s decision or the change in law that requires the action.

v. The appeal summary will be submitted to DMAS and the member at least ten (10) days prior to the date of the hearing for standard appeals. The summary will be faxed to DMAS and faxed or overnight mailed to the member as expeditiously as the member’s health condition requires, but no later than four (4) business hours after DMAS informs Virginia Premier of the expedited appeal.

vi. Virginia Premier will attend the hearing either via telephone or in person with representation of appropriate decision-making individuals at the request of DMAS. Virginia Premier will absorb any telephone / travel expenses incurred.

vii. Virginia Premier shall comply with DMAS’ decision and all decisions by DMAS shall be final.

viii. In the cases where Virginia Premier’s decision was not upheld by DMAS, Virginia Premier will promptly authorize the disputed services with a written notification to the member, their representative and DMAS.

ix. The rules that govern representation at the State Fair hearing.

Administrative concerns (such as receipt of ID cards, transportation issues, etc.) will be handled through Member Services.

If a quality of care or service complaint is identified, the issue is forwarded to the Medical Management Department for investigation and prompt resolution.

If you are not happy with the answer given to you by Virginia Premier concerning your grievance or other action, you or another person authorized by you can file an appeal within thirty (30) days of receiving Virginia Premier's response. Your authorized representative can also file an appeal on behalf of your estate in the event of your death. You may also request a filing date extension of up to 14 days if it is requested within the thirty-day (30) time frame.

Virginia Premier’s Continuous Quality Improvement Committee (CQIC) oversees the grievances and appeals review process. Administrative reviews are the responsibility of the Member Services Department. Quality of care/service reviews are the responsibility of the Medical Management Department.

Grievances and Appeals Issues

Definitions

Quality of Care: Issues at any level that include any implication of malpractice, or:
Appropriateness of Care: the member alleges a management of care issue, conflicting diagnoses, improper treatment or exam, lack of thorough exam, unnecessary treatment, wrong treatment, unclear treatment, refusal of care that caused medical or surgical complications leading to additional service or care.
Continuity of Care: the member expresses dissatisfaction with the appropriateness of medical care resulting in a disruption in medical treatment. The member needs prompt assistance in obtaining appropriate medical treatment from another participating provider. The primary and often pressing issue is the need to obtain medical care.

Refusal of Care: the member expresses dissatisfaction with a denial of care by participating provider for such reasons as the lack of an identification card, late for an appointment, Primary Care Physician (PCP) is unavailable and no covering physician is available.

Refusal to Refer: the member expresses dissatisfaction with a denial of a PCP to refer the member for specialty care.

Quality of Service: Issues at any level that include:

- **Accessibility of Service:** the member expresses dissatisfaction with access to care.
- **Attitude of Provider:** the member expresses dissatisfaction with the attitude of a participating provider or the provider’s office staff.
- **Facility Environments:** the member expresses dissatisfaction with a provider’s office environment.
- **Uneducated Provider or Staff:** the member expresses dissatisfaction with the provider or staff being unaware of Virginia Premier procedures to follow to access care.
- **Administrative:** Issues at any level, which involves any topic other than ones, which have malpractice implications, quality of care or quality of service issues. These may include: late receipt of identification cards, inaccurate provider directories, inaccurate verification of benefits by Virginia Premier representatives, problems with transportation services, etc.

**Filing an Appeal**

The appeals process is a mechanism through which a member or physician/provider can request a review of an adverse action. An adverse benefit determination is the denial of a service authorization request, the reduction, suspension, or termination of a previously authorized service and/or denial in whole or in part of a payment for a covered service. Upon exhaustion of the plan level appeal process, member or physician/provider may appeal to the DMAS after a letter is sent informing them of Virginia Premier's decision. The appeal can also be requested at the time the decision is verbally given over the telephone or in person. DMAS will consider all requests for appeals, when the request for an appeal is made within one hundred twenty (120) calendar days of notification of the decision, after the exhaustion of the plan level appeal process.

Virginia Premier offers two types of appeals: the **Expedited Appeal** and the **Standard Appeal**, which can be appealed to the following address.

Virginia Premier
Medical Management Grievances and Appeals
P.O. Box 5244
Richmond, Virginia 23220-0924
Expedited Appeal

Expedited appeals may be requested by phone or in writing. All oral requests must be followed by a written appeal request. This applies to requests concerning admissions; continued stay or other health care services that:

- could seriously jeopardize the life or health of the member or the ability to regain maximum function, based on a prudent layperson’s judgment, or
- in the opinion of a practitioner with knowledge of the member’s medical condition, would subject the member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request.

A provider, member or member’s authorized representative may request an expedited appeal by notifying Virginia Premier via telephone or by faxing the clinical documentation to support the request, along with the attached form to the numbers listed below. Once the appeal is received, Virginia Premier will select a physician of the same or related specialty to review the case. This physician will be responsible for returning a decision within seventy-two (72) hours of receiving the information required for the expedited appeal, but is not the same physician who rendered the initial denial. A member or physician / provider must exhaust all Virginia Premier appeals before appealing to DMAS.

Standard Appeal

A provider, member or member’s authorized representative may request a standard appeal telephonically or in writing within sixty (60) calendar days of the date of the adverse action letter. All oral requests must be followed by a written appeal request. This type of appeal applies to requests for non-urgent pre-service or post-services. The practitioner / provider may submit written comments, documents, records and other information relevant to the appeal.

Appeals that involve clinical issues will be reviewed by a practitioner that was not involved in the initial denial that is of the same or similar specialty of the treating practitioner. An appointed Virginia Premier staff member that was not involved in the initial adverse decision will review non-clinical appeals such as benefit determinations. The member or practitioner / provider will be notified of the appeal decision in writing within thirty (30) calendar days of the appeal request.

Once the related information is received, the appeal will be reviewed by a physician of the same or related specialty, and a decision rendered in thirty (30) calendar days, but is not the physician who rendered the initial denial. A member or physician / provider must exhaust all Virginia Premier appeal before appealing to DMAS. Virginia Premier will provide in writing, clinical rationale for the adverse benefit determination to the member or physician / provider.

The practitioner or provider may appeal to DMAS upon exhaustion of Virginia Premier’s appeals process by notifying DMAS in writing at the address below within 120 calendar days of notification of Virginia Premier’s appeal decision.

Department of Medical Assistance Services (DMAS) Appeals Division, 600 E Broad Street Richmond, VA 23219, Phone: (804) 371-8488
Filing a FAMIS Appeal

Providers can appeal to KEPRO for an External Review after exhausting the Virginia Premier appeals process, for members participating in the FAMIS program. Providers must ask KEPRO for an External Review in writing; requests by phone will not be accepted. The request must be sent within thirty (30) calendar days from the date of the last notice saying the appeal was denied. KEPRO, an external, independent review organization, will review the appeal request.

Please send these requests for review to:
FAMIS External Review c/o KEPRO
2810 N. Parham Road Suite 305
Henrico, VA 23294
Fax: 877-652-9329
Phone: 888-827-2884
Email: VAproviderissues@kepro.com

For more information or to create an external review appeal, visit https://dmas.kepro.com.

Filing a Grievance

The grievance process is a mechanism through which a provider, member, and/or a member’s representative may request a review of a matter that has caused dissatisfaction with Virginia Premier. A grievance is an expression of dissatisfaction about any matter other than an action (i.e., denial, suspension or termination of services) taken by Virginia Premier. Possible subjects for grievances include, but are not limited to, the quality of care or services provided and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the member’s rights. Members can request a grievance by telephone or in writing.

Virginia Premier will resolve and respond to all grievances within thirty (30) calendar days from the date of initial receipt of the grievance. Only written grievance requests will be responded to in writing, unless the member requests a written response to a verbal grievance. When the grievance is of a health care nature, individuals at Virginia Premier with appropriate clinical expertise in treating the member’s condition or disease will make decisions on grievances.

Whenever a member, member’s representative, or provider is not satisfied with the resolution of a grievance, the member, member’s representative, or provider has the right to appeal the outcome of the grievance. Virginia Premier will answer any questions regarding the grievances and appeals Process during normal business hours, Monday through Friday 8:00 am to 8:00 pm by contacting Virginia Premier’s Medical Management Department:
State Fair Hearing Process

Members can write directly to the State Medicaid Program to file an appeal if after exhausting the plan level appeal process if they disagree with the health plan’s decision. Letters should be addressed to:

Department of Medical Assistance Services (DMAS) Appeals Division 600 E Broad Street
Richmond, VA 23219

Phone: (804) 371-8488

Providers may also appeal to the State Medicaid Program after exhausting their appeal rights with Virginia Premier. FAMIS members may also request an External Review through KEPRO after exhausting their appeal rights with Virginia Premier.

During an appeal, each member also has the right to:

• Know that he/she may have to pay for the cost of the benefits if the state hearing decision is the same as Virginia Premier’s decision, to deny the benefits. If the final decision of the appeal is to deny the benefits, Virginia Premier may bill the member for the cost of all services or benefits that were pending during the appeal process.

• Have benefits continue pending the outcome of the appeal and/or state hearing.

• The member can request continued benefits by writing a letter stating, “please continue benefits during my appeal” and forwarding it to Virginia Premier, or by calling 855-813-0349.

• Ask for an extension, orally or in writing, up to 14 calendar days, while the appeal is going on, if the extension is best for the member.

• To be contacted by Virginia Premier, in writing, of the appeal extension reason like “the appeal needs to be extended for additional information” and how the delay is best for the member.

• Look at all documents before and during the appeal, by writing to Virginia Premier with the request; the member can call 855-813-0349 for help

• To include, as parties to the appeal, the legal representative of a deceased member’s estate.

PROVIDER PARTICIPATION INFORMATION

General Guidelines

Participating physicians are responsible for fulfilling certain obligations and commitments as participants in our provider network. Contracted providers agree to abide by all rules and
guidelines stated in the contract between Virginia Premier and the Department of Medical Assistance Services. Responsibilities include, but are not limited to, the following:

- Providing care and services to Virginia Premier members without discrimination or regard for the member's race, creed, national origin, sex, age, religion, health status, and source of payment or frequency of utilization of covered services.

- Physicians must be participating Medicaid providers and follow the process for enrolling with Medicaid through the Department of Medical Assistance Services online portal: https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderEnrollmentLogin

- Providers must comply with provider access standards as set forth in the terms of the Medicaid Agreement to ensure that Virginia Premier members have appropriate access to routine, urgent and emergent care.

- Providers must submit timely utilization data in a format that will allow Virginia Premier to comply with DMAS reporting requirements. This includes information to demonstrate compliance with provision of EPSDT services.

- Providers must comply with all record keeping, record retention and special reporting requirements as set forth in the provider contract.

- Providers agree to allow authorized Virginia Premier representatives access to conduct office site reviews, with appropriate access to member’s medical records. Additionally, the provider agrees to preserve the full confidentiality of all medical records as stated in their contract.

- Providers agree to ensure the confidentiality of all patient records, including family planning services in accordance with the Medicaid Agreement.

- Providers must comply with the Virginia Premier’s Medical Management procedures and must clearly specify referral approval requirements to any subcontracted providers.

- Providers agree not to charge eligible Virginia Premier members for medically necessary covered services under the DMAS contract. Providers may only bill if the member has consented in writing to pay for a non-Medicaid covered service prior to receiving the services.

- Providers agree to cooperate with any external review organization contracted by DMAS to perform quality studies.

- Providers agree to assist Virginia Premier enrollees with special needs. This may range from assistance with understanding managed care and the role of their PCP to referring members to community resources or Early Intervention Services.

- Providers agree to provide appropriate written notice regarding any operational changes related to their practice. These may include address or phone number changes as well as panel status changes.
Credentialing and Re-credentialing Program Description

Overview of Program

The Credentialing Program of Virginia Premier shall be 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, and 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 evaluation process (the “Credentialing Program”). 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 are 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-review 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 organization’s 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 consider 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.

Establish Report to the HQUM and CQIC and other proper authorities, as required. Annual Review of the credentialing program description, and other related objectives.

Practitioners Credentialed and/or Re-credentialed

Initial and ongoing reviews of the professional practitioners include:
• Practitioners who have an independent relationship with Virginia Premier at an outpatient setting. An independent relationship exists when Virginia Premier selects and directs its members to see a specific practitioner or group of practitioners. An independent relationship is not synonymous with an independent contract. NCQA does not require the organization to credential some practitioners with whom it holds independent contracts.

• Practitioners who see members outside the inpatient hospital setting or outside freestanding, ambulatory facilities.

• Dentists who provide care under Virginia Premier medical benefits.

• Non-physician practitioners who have an independent relationship with Virginia Premier, as defined above, and who provide care under the organization’s medical benefits.

• Hospital-based practitioners who have an independent relationship with Virginia Premier and an outpatient setting:
  o Anesthesiologists with pain-management practices
  o Cardiologists
  o University faculty who are hospital based and who also have private practices

• Dentists providing care under medical benefits:
  o Endodontists
  o Oral surgeons
  o Periodontists

• Non-physician practitioners who may have an independent relationship with Virginia Premier and provide care under Virginia Premier’s medical benefits:
  o Behavioral health practitioners
  o Nurse practitioners
  o Nurse midwives
  o Optometrists
  o Physical therapists
  o Occupational therapists
  o Vision Services providers providing care under medical benefits
  o Speech and language therapists

Types of practitioner files audited (internally) during the year to ensure ongoing compliance:

• Medical practitioners:
  o Medical doctors (MD)
  o Dentists (DDS/DMD)
  o Chiropractors (DC)—only applicable to FAMIS members under the Medicaid line of business
  o Osteopaths (DO)
  o Podiatrists (DPM)
Nurse Practitioners (NP, PNP, ANP)

- Behavioral health practitioners:
  - Psychiatrists and other physicians
  - Addiction medicine specialists
  - Doctoral or master’s-level psychologists who are state certified or licensed
  - Master’s-level clinical social workers who are state certified or licensed
  - Master's-level clinical nurse specialists or psychiatric nurse practitioners who are nationally or state certified or licensed
  - Other behavioral health care specialists who are licensed, certified or registered by the state to practice independently

Virginia Premier’s Community Mental Health Services and ARTS providers (public and private) Shall meet any applicable DBHDS certification and licensing standards. Behavioral health and ARTS providers shall meet the Department’s qualifications as outlined in 12VAC30-50-226, 12VAC30-60-143, 12VAC30-50-130 and 12VAC30-60-61.

ARTS providers shall meet the requirements in 12VAC30-130-5000, et.al. and the Department’s most current behavioral health provider manuals, including the ARTS, community mental health services (CMHS), mental health clinic, and psychiatric services provider manuals found at: [www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual](http://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual)

In accordance with 12 VAC 30-50-131, all individual practitioners providing Early Intervention services must be certified by the Department of Behavioral Health and Developmental Services (DBHDS) to provide Early Intervention services. Providers of Early Intervention Care Management / Service Coordination must be certified through DBHDS as a Service Coordinator.

Virginia Premier shall use DMAS recognized licensed and credentialed treatment professionals as defined in 12VAC30-60-143 and 12VAC30-60-61, and the EPSDT Behavioral Therapy Manual Supplement. The contractor shall implement the registration requirements for peers and qualified mental health professionals with the department of health professions as directed by the Department and in accord with all applicable regulations.

**Process and Requirements**

Virginia Premier credentials all practitioners prior to being admitted into the Virginia Premier 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 must also follow the appropriate steps to enroll through the state Medicaid online portal. 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, Virginia Premier’s credentialing staff will promptly download the application to initiate the credentialing
process. The following information is obtained and verified according to the standards and utilizing 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)
- Quality measures (initial credentialing site visit and medical record keeping practices) 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**

The Virginia Premier credentialing staff will conduct primary source verification as required by the most current and applicable Virginia Premier, DMAS, and/or NCQA guidelines. Virginia Premier 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.

**Site Visit and Assessments / Surveys of Medical Record Keeping Practices**

Site surveys are conducted at participating provider offices to ensure that Virginia Premier officesite and medical record standards are met. The Quality Department is responsible for conducting offices surveys and medical reviews for all randomly selected practitioners. Each office is evaluated against regulatory and accreditation standards, which have been adopted and incorporated into Virginia Premier policies and procedures. Offices sites will be surveyed for the following categories:

- Physical accessibility Physical appearance
- Adequacy of waiting and examining room space
- Availability of appointments Adequacy of treatment record keeping
- Site visits will also be conducted within 60 days for member complaints regarding: Physical accessibility
- Physical appearance
- Adequacy of waiting and examining room space
Records must be legible, orderly and easily located. A “blinded” or “model” medical record/treatment record may be selected for the medical record keeping practices assessment. The established performance threshold must be met. If the assessment falls below the 90% threshold, the practitioner will be required to develop and submit a corrective action plan.

In the event that the practitioner does not resolve the initial concern within the identified timeframe, the Quality staff will forward any quality issues of immediate concern to the Chief Medical Officer or designee for further action. The practitioner’s office shall be re-evaluated at least every six months until the deficiency is resolved. If the concern remains unresolved, the Chief Medical Officer or designee may recommend to the Credentialing Committee that the practitioner not be re-credentialed.

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.

Annual Reviews

Virginia Premier conducts an annual review of the credentialing process to assess compliance with policies and procedures in accordance with Virginia Premier standards,
DMAS standards, the standards set forth by National Committee for Quality Assurance (NCQA) and other applicable regulatory bodies. Additionally, Virginia Premier conducts annual reviews on delegated vendors to assure that they are in compliance with Virginia Premier, regulatory and accreditation standards and other applicable regulatory bodies.

**Request for a Practitioner’s Professional Qualifications**

Please be aware that if a member requests information related to a practitioner’s professional qualifications, such as the specialty, board certification information, etc., the member can contact Virginia Premier. A Member Services Representative will obtain the information from the Credentialing Department or another appropriate source and provide it to the member.

The member can also go to Virginia Premier’s website at: [www.virginiapremier.com](http://www.virginiapremier.com) or the Virginia Board of Health Professions website at: [www.vahealthprovider.com](http://www.vahealthprovider.com)

**Provider Sanctions**

Virginia Premier has developed policies and procedures for credentialing activities including sanctioning practitioners or providers on issues of quality of care and service. Sanctions may include mandated continuing education, corrective action planning, probationary periods, and re-evaluation of the contract and/or the termination of the practitioner or provider from the network. The policies include an appeal process for practitioners and providers, which are communicated to them through a variety of media. Virginia Premier also maintains procedures to guide reporting of serious quality concerns to the appropriate authorities.

**Provider Availability: Access and After-Hours Standards**

Participating providers must comply with the following access standards for Virginia Premier members:

<table>
<thead>
<tr>
<th>Service</th>
<th>Virginia Premier Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appointment for health assessment, EPSDT screens, general physical exams, first examinations (preventive)</td>
<td>Scheduled within 30 days of request.</td>
</tr>
<tr>
<td>Initial health screens for new members under EPSDT regulations (preventive)</td>
<td>Scheduled within 30 days of request and completed within 3 months of enrollment date.</td>
</tr>
<tr>
<td>Appointment for Routine primary care and specialty care (non-urgent care for symptomatic conditions)</td>
<td>Scheduled within 14 calendar days of request.</td>
</tr>
<tr>
<td>Service</td>
<td>Virginia Premier Standard</td>
</tr>
<tr>
<td>------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Appointment for Behavioral Health / Substance Abuse Services</td>
<td>i. Care for non-life-threatening emergency within 6 hours.</td>
</tr>
<tr>
<td></td>
<td>ii. Urgent Care within 48 hours.</td>
</tr>
<tr>
<td></td>
<td>iii. Routine visits within 10 business days. Follow-up visit after inpatient admission within seven (7) calendar days.</td>
</tr>
<tr>
<td>Answering Telephone Hold</td>
<td>Within two (2) to (4) four rings 30 seconds or less</td>
</tr>
<tr>
<td>Virginia Premier 24 Hours Medical Help Line</td>
<td>Practitioners shall advise members to contact the Virginia Premier Nurse Advice Line for medical concerns prior to seeking services at the emergency room</td>
</tr>
</tbody>
</table>
**Wait Time**

Office visit waiting times should be reasonable and the member should be kept informed if unavoidable delays should arise. Generally, waiting times should not exceed 30 minutes for scheduled appointments or urgent appointments; one hour for members who are “overbooked” as walk-ins.

**Missed Appointments**

For Virginia Premier members who fail to keep their scheduled appointments, the provider office should document the occurrence and attempt to contact the member to reschedule the appointment. Chronic no-show patients or patients who fail to follow a recommended Individualized Care Plan should be referred to Case Management at (800) 727-7536. A Virginia Premier Outreach Worker will contact the member and work with them directly to facilitate compliance.

Note: Virginia Premier members cannot be billed for a missed appointment in accordance with Medicaid regulations.

**Medical Record Keeping Policies**

Participating physicians are required to maintain adequate medical records and documentation relating to the care and services provided to Virginia Premier 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 in the case of a minor child, their legal guardian. The medical record provides the mechanism that creates, 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 DMAS 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

Virginia Premier has 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.

Medical record-keeping practices may be assessed for:

- Member grievances
- Quality of Care (QOC) Indicators
- Sentinel Events
- Practicespecific member surveys
- Reports from Virginia Premier employees
- Credentialing Department ongoing monitoring process
- Other Quality Initiatives

The Virginia Premier Medical Record Standards are detailed in the following section.

**MEDICAL RECORD-KEEPING REQUIREMENTS**

Confidentiality of medical records must be maintained by:

- Medical records being stored securely (i.e., confidential filing system, etc.)
- Only authorized personnel having access to medical records
- Conducting training on confidentiality related to member information periodically, and as needed. Medical record documentation standards will be utilized. Each medical record must include the following:
  - History and physical
  - Allergies and adverse reactions
  - Problem list
  - Medications
  - Documentation of clinical findings and evaluation for each visit
  - Preventive services/ risk screening

Medical records must be organized and stored in a manner that allows for easy retrieval.

**Retention and Transfer of Records**

Participating physicians are required to maintain all records pertaining to Virginia Premier members for ten (10) years or longer if required under applicable state law.
Virginia Premier requires that participating physicians make medical records available to members and their authorized representatives within ten (10) working days of receiving a request.

PCPs are responsible for obtaining copies of medical records from both participating and non-participating providers to whom they make referrals, in order to ensure continuity of care and integrated medical records.

Practitioners who do not meet Virginia Premier's medical record standards performance threshold will be expected to document and implement a corrective action plan within a specified time frame. At least every six months after the initial review, each deficiency will be monitored for progress and/or until the performance standards are met. If deficiencies are not resolved within a six-month time frame, they will be presented to the Senior Medical Director and/or the Credentialing Committee to begin a review and sanctioning process with the practitioner.

**Office Site Reviews**

Site visit assessments may be conducted, as the result of one or more of the following quality concerns:

- Member grievances
- Quality of Care (QOC) Indicators
- Practicespecific member surveys
- Reports from Virginia Premier employees
- Credentialing Department ongoing monitoring process
- Other quality-related initiatives, such as HEDIS

The purpose of the office site review is to ensure practitioners meet the Virginia Premier regulatory and accreditation site standards for quality, safety and accessibility. Virginia Premier Quality staff will assess the following during an office site visit:

- Facility accessibility, appearance and adequacy
- Safety
- Adequacy of medical supplies and practices

Practitioners who do not meet the Virginia Premier site visit assessment performance threshold will be expected to document and implement a corrective action plan within a specified time frame. At least every six months after the initial review, each deficiency will be monitored for progress and/or until the performance standards are met. If deficiencies are not resolved within a six-month time frame, they will be presented to the Medical Director and/or the Healthcare Quality and Utilization Management Committee to begin a review process with the practitioner.

**Waiver Audits**

Virginia Premier conducts waiver audits on behalf of DMAS. The Virginia Premier team works with DMAS to monitor elements of the waiver quality improvement strategies which
must address assurances, including service plans, qualified providers, financial authority, member’s health / safety / welfare, level of care, and administrative authority. Virginia Premier has had success with the development of a web-based tool for data collection, aggregation and reporting. Virginia Premier has been identified as a best practice by DMAS for our work in this area.

COMPLIANCE AND PROGRAM INTEGRITY

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

The Program Integrity department is designed to assist the organization to uphold our continued commitment in making proper and ethical decisions. The Program Integrity standards apply to officers, directors, employees and affiliated associates such as providers, vendors, and subcontractors. It consists of the following: policies and procedures, standards of professional 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 conflict of interest
- HIPAA
- Other regulatory requirements or laws, such as Sarbanes-Oxley and Stark Law

You can call: our Program Integrity Department at 1-800-727-7536 the Compliance Helpline at 1-800-981-6667 or email corp_compliance@sentara.com. Use our anonymous form.

Corporate Compliance and Integrity Plan

Virginia Premier is committed to conducting all facets of its operations in compliance with applicable laws, regulations, policies and procedures. Virginia Premier maintains a policy of “zero tolerance” for fraud, waste, and abuse in every aspect of our business.

Standards of Professional Conduct

Virginia Premier requires employees and affiliates to conduct business and personal activities in a manner that is ethically and legally responsible. The Standards of Professional Conduct outlines this commitment.

- Treat members with respect and dignity
• Deal openly and honestly with fellow employees, members, providers, representatives, agents, governmental entities, and others

• Adhere to federal and state laws, regulations and Virginia Premier policies in procedures in all business and personal dealings whether at work or outside of work

• Exercise discretion in the processing of claims regardless of provider, practitioner, and vendor source

• Notify and return overpayments to the health plan immediately upon receipt of such payments

• Notify the Program Integrity Officer of any instances of non-compliance and cooperate with all investigational efforts by Virginia Premier and other state and federal agencies

• Use supplies and services in an efficient manner to reduce cost to the health plan

• Do not misuse Virginia Premier resources nor influence in such a way as to discredit the reputation of Virginia Premier

• Maintain high standards of business and ethical conduct in accordance with regulatory and accredited agencies to include standards of business to address fraud, waste, and abuse

• Practice good faith in transactions occurring during the course of business

• Conduct business dealings in a manner that the organization shall be the beneficiary of such dealings

• Preserve patient confidentiality, unless there is written permission to divulge information, except as required by law

• Refuse any illegal offers, solicitations, payment or other enumeration to induce referrals of the members we serve for an item of service reimbursable by a third party

• Disclose financial interest / affiliations with outside entities to Virginia Premier as required by the Conflict of Interest Statement

• Hold all contracted parties to the same Standards of Professional Conduct as part of their dealings with Virginia Premier

• Notify the Program Integrity Officer of any instances of non-compliance and cooperate with all investigational efforts by Virginia Premier and other state and federal agencies

• Providers providing services to CCC Plus waiver members shall comply with the provider requirements as established in the DMAS provider manuals available at www.virginiamedicaid.dmas.virginia.gov/wps/portal and the following regulations: 12 VAC 30-120-900 through 12 VAC 30-120-995

• Providers of CCC Plus waiver services (including Adult Day Health Care [ADHC]) shall maintain compliance with the provisions of the CMS Home and Community Based Settings Rule as detailed in 42 CFR §441.301(c)(4) and (5)
Health Insurance Portability and Accountability Act of 1996 (HIPAA)

What is HIPAA?

HIPAA is a federal privacy law enacted on August 21, 1996, that mandates health plans, providers and health care clearinghouses to take greater care in use and disclosure of protected health information (PHI).

Who is Impacted by HIPAA?

Health plans, providers and health care clearinghouses are impacted by HIPAA.

What Does “Confidentiality” Mean?

Confidentiality means only discussing patient or member’s information with other staff or individuals on a “need-to-know” basis for the purpose of treatment, payment, or health care operations. Here are simple steps you can use to protect the privacy and security of patient health information:

- Post your Notice of Privacy Practices in patient common areas
- Make sure every patient reads and signs the Notice of Privacy Statement
- Keep medical records in a restricted area and locked file cabinet
- Make sure PHI is safely filed away at the end of each workday
- Make sure computers are logged off or shut down according to company policy
- Encourage staff to shred documents that are not part of patient record that contains protected health information
- Use a fax coversheet and confirm fax numbers when faxing patient health information
- Place the fax machine in a secure location away from public viewing
- Conduct staff training on HIPAA policies and procedures
- Designate a staff member to handle compliance and/or HIPAA concerns for your office
- Establish a policy and procedure for computer and Internet usage
- Establish a policy and procedure for release of medical records
- Immediately terminate access for computer systems and obtain keys from terminated employees
- Establish a policy to ensure all visitors check in at the front desk
- Ensure computers are backed up daily
- Ensure anti-virus software for computers is updated on a regular basis
- Ensure computer passwords are changed at a minimum, every 90 days
- Terminate an employee’s access to the facility and computers upon termination of employment

What is Protected Health Information (PHI)?

PHI is a subset of health information including demographic information collected from an individual and is created or received by a health care provider, health plan, employer, or health care clearinghouse. Below is a sampling of PHI identifiers that covered entities deal with on a daily basis and must protect.
- Name
- Address
- Dates (date of birth, inpatient admission dates, discharge dates, date of death)
- Telephone Number
- Fax Number
- Social Security
- Health Plan Beneficiary
- Medical Record
- Biometric identifier

**Uses and Disclosures of PHI**

Covered entities are not required to obtain a member’s approval to use or disclose protected health information for Treatment, Payment and health care Operations (TPO).

**Treatment** – Provision, coordination, or management of health care and related services

**Payment** – Reimbursement for health care services, including billing and claim management

**Health Care Operations** – Business activities of the organization, such as quality assessments and improvement activities, training programs, accreditation, licensing, credentialing, premium rating, legal services, business management, and general administrative activities

Authorization is required for any use or disclosure other than TPO. Authorization is required for psychotherapy notes.

**Other Permitted and Required Uses and Disclosures**

The following may be made without a patient’s consent, authorization or opportunity to object:

- Abuse and Neglect
- Business Associates
- Communicable Diseases
- Coroners, Medical Examiners, and Funeral Directors
- Organ and Tissue Donation
- Criminal Activity
- Food and Drug Administration
- Health Oversight
- Inmates
- Law Enforcement
- Legal Proceedings
- Military Activity and National Security
- Public Health
• Required Uses and Disclosures
• Research
• Required by Law
• Workers’ Compensation

Authorization must be obtained from the patient (Virginia Premier member) before you may use or disclose any PHI for reasons other than treatment, payment or health care operations, and in all cases involving psychotherapy notes.

Patients’ Rights Regarding Medical Information about Them:

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.

How Virginia Premier Protects Information about Members

Virginia Premier is dedicated to safeguarding members’ protected health information (PHI), and has established a number of policies and procedures to ensure their PHI is kept secure. The safeguards in place include the following:

• Requirement for proper written authorization to release PHI
• Providing only the minimum necessary information to accomplish the intended purpose
• Establishing rules and requirements to accept an individual designated as a personal
representative
• Limiting how we use or disclose PHI
• Limiting who may see information about our members
• Password-protecting computers, and securing storage areas and filing cabinets
• Requiring employees to wear ID badges at all times, and requiring the use of ID badges to enter work areas
• Establishing policies and procedures related to record retention and proper disposal of PHI
• Requiring our business partners to sign a Business Associate Agreement to protect the privacy of data we share with them in the normal course of business
• Training our employees about company privacy and security policies and procedures

The HITECH Act enacted into legislation as part of the American Recovery and Reinvestment Act (ARRA) amended HIPAA as follows:
• Broadens the applicability of the HIPAA Privacy Rules and penalties to include business associates:
• Add specific obligations upon business associates and covered entities to provide certain notifications in the event the security of Protected Health Information (PHI) is breached;
• Clarifies that HIPAA's criminal sanctions apply to employees or other individuals that wrongfully use or access PHI held by a covered entity;
• Increases criminal and civil penalties for HIPAA Privacy Rule violators;
• Prohibits sale of PHI without written consent;
• Tightens certain HIPAA accounting for disclosure requirements;
• Expand the Business Associates Agreement requirements;
• Makes business associates directly liable for compliance with certain HIPAA Privacy and Security Rules;
• Expands individuals' rights to receive electronic copies of their health information; and
• Establishes ‘Low Probability’ standard to determine the extent of a breach.

Breach Notification Requirements
The following steps must be taken in the event of a breach of unsecured protected health information:
• Perform a risk assessment to determine if there is a “low probability” that the PHI has been or will be compromised. The following four (4) factors must be assessed to determine the low probability of compromise:
  1. The nature and extent of the PHI involved, including the types of identifiers and the likelihood of re-identification.
  2. The unauthorized person who used the PHI or to whom the disclosure was made.
  3. Whether the PHI was actually acquired or viewed or whether the opportunity
existed to acquire or view but actual viewing and acquiring did not occur.

4. The extent to which the risk has been mitigated.

- All four of these factors must be addressed in the risk assessment to determine the level of compromise of PHI, and in all cases any breach involving Virginia Premier members must be reported to Virginia Premier. If there is not a low probability that PHI has been breached the following steps must be taken.

Methods of Notice:

- Notice to the individual(s) shall be provided promptly and by first class mail at the last known address of the individual or next of kin, or if specified by the individual by electronic mail. In the event there is insufficient or out-of-date contact information that precludes direct written notice, a substitute form of notice shall be provided. In the case where there is 10 or more individuals for which there is insufficient or out-of-date contact information, notification would be made on the provider’s website. In any case deemed by the provider to require urgency because of the possible imminent misuse of unsecured PHI, the provider may provide information to individuals by telephone.

- Notice shall be made to prominent media outlets serving the state, following the discovery of a breach, if unsecured PHI of more than 500 individuals in a single state or jurisdiction is, or is reasonably believed to have been accessed, acquired, or disclosed.

- Notice shall be provided to the Secretary of the U. S. Department of Health and Human Services of unsecured PHI that has been acquired or disclosed in a breach, if the breach involves 500 or more individuals. If the breach involves less than 500 individuals, the provider shall maintain a log of any such breach and annually submit the log to the Secretary.

Timeliness of Notification:

All notifications shall be made without unreasonable delay and in no case later than sixty (60) calendar days after discovery of the breach.

Content of Notification:

- A brief description of what happened, including the date of the breach and the date of the discovery of the breach, if known.

- A description of the types of unsecured PHI that were involved in the breach.

- The steps individuals should take to protect themselves from potential harm resulting from the breach.

- A brief description of what the provider is doing to investigate the breach, to mitigate losses, and to protect against further breaches.

- Contact information for individuals to ask questions or learn additional information.

Understanding the Deficit Reduction Act (DRA) of 2005 (False Claims Act)

Background: The Deficit Reduction Act of 2005 (DRA) mandates compliance programs for those institutions receiving $5 million or more annually in Medicaid payments. The DRAs False Claims Act Amendment is intended to reduce the amount of fraud, waste, and abuse in
state and federal health care programs through employee education about the federal False Claims Act, state false claims acts, civil and criminal penalties, and protections from retaliation for those employees who report in good faith wrongdoings, misconduct, or violations of laws and regulations.

**Federal False Claims Act:** The federal False Claims Act covers fraud involving any federally funded contract or program such as Medicare or Medicaid and establishes liability for any person who knowingly presents or causes to be presented a false or fraudulent claim to the U.S. government for payment.

**Self-Disclosure of Overpayments:** Under the Affordable Care Act Section 6402(d), any provider of services or supplier who receives a payment under Medicare or Medicaid to which the person or entity, after applicable reconciliation, is not entitled, must return the funds within 60 days. The 60-day time limit begins from the time the provider/supplier identifies the overpayment or when the overpayment is brought to the attention of the provider/supplier by Virginia Premier.

Failure to report overpayments within the 60-day time requirement constitutes an obligation under the False Claims Act and could create FCA liability.

**Virginia Fraud Against Taxpayers Act:** The Virginia Fraud Against Taxpayers Act is Virginia’s version of the federal False Claims Act and contains parallel provisions. This state law helps the Commonwealth combat fraud and abuse and recovers losses resulting from fraud in programs, purchases, and contracts.

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

**Examples of Fraud, Waste, and Abuse Committed by Employees**
- Fabricating claims or changing provider addresses to intercept payments
- Providing false information on employment application
- Identity theft
- Accepting or offering a kickback or bribery in exchange for money

**Examples of Fraud, Waste, and Abuse Committed by Providers**
- Participating in kickbacks (payments or other types of compensation made in order to influence and gain profit from an individual or company).
- Forgery of a physician’s signature.
- Billing for medical services that were not given.
- Billing for undocumented or medically unnecessary services.
- Duplicate billing
- Assigning incorrect codes to secure a higher reimbursement (upcoding)
- Unbundling codes with the intent to increase reimbursement
Examples of Fraud, Waste, and Abuse Committed by Members

- Loaning / sharing ID cards to obtain health care services or prescriptions
- "Doctor shopping" and excessive trips to the ER for controlled substances (narcotics).
- Falsifying information on application in order to receive benefits
- Falsifying or altering claims for reimbursement of services or prescriptions
- Falsifying or altering prescriptions to obtain prescriptions
- Reporting lost or stolen prescriptions which had been sold

Qui Tam Whistleblower Provisions: As a means to encourage individuals to come forward and report misconduct involving false claims, the False Claims Act’s “whistleblower” provision allows any person with actual knowledge of allegedly false claims, who has first made a good faith effort to exhaust internal reporting procedures, to file a lawsuit on behalf of the government and potentially share in a percentage of the amount recovered.

No Retaliation: The Federal False Claims Act grants protection from retaliation for filing a lawsuit or assisting in a False Claims Act action. Virginia Premier policy prohibits any type of retaliation against those who report concerns. This policy works in conjunction with the Federal False Claims Act and the Virginia Fraud Against Taxpayers Act in protecting those who report misconduct.

Virginia Premier has established several mechanisms to detect and combat fraud and abuse. Our compliance and integrity program outlines auditing and monitoring techniques used to detect fraud, abuse and waste. Additional procedures and processes are established to audit and monitor activities at every level.

Auditing: In an ongoing effort to ensure quality services to our members and verify accurate billing practices of our providers, Virginia Premier conducts periodic unannounced reviews or audits. This includes reviewing medical records, claims and other documentation.

Excluded Entities and Individuals

In accordance with the Code of Federal Regulations at 42 C.F.R. § 438-310; C.F.R. § 1002; and 12 VAC 30-10-690 of the Virginia Administrative Code, Virginia Premier is prohibited from participating with or entering into a provider agreement with any individual or entity that has been excluded from participation in federal health care programs. Additionally, Virginia Premier is prohibited from contracting with any provider who has been terminated from a state Medicaid program, FAMIS, or Medicare for fraud, waste or abuse.

Likewise, under federal and state laws and regulations providers who receive reimbursement from Virginia Premier are prohibited from employing, doing business with, or entering into a contract with excluded individuals or entities. Providers are required to use the U.S. Department of Health and Human Services and the Office of the Inspector General (OIG) online exclusion database, available at exclusions.oig.hhs.gov to screen managing employees, physicians, nurse practitioners, nurses, and contractors to determine whether any of them have been excluded from federal health care programs. The screening should be done prior to hire or contract signing and monthly thereafter.

In the event a provider, a provider’s employees as stipulated above, or contractor is excluded, debarred, suspended or otherwise determined to be, or identified as, ineligible to...
Participate in federal health care programs, or is listed on the OIG List of Excluded Individuals and Entities (LEIE), this agreement will, at the sole option of Virginia Premier, immediately terminate.

To ensure compliance, all providers shall implement a procedure for LEIE screening on no less than a monthly basis for all managing employees, physicians, nurse practitioners, nurses, and contractors. Upon reasonable request, providers shall provide written verification of such screenings.

**Affirmative Statements and Incentives**

Virginia Premier affirms the following regarding utilization management (UM) practices:

- UM decisions are based only on appropriateness of care and service and the existence of coverage;
- Practitioners or other individuals are not rewarded for issuing denials of coverage or service care; and
- UM decision makers do not receive financial incentives to encourage decisions that result in underutilization.

Practitioners may freely communicate with patients about their treatment, regardless of benefit coverage.
<table>
<thead>
<tr>
<th><strong>Activities of Daily Living</strong></th>
<th>Means personal care activities and includes bathing, dressing, transferring, toileting, feeding, and eating.</th>
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</table>
| **Abuse**                     | i. 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 (a) 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 healthcare. |
| **Assessment**                | Means face-to-face interaction in which the provider obtains information from the individual, and parent, guardian, or other family member or members, as appropriate, about the individual's health status. It includes documented history of the severity, intensity, and duration of health problems and behavioral and emotional issues. |
| **Appeal**                    | A provider appeal is a request made by a Virginia Premier provider (in-network or out-of-network) to review the reconsideration decision in accordance with the statutes and regulations governing the Virginia Medicaid appeal process. After a provider exhausts the contractor's reconsideration process, Virginia Medicaid affords the provider the right to two administrative levels of appeal (informal appeal and formal appeal) in accordance with the Virginia Administrative Process Act (Code of Virginia § 2.2-4000 et seq.) and Virginia Medicaid's provider appeal regulations (12 VAC 30-20-500 et seq.). |
| **At Risk of Hospitalization**| As it relates to Intensive In-Home Services (H2012), means one or more of the following: (i) within the two weeks before the Comprehensive Needs Assessment, the individual shall be screened by an LMHP, LMHP-R, LMHP-S or LMHP-RP for escalating behaviors that have put either the individual or others at immediate risk of physical injury such that comprehensive crisis services, hospitalization or other high intensity interventions are or have been warranted; (ii) the parent/guardian is unable to manage the individual's mental, behavioral, or emotional problems in the home and is actively, within the past two to four weeks, seeking an out-of-home placement; (iii) a representative of either a juvenile justice agency, a department of social services (either the state agency or local agency), a community services board/behavioral health authority, the Department of Education, or an LMHP, as defined in |
12VAC35-105-20, or LMHP-R, LMHP-S, or LMHP-RP and who is neither an employee of nor consultant to the intensive in-home (IIH) services or therapeutic day treatment (TDT) provider, has recommended an out-of-home placement absent an immediate change of behaviors and when unsuccessful mental health services are evident; (iv) the individual has a history of unsuccessful services (either mobile crisis response, community stabilization, outpatient psychotherapy, outpatient substance use disorder services, or mental health skill building) within the past 30 calendar days; (v) the treatment team or family assessment planning team (FAPT) recommends IIH services or TDT for an individual currently who, within the past thirty calendar days, is either: (a) transitioning out of residential treatment services, either psychiatric residential treatment facility (PRTF) or therapeutic group home (TGH), (b) transitioning out of acute psychiatric hospitalization, or (c) transitioning between foster homes, mental health case management, mobile crisis response, community stabilization, outpatient psychotherapy, or outpatient substance use disorder services.

<table>
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<tr>
<th><strong>Authorization</strong></th>
<th>The process of obtaining prior approval from the health plan before rendering specified services or procedures to a member.</th>
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<tr>
<th><strong>Centers for Medicare &amp; Medicaid Services (CMS)</strong></th>
<th>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</th>
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<tr>
<th><strong>Claim</strong></th>
<th>An itemized statement of services rendered by health care providers (such as hospitals, physicians, dentists, etc.) billed electronically or on HCFA 1500 UB 04.</th>
</tr>
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<tr>
<th><strong>Clean Claim</strong></th>
<th>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.</th>
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<tr>
<th><strong>Co-Payment</strong></th>
<th>The member’s portion of the payment due at the time of service</th>
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<tr>
<th><strong>Department of Medical Assistance Services (DMAS)</strong></th>
<th>DMAS administers a number of programs in the State to assist needy Virginians. These programs include the Medicaid Program, the Indigent Health Care Trust Fund, the State and Local Hospital Program and the Family Access to Medical Insurance Security Plan (FAMIS).</th>
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<tr>
<th><strong>DSS</strong></th>
<th>Department of Social Services (DSS)</th>
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<tr>
<th><strong>Emergency</strong></th>
<th>A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent lay-person who</th>
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**possesses** an average knowledge of health and medicine, could 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.

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<tr>
<th><strong>Enrollment Broker</strong></th>
<th>An independent broker who enrolls recipients in the Medicaid HMO plans, and who is responsible for the operation and documentation of a toll-free recipient service helpline. The responsibilities of the enrollment broker include, but are not limited to, recipient education and enrollment.</th>
</tr>
</thead>
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<tr>
<td><strong>Fee for Service</strong></td>
<td>The traditional health care payment system in 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>
</tr>
<tr>
<td><strong>Fraud</strong></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>
</tr>
<tr>
<td><strong>Grievance</strong></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 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 adverse to the member or the payment or reimbursement of health care service claims.</td>
</tr>
<tr>
<td><strong>Health Maintenance Organization (HMO)</strong></td>
<td>A medical care organization to deliver and finance health care services to its members for a fixed prepaid premium. A primary care physician must provide or authorize all services provided to members. Members must use in-network physicians.</td>
</tr>
<tr>
<td><strong>Health Risk Assessment (HRA)</strong></td>
<td>A comprehensive assessment of a member’s medical, psychosocial, cognitive, and functional status in order to determine their medical, behavioral health, LTSS and social needs.</td>
</tr>
<tr>
<td><strong>Interdisciplinary Care Plan (ICP)</strong></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>
</tr>
<tr>
<td><strong>Interdisciplinary Care Team (ICT)</strong></td>
<td>A team of professionals that collaborate, either in person or through other means, with the member to develop and implement an Individualized Care Plan 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>
</tr>
<tr>
<td><strong>Managed Care</strong></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>
</tr>
<tr>
<td><strong>Medicaid</strong></td>
<td>Medicaid is a Federal-State medical assistance program under Title XIX of the Social Security Act and various Demonstrations and waivers thereof that arranges for and administers reimbursement for reasonable and necessary medical care for persons meeting both medical and financial eligibility requirements. DMAS administers the Medicaid program in Virginia.</td>
</tr>
<tr>
<td><strong>Medical Necessity</strong></td>
<td>Services sufficient in amount, duration, scope and environment to improve health status.</td>
</tr>
<tr>
<td><strong>Medicare</strong></td>
<td>Title XVIII of the Social Security Act, the federal health insurance program for people age 65 or older, people under 65 with certain disabilities, and people with End Stage Renal Disease (ESRD) or Amyotrophic Lateral Sclerosis. Medicare Part A provides coverage of inpatient hospital services and services of other institutional providers, such as skilled nursing facilities and home health agencies. Medicare Part B provides supplementary medical insurance that covers physician services, outpatient services, some home health care, durable medical equipment, and laboratory services and supplies, generally for the diagnosis and treatment of illness or injury. Medicare Part C provides Medicare members with the option of receiving Part A and Part B services through a private health plan. Medicare Part D provides outpatient prescription drug benefits.</td>
</tr>
<tr>
<td><strong>Member</strong></td>
<td>An individual who is eligible for Medicaid / FAMIS Plus and who is currently enrolled with Virginia Premier. All members are assigned a PCP to provide and/or coordinate all health care services.</td>
</tr>
<tr>
<td><strong>Minimum Data Set</strong></td>
<td>Part of the federally-mandated process for assessing individuals receiving care in certified skilled nursing facilities in order to record their overall health status regardless of payer source. The process provides a comprehensive assessment of individuals’ current health conditions, treatments, abilities and plans for discharge. The MDS is administered to all residents upon admission, quarterly, yearly and whenever there is a significant change in an individual’s condition.</td>
</tr>
<tr>
<td><strong>Model of Care (MOC)</strong></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 designated program.</td>
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<tr>
<td><strong>National Committee on Quality Assurance (NCQA)</strong></td>
<td>A not-for-profit organization performing accreditation review of managed care plans.</td>
</tr>
<tr>
<td><strong>Network Provider</strong></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>
</tr>
<tr>
<td><strong>Non-par Provider</strong></td>
<td>Non-participating Provider – 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><strong>Options</strong></td>
<td>One of three managed care programs administered by DMAS. Options is a voluntary Health Maintenance Organization (HMO) enrollment program. Recipients may choose between a Medallion PCP or enrollment in a Medicaid HMO to provide their health care needs.</td>
</tr>
<tr>
<td><strong>Primary Care Physician (PCP)</strong></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><strong>Register or Registration</strong></td>
<td>Means notifying the FFS contractor or MCO that an individual will be receiving services that do not require service authorization.</td>
</tr>
<tr>
<td><strong>Residential Treatment Services</strong></td>
<td>Means 24-hour, supervised, medically necessary, out-of-home programs designed to provide necessary support and address mental health, behavioral, substance use disorder, cognitive, or training needs of a youth in order to prevent or minimize the need for more intensive inpatient treatment. Services include, but shall not be limited to, assessment and evaluation, medical treatment (including medication), individual and group counseling, neurobehavioral services, and family therapy necessary to treat the child. The service provides active treatment or training beginning at admission related to the resident’s principle diagnosis and admitting symptoms. These services do not include interventions and activities designed only to meet the supportive non-mental health special needs including, but not limited to, personal care, habilitation, or academic educational needs of the resident.</td>
</tr>
<tr>
<td><strong>Service Authorization</strong></td>
<td>The process to approve specific services for an enrolled Medicaid, FAMIS Plus, or FAMIS individual by the FFS contractor or MCO prior to service delivery and reimbursement in order to validate that the service</td>
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requested is medically necessary and meets DMAS and DMAS contractor criteria for reimbursement. Service authorization does not guarantee payment for the service.

| **Urgent Care** | A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of medical attention within twenty-four hours (24) could reasonably be expected to result in:
|                | • Placing the patient’s health in serious jeopardy
|                | • Serious impairment to bodily function; or
|                | • Serious dysfunction of any bodily organ or part |