



Provider Manual

2014

Corporate Office

600 East Broad Street
Suite 400
Richmond, VA 23219-1800

Tidewater

3388 Princess Anne Rd
Suite 2000
Virginia Beach, VA 23456

Roanoke

5060 Valley View Boulevard NW
Roanoke, VA. 24012



Dear Provider:

Thank you for becoming a participating provider with Virginia Premier CompleteCare (VPCC). Attached is the 2014 VPCC 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 teams (ICT), plans of care (POC), health risk assessments (HRAs) and compliance.

In this manual we refer to various Exhibits. These exhibits are available in printable version on our website, at www.vapremier.com.

Exhibit A	Obstetric and Authorization Form
Exhibit B	Certificate of Medical Necessity Form
Exhibit C	Prescription Prior Authorization Request Form
Exhibit D	Initial Outpatient Treatment Report Form (IOTR)
Exhibit E	Outpatient Treatment Report Form (OTR)
Exhibit F	Request for Psychological Testing
Exhibit G	Quality Program Description
Exhibit H	Credentialing Program Description
Exhibit I	Practitioner Golden Globe Award
Exhibit J	20 Tips to Prevent Medical Errors
Exhibit K	Clinical Practice Guidelines

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. 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,

Virginia Premier's Network Development Department

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Note: Please contact your local Provider Services Representative to request forms and additional staff training.

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



INTRODUCTION AND WELCOME

Virginia Premier is pleased to welcome you to our participating provider network. At Virginia Premier, our mission is to improve the health of the Medicare-Medicaid population in the Commonwealth of Virginia. We believe these under-served populations are entitled to the same quality healthcare as commercially insured populations, and they also require a focused approach that is specifically designed to meet their unique needs.

Our Mission

Virginia Premier Health Plan, a managed care organization owned by the Virginia Commonwealth University Medical Center, meets the needs of underserved and vulnerable populations in Virginia by delivering quality driven, culturally sensitive, and financially viable healthcare.

Our Vision

By organizing and financing the delivery of evidence based care, Virginia Premier will:

- Engage members and providers in achieving improved healthcare outcomes
- Pioneer new models of healthcare delivery in support of improving efficiency and achieving healthcare reform
- Support the educational and research missions of the Virginia Commonwealth University Health System

COMMONWEALTH COORDINATED CARE

Commonwealth Coordinated Care (CCC) is an innovative, integrated program designed to better serve individuals who are eligible for Medicare and Medicaid in the Commonwealth of Virginia. Built on principles of independent living, wellness promotion and cultural competence, this program aims to improve the entire member care experience. By engaging member's in their care and allowing them to access self-direct services as appropriate, VPCC addresses member's' health and functional needs in order to better equip individuals to live independently in their communities.

Members enrolled in the VPCC program will receive comprehensive, patient-centered care. Virginia Premier CompleteCare (VPCC) 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 Plan of Care (POC). Each member is assigned a Care Manager upon enrollment who is responsible for facilitating the POC. The POC 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 a POC 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. 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 care setting appropriate to the Members' needs, with a preference for the home and the community.

Virginia Premier currently operates within the five (5) demonstration regions identified by the Commonwealth of Virginia. These regions are outlined on page 11. Members are individuals who are 21 years of age or older at the time of enrollment, entitled to benefits under Medicare Part A and enrolled under Medicare Parts B and D, and receiving full Medicaid benefits, to include those individuals enrolled in the Elderly Disabled with Consumer Direction (EDCD) Waiver and those residing in nursing facilities (NF). Medicare covered benefits shall be provided in accordance with 42 CFR 422 and 42 CFR 423 et seq. 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, MOU or the three-

way contract. 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.

How to Reach Us

Virginia Premier CompleteCare Directory		
General	Phone Number	855-338-6467
	Fax	877-739-5708
For Providers	Provider Services	855-338-6467
	Contracting	855-338-6467
	Claims	855-338-6467
	Medical Management (Referrals and Authorizations)	(804) 819-5151, press 3 (888) 251-3063 Fax (804) 819-5186 or (866) 284-1057
	DMAS AVRS Line (Automatic Voice Response System)	800-884-9730
	VPCC RVP Eligibility Verification	855 338-6467
For Members	Member Services	855-338-6467
	Transportation	855-338-6467
	After Hours Nurse Advice Line (24/7)	800-256-1982
	Virginia Enrollment Broker	855-889-5243
Local Offices	Phone	Mail
Richmond	804-819-5151	PO Box 5307 Richmond, VA 23220-0307
Roanoke	540-344-8838	PO Box 1751 Roanoke, Virginia 24008-1751
Northern Virginia	855-338-6467	PO Box 5307 Richmond, VA 23220-0307
Tidewater/Virginia Beach	757-461-0064	PO Box 62347 Virginia Beach, VA 23466-2347

Service Regions

Central Virginia		
Amelia	Greensville	Petersburg
Brunswick	Hanover	Powhatan
Caroline	Henrico	Prince George
Charles City	Hopewell	Richmond City
Chesterfield	King and Queen	Richmond County
Colonial Heights	King George	Southampton
Cumberland	King William	Spotsylvania
Dinwiddie	Lancaster	Stafford
Essex	Lunenburg	Surry
Emporia	Middlesex	Sussex
Franklin City	New Kent	
Fredericksburg	Northumberland	
Goochland	Nottoway	
Northern Virginia		
Alexandria	Fairfax City	Loudoun
Arlington	Fairfax County	Manassas Park
City of Manassas	Falls Church	Prince William
Culpeper	Fauquier	
Roanoke		
Alleghany	Floyd	Patrick
Bath	Franklin County	Pulaski
Bedford City	Giles	Radford
Bedford County	Henry	Roanoke City
Botetourt	Highland	Roanoke County
Buena Vista	Lexington	Rockbridge
Craig	Martinsville	Salem
Covington	Montgomery	Wythe
Tidewater		
Chesapeake	Newport News	Virginia Beach
Gloucester	Norfolk	
Hampton	Poquoson	
Isle of Wight	Portsmouth	
Mathews	Suffolk	
Western / Charlottesville		
Albemarle	Greene	Orange
Augusta	Harrisonburg	Rockingham
Buckingham	Louisa	Staunton
Charlottesville	Madison	Waynesboro
Fluvanna	Nelson	

Transportation Services

Virginia Premier owns and operates its own transportation service for our members. Our vans will transport members to and from scheduled medical appointments with participating providers. Transportation services may also be used to take members to health education classes and to meet with their Department of Social Services (DSS) caseworker for re-certification. This service is offered to VPCC members free of charge.

To arrange for transportation services call:

855-338-6467

To schedule transportation for an appointment, members, the member's caregiver or providers are required to call the VPCC Member Services Department at least 72 hours prior to their scheduled medical appointment time Monday through Friday from 8:00 a.m. – 8:00 p.m. Re-occurring transportation trips are available upon request. Virginia Premier's care manager will assist members in arranging transportation as identified in the plan of care or through the Interdisciplinary Care Team (ICT). The Member Engagement Representative will verify the member's eligibility by asking the member a series of questions. In order to schedule transportation the Member Engagement Representative will need the following information: the member's name, member Identification Number (listed on the member's card), address, telephone number, date, time, and location of the appointment, the name and the telephone number of the medical provider for the scheduled appointment.

Van transportation service is not available for same day appointments.

Members should not be referred to VPCC's transportation service under the following circumstances:

- Patient is in labor
- Patient has a medical emergency (i.e. seizures, chest pain, asthma or loss of consciousness)

This type of transportation will not be coordinated through VPCC Transportation department. Private or "911" ambulance service is available for members whose medical condition precludes the use of VPCC's regular van service. Transportation that requires non-emergent ambulance transfer should be coordinated with VPCC's Transportation department.

ID CARDS AND ELIGIBILITY

New Member Information

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

- o Welcome Letter
- o Member Handbook with details about:
 - Primary Care Physician
 - Long Term Services and Supports (LTSS) providers
 - Skilled Nursing Facilities
 - Interdisciplinary Care Teams (ICT)
 - Plan of Care
 - How to make appointments
 - When the member may need a specialist
 - After hours care
 - Appropriate use of the Emergency Room
 - Summary of Benefits
 - Member Services
 - Health Education Materials
 - Transportation Information

VPCC members are sent the New Member Packet and Member Identification Card prior to their effective date of coverage.

Eligibility Verification

Each new member enrolled with VPCC 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 for services. Physician offices can verify member eligibility through the monthly PCP enrollment and panel listing, online through NaviNet (www.Navinet.net) or by calling VPCC directly.

VPCC has an IVR (interactive voice response) system that allows providers to check member eligibility by entering in member data utilizing your phones keypad. For eligibility verification for VPCC members you may utilize the IVR or speak with a representative by calling:

All Regions	(855) 338-6467
DMAS AVRS Line	(800) 884-9730
NaviNet	www.NaviNet.net

Member Identification Card

Patients should be asked to present their member ID card at each visit. Remember that possession of an ID card does not guarantee eligibility for benefits, coverage or payment. The ID card includes valuable information as displayed below.

ID Card Sample

Front of Model Member Identification Card

 Commonwealth Coordinated Care Medicare & Medicaid working together for you	 MedicareRx Prescription Drug Coverage
 VAPremier Health Plan, Inc.	
Member name: <Cardholder Name>	RxBin: 012312
Member ID: <Cardholder ID#>	RxPCN: Part D
Health Plan (80840): <Card Issuer Identifier>	RxGRP: H3067001
PCP Name: <PCP Name>	RxID: <RxID#>
PCP Phone: <PCP Phone>	
H3067-001	

Back of Model Member Identification Card

For urgent or emergency care, dial 911 or go to the nearest urgent/emergency facility. If you cannot reach your PCP, call our NurseLine at 1-800-256-1982 for medical assistance.

Member Service: 1-855-338-6467
Website: www.vapremier.com/ccs

Send claims to: VPCC Claims
PO Box 4468
Richmond, VA 23220

Visit Procedures

In order to work effectively with our members and to ensure prompt and accurate reimbursement, Virginia Premier Health Plan recommends the following procedures:

- Identify the patient's health insurance every time a member presents for services at the time of appointment.
- Remind the patient to bring in their most recent member ID and a list of medications to the appointment.
- Verify eligibility, benefits and PCP assignment in advance of services being rendered.
- Make a copy of the patient ID card for your files.
- Review the Member's Plan of Care.
- PCP should check their member enrollment listing.
- Refer patients to in-network specialist for services. If covered services are provided by one of the individuals on the Interdisciplinary Care Team, then the Member should be referred to that individual. If referrals are being made to a non-participating specialist, call VPCC to obtain an authorization prior to specialty services being rendered;
- Refer patients to in-network LTSS providers for services. If covered services are provided by one of the individuals on the Interdisciplinary Care Team then the Member should be referred to that individual.
- Specialist should check to make sure an appropriate authorization is on file prior to rendering services (if applicable).
- Submit claims in accordance to timely filing guidelines with correct coding and diagnosis to ensure you are reimbursed for services.

Co-payments and Coinsurance

VPCC members do not have any co-payments or coinsurance for provider services. For Pharmacy copay amounts please reference page 42.

Enrollment Broker

The state has hired an outside vendor, Maximus, to process enrollments for members. The Health Plans 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 VPCC network include Board Certified or Board Eligible practitioners in the fields of Internal Medicine, General Practice, Family Practice and Geriatrics. Each VPCC member chooses a PCP who assumes responsibility for the management of our member's healthcare needs.

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

- Develop, maintain and monitor Plan of Care (POC) for the member;
- Actively participate as a member of the Interdisciplinary Care Team (ICT);
- Provide information to member regarding LTSS services;
- Maintain and provide to VPCC, 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 healthcare services for the member to include 24-hour coverage;
- Generate referrals to in-network specialist when services cannot be performed by the PCP;
- Contact VPCC to obtain necessary prior authorization for designated services (e.g. out of network referrals, specified diagnostic tests); and
- Comply with all established VPCC policies and procedures as documented in this provider manual.

Availability

PCP must provide coverage for their practice twenty-four (24) hours a day, seven (7) days a week. The PCP's office must also have a published after hours telephone number. 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 healthcare manager 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. During normal business hours, members are instructed to contact their PCP for medical advice. We provide the member direct access through a 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 manager, the member's PCP, the LTSS provider or direct the member to a physician or facility for routine, urgent or emergency care.

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

After hours, in non-emergent situations, members may contact the Nurse Advice Line at: **800-256-1982**. The same number is used for Care Management Support.

Member Lists

Each month, Primary Care Physicians will receive a Member List of all patients paneled to that provider. This listing provides important information and should be reviewed by your office staff. This listing may be used to verify eligibility however providers should continue to verify eligibility through ARS or Medicaid. Please refer to these resources before providing services or referring members to specialists.

PCP Assignment

- New members are asked to select a Primary Care Physician at the time of enrollment.
- Members may select any VPCC participating PCP whose panel is open to accepting new members.
- If the member does not select a PCP, VPCC 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.
- VPCC 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 receive a Member List each month, reflecting all VPCC members paneled to that provider.

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

Member/Provider Incompatibility

VPCC recognizes that the physician-patient relationship is a personal one and may become unsatisfactory to either party. VPCC 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 VPCC to determine the appropriateness of the request. Member transfer requests that involve quality of care issues will be forwarded to our Medical Director for review.
- Decisions regarding member transfer requests will be made effective the 1st day of the following month. The member, the provider and the ICT 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, POC and to inform the ICT of the change 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 VPCC'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 VPCC'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 POC until the transfer to another PCP has taken place. Mail or Fax your request to:

VPCC
Member Services Department
P.O. Box 4466
Richmond, Virginia 23220-0307
FAX (804) 819-5187

Change in Member Status

VPCC members may be dis-enrolled from VPCC by the Department of Medical Assistance Services (DMAS) or the Centers for Medicare and Medicaid Services (CMS) if the member no longer meets DMAS' or CMS' eligibility requirements for Medicare-Medicaid Plan enrollment. PCPs are responsible for notifying VPCC's Member Services Department, VPCC's Care Manager and the ICT if they know of a member's change in eligibility status, e.g. admission to an extended care facility.

Sample Member Listing Report

PCP Name Member Name VPCC ID# Group= eligibility category:

10/09/99

VAC
Members By Primary Care Provider
Effective as of 10/09/1999

Page 1

PCP	Name	POL#	Eff Date	Term Date	Status	Cont Type	Member	MedP Type	Employer Group	Plan	PCP HMO
Welby MD	Marcus A	#9998									
ADAMS, PATIENT	760100000000	12/01/14			ACTIV	NAP	SELF	MRP	XXVAC	CCC	VPCC
ARNOLD, PATIENT	760100000000	10/01/14			ACTIV	NAP	SELF	MRP	XXVAC	CCC	VPCC
BAKER, PATIENT	041100000000	04/01/14			ACTIV	NAP	SELF	MRP	XXVAC	CCC	VPCC
BROOKS, PATIENT	087100000000	09/01/14			ACTIV	NAP	SELF	MRP	XXVAC	CCC	VPCC
CARTER, PATIENT	760100000000	07/01/14			ACTIV	NAP	SELF	MRP	XXVAC	CCC	VPCC
DAVIS, PATIENT	601000000000	12/01/14			ACTIV	NAP	SELF	MRP	XXVAC	CCC	VPCC
JONES, PATIENT	760100000000	10/01/14			ACTIV	NAP	SELF	MRP	XXVAC	CCC	VPCC
LEWIS, PATIENT	041100000000	04/01/14			ACTIV	NAP	SELF	MRP	XXVAC	CCC	VPCC
OBRIEN, PATIENT	087100000000	09/01/14			ACTIV	NAP	SELF	MRP	XXVAC	CCC	VPCC
PARKER, PATIENT	760100000000	10/01/14			ACTIV	NAP	SELF	MRP	XXVAC	CCC	VPCC
ROGERS, PATIENT	760100000000	10/01/14	10/30/14		ACTIV	NAP	SELF	MRP	XXVAC	CCC	VPCC
WILSON, PATIENT	041100000000	04/01/14			ACTIV	NAP	SELF	MRP	XXVAC	CCC	VPCC
TOTAL: 11											

Effective Date

Termination Date

PCP Enrollment Totals

Immunizations

Primary Care Physicians are responsible for administering appropriate immunizations to VPCC members. VPCC recommends administration of immunizations according to the Advisory Committee on Immunization Practices (ACIP). PCP compliance with immunization standards will be monitored through VPCC'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 www.vdh.state.va.us.

MEDICAL MANAGEMENT

Utilization Management Program

Virginia Premier's Medical Payment Policy Committee (MPP) determines procedures that are considered investigational or are medically necessary if they meet medical criteria (including InterQual) and those procedures requiring authorization. Practitioners and LTSS providers are urged to review our website for operational updates. These updates will be posted to our website under the "Provider" tab at www.premier.com. Specific questions relating to the MPP can be obtained by contacting our Medical Management Department.

Commonwealth Coordinated Care is prohibited from providing incentives for denying, limiting, or discontinuing medical services for its members inclusive of practitioners and VPCC Staff. Utilization management 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. VPCC does not discriminate against particular practitioners or LTSS providers that serve high-risk populations or specialize in conditions that require costly treatment. Additional information pertaining to VPCC Utilization Management Program can be accessed at www.vapremier.com.

Referrals

Primary Care Physicians (PCPs) in the VPCC network include Board Certified or Board Eligible practitioners in the fields of Internal Medicine, General Practice, Family Practice and Geriatrics. Each VPCC member chooses a PCP who assumes responsibility for the management of our member's healthcare needs inclusive of medical and behavioral health needs. If a PCP, POC or ICT determines that a member requires the services of a medical or behavioral health specialist or other treatment that they are unable to provide, the PCP must make a recommendation to the appropriate specialist for the services, however VPCC does not require a referral to be sent to the health plan from the PCP in order for the member to obtain in network specialist services

PCPs will request and ensure receipt of copies of medical records of the services provided by the specialist. PCP will evaluate the outcome of the Specialist services, document them in the POC 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 VPCC to refer to a non-participating specialist. Any approval by VPCC for a course of treatment or referral services does not release the PCP or treating provider 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 VPCC in the following circumstances:

- VPCC's contracted providers are unable to provide the specialty service required for the member's medical care.
- VPCC does not have a provider in the network with appropriate training or experience.
- Services are prior authorized by another Health Plan, DMAS or Medicare prior to enrollment with Virginia Premier to avoid interruption of care.

Tidewater	
Address	VPCC Attention: Referral Coordinator 3388 Princess Anne Rd., Suite 2000 Virginia Beach, Virginia 23456
Phone	757-461-0064, press 4 1-888-251-3063
Fax	757-466-1133

Central Virginia / Fredericksburg / Western / NOVA	
Address	VPCC Attention: Referral Coordinator 600 East Broad Street, Suite 400 Richmond, Virginia 23219-1800
Phone	804-819-5151, press 3 1-888-251-3063
Fax	804-819-5186 1-866-284-1057

Roanoke	
Address	VPCC Attention: Referral Coordinator 5060 Valley View Boulevard NW Roanoke, VA. 24012
Phone	540-344-8838 1-888-338-4579
Fax	540-344-8007 1-800-827-7192

Out-of-Plan Referrals

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

- All out-of-plan referrals must receive advance approval by the Medical Management Department representative or the Medical Director as indicated.
- Out-of-plan referrals should be documented in the POC.
- The PCP should call the Medical Management 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 can be provided in network.
- If approved, the PCP, ICT or the Medical Director will recommend the appropriate out-of-plan specialist to be utilized. The PCP will obtain an authorization number from the Medical Management Department.
- The specialist must complete the evaluation and document the findings and send a report back to the PCP to be included in the POC. If the referral is not approved by Virginia Premier, the PCP and member will be notified and provided

with alternative recommendations. The PCP and/or member have the right to appeal the denial and may discuss medical indications with the Medical Director.

- When VPCC is retrospectively notified of the use of a non-participating provider without prior authorization from the Medical Management Department, the resulting claims will be denied for payment unless the member is within their first one-hundred eighty (180) days with the health plan.

Pre-Authorization

- The PCP is responsible for providing and/or managing all healthcare services for the VPCC member. However, some services also require pre-authorization from the health plan. The pre-authorization process allows VPCC 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 VPCC network.
- Evaluate the medical necessity criteria for the service.
- Enter the member into VPCC's Case or Disease Management program if appropriate.
- Update the members POC.
- Assist with transition in care and referral to community resources as needed.

To pre-authorize services, contact VPCC's Medical Management Department at the number listed for the service area. Failure to pre-authorize services will result in denial of payment and the provider will be held responsible for the services.

Authorization Decision Timeframes

The following timeframe for decision requirements apply 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, not to exceed fourteen (14) calendar days following receipt of the request for service, 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 DMAS and CMS upon request that the need for 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 three (3) working days after receipt of the request for service.

Virginia Premier may extend the three (3) business day turnaround time frame by up to fourteen (14) calendar days if the Member requests an extension or Virginia Premier

justifies to DMAS and CMS a need for additional information and how the extension is in the Member's interest.

Procedures Requiring Pre-Authorization

(The full listing of services can be found at www.vapremier.com, under the "Providers" tab.)

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

- All inpatient hospitalizations (and extensions beyond original LOS)
- All 23 hour observation admissions, excluding OB observation
- Chemotherapy
- Chiropractic
- Cosmetic Surgery (e.g. Keloid & Scar Revisions, Varicose Veins, Mammoplasty, Reduction and Augmentation)
- Durable Medical Equipment (DME)(Includes Orthotics and Prosthetics when applicable*)
- Health Education & Training Services
- Home Health Services
- Hyperbaric Therapy
- Infusion Services
- Organ Transplant Evaluation and Surgery
- Outpatient Surgical Procedures done in a Hospital/Ambulatory Surgical Setting
- Out of Network Referrals
- Pain Management (e.g. joint injection, spinal cord stimulator)
- Psychological/Neuropsychological Testing
- 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
- Renal Dialysis
- Specialty Drugs

Note: If a provider has any questions pertaining to prior authorization, please contact VPCC's Medical Management Department prior to performing the procedure.

Hospital Admissions: Elective Admissions

All hospital admissions, 23 Hour Observations (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 the VPCC's Referral Coordinator of the planned admission. If this is an emergency admission, VPCC must be notified within 24 hours of admission, or the next business day.
- If the notification is from a specialist, the Referral Coordinator will request that the specialist make the PCP aware of the proposed elective admission and requested procedure and have it documented in the member's POC

- The Referral Coordinator will verify eligibility, then obtain baseline information including:
 - 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 Referral Coordinator will request clinical information for the elective admission be sent to the Utilization Review Nurse (UR).

1. Appropriate ICD-9/10 codes are determined using ICD-9/10 referral sources Health Care Management Guidelines by Interqual. Pre-admission criteria are utilized by the UR nurse to determine medical appropriateness of the admission.
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 VPCC 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.
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 VPCC to verify status of approval.

Medical Management Staff Availability

Medical Management personnel are available to assist you in expediting care for your VPCC patient.

Medical Management Offices are open from 8:00 a.m. to 6:00 p.m. daily. After hours and on weekends a confidential answering machine will receive your call. Please leave detailed information and a VPCC representative will respond to your call on the next business day.

Admission/Concurrent Review

All inpatient hospital stays will be reviewed using Interqual guidelines to determine medical necessity. At the time of the review for emergency admission, VPCC will determine if the admission was medically necessary. Pending availability of clinical data, determinations will be made within 24 hours of VPCC's notification with subsequent notification to providers within 24 hours of making the decision. The admission will be documented in the member's POC.

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 Medical Management 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, VPCC's Medical Management team will screen each patient for discharge planning and case management needs. Every VPCC member will have an assigned Care Manager. The Care Management Team works closely with the member's PCP, family, member, ICT and all involved providers and care givers to coordinate healthcare services across the continuum of care. Care Management is provided by Registered Nurses. Care Managers may also intervene when patients are non-compliant with their treatment plan. Circumstances that warrant referral to the Case Management Team include:

- Presence of progressive, chronic, or life-threatening illness
- Multiple admissions and emergency department visits
- Need for inpatient or outpatient rehabilitation
- Need for home care of IV therapy
- Terminal illness
- High risk pregnancies
- Acute/traumatic injury, or an acute exacerbation of a chronic illness
- Complex social factors
- Vulnerable sub-population
- EDCD waiver participants
- Nursing Facility residents

To refer a patient for Care Management Services, call our Medical Management department.

Continuity of Care

Virginia Premier will honor all existing POCs and prior authorizations (PAs) as provided by DMAS, DMAS' contracted managed care entities, and Medicare until the authorizations ends or 180 days from Enrollment, whichever is sooner. For EDCD Waiver Member's, Virginia Premier will develop and implement the POC 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 POC to be developed.

Virginia Premier will allow new Member's to maintain their current providers (including out-of-network providers) for 180 days from Enrollment for new Member's into the CCC. Virginia Premier will also allow Member's to maintain their preauthorized services as provided from DMAS, DMAS' contracted managed care entities, and Medicare for the duration of the PA or for 180 days from Enrollment for new Member's into the CCC, whichever is sooner, except for individuals residing in a NF at the date of Enrollment into the health plan. Individuals in NFs at the 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, POC, and other pertinent information necessary to assure continuity of care to another MMP or to for Member's that choose to Opt Out or transfer to another MMP. The information will be provided no later than ten (10) calendar days from receipt of the notice of disenrollment to the Virginia Premier and no later than the effective date of transfer in the method and format specified by DMAS and CMS.

Virginia Premier will allow Member's to maintain their current providers (including out of network providers) for 30 days from enrollment for Member's who transfer from another MMP. Virginia Premier will also allow Member's to maintain their preauthorized services as provided through DMAS, DMAS' contracted managed care entities, and Medicare for the duration of the PA or for 30 days from Enrollment, for Member's who transfer from another MMP, whichever is sooner, except for individuals residing in a nursing facility at the date of enrollment into the MMP. Individuals in nursing facilities at the time of Enrollment may remain in the facility as long as they continue to meet DMAS criteria for nursing home care, unless they or their families prefer to move to a different nursing facility or return to the community.

Virginia Premier will ensure that Member's in NFs who wish to move to the community have a valid pre-admission screening in order to access LTSS. If appropriate, Member's will be given the choice of a 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 POC 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 Health Plan's Medical Management 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 by letter, citing the reason for the decision (lack of medical necessity, lack of information, failure to notify). The decision will also be documented in the Member's POC. 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 utilization review 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 VPCC'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 VPCC has denied.*

If the patient/family member insists upon continued hospitalization (even though both the attending physician and VPCC 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 VPCC Utilization Management 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 VPCC. Appeals will be considered if received within sixty (60) days of the decision.

NOTE: A decision made by VPCC 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 VPCC 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

VPCC uses McKesson Interqual© criteria, nationally recognized clinical practice guidelines/standards and approved VPCC 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

VPCC's criteria is available for review by practitioners, members and facilities at the following office locations.

Virginia Premier CompleteCare Medical Management

600 E. Broad Street Suite 400 Richmond, VA 23219	3388 Princess Anne Rd Suite 2000 Virginia Beach, VA 23456	5060 Valley View Boulevard NW Roanoke, VA. 24012
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1-855-338-6467	1-800 828-7989	1-888 338-4579
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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. (Please reference page 40, 41, 69)

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, VPCC 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.

If the PCP sends the member to the Emergency Room (ER) a notification must be sent to VPCC so the claim can be paid without retrospective review. All visits authorized by the PCP or when the Nurse Advice Line directs a member to the ER will be paid regardless of whether or not the visit meets the prudent layperson definition of an emergency.

VPCC 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.

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. Physician Emergency Room services that do not meet the Prudent Layperson standard will be reimbursed for a medical screening. Members should be referred back to their primary care physician for any follow-up.

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

MEDICAL SERVICES

Gynecology and Obstetrical Services

All female Virginia Premier CompleteCare members have direct access to in-network OB/GYN's for annual and routine visits and all necessary follow-up care without a referral. When a VPCC member has selected their OB/GYN, the OB/GYN must become part of the Interdisciplinary Care Team (ICT). If the VPCC 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.

Outpatient surgical procedures or hospitalizations require pre-authorization from VPCC. Services can be coordinated through VPCC'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 which can be accessed at www.vapremier.com.
 - o This form is used to identify pregnant members early and to assist with the care coordination. VPCC seeks to partner with the provider to ensure consistent prenatal care by the member.
- Return the request form to the Medical Management Department and fax 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 VPCC's Case Management Department for assistance with prenatal care and enrollment in the Healthy Heartbeats™ program.

Length of Stay Policy

For routine vaginal delivery, VPCC 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 VPCC postpartum patients will receive a home visit from a RN within 48 hours of discharge unless refused by the member or attending OB/GYN physician. The home visit will be documented in the POC

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 VPCC 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 VPCC and assume an active role within the interdisciplinary care team. The OB/GYN will be responsible for communicating with the ICT and ensuring the POC is updated accordingly.

Family Planning

Family planning services are covered benefits for VPCC 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 VPCC members. VPCC 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 attached. 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.

Interpreter Services

Providers seeing members whose speech is such that they cannot be understood without an interpreter or whose primary language is not spoken by the provider are required to assist the member with obtaining interpreter services.

Healthy Heartbeats™

To meet the needs of routine and high-risk pregnant women, VPCC implemented the Healthy Heartbeats™ Program. This nationally recognized prenatal care program combines extensive outreach and home visits with case management, 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 ICT team that includes an outreach worker, a case manager, and a health educator. This team arranges for personalized in-home assessments and follow-up services that allow the plan to develop case management services tailored to the needs of each patient. Ancillary services such as nutritional counseling and peer support groups for breast-feeding mothers are also provided through a unique partnership with the Women, Infants and Children Program (WIC). VPCC has also collaborated with local hospitals throughout the Richmond, Tidewater and Roanoke regions on the delivery of prenatal education classes.

To encourage participation in the program, members receive incentives for accessing prenatal care, WIC and home outreach services. After delivery, the program provides a home health nurse visit that supports new mothers in the first 48 to 72 hours after discharge. This individual reinforces many of the educational lessons taught during the prenatal period.

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

- 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 plan of care

Substance Abuse Services for Obstetric Patients

These services are available to VPCC member's and are coordinated through the ICT team and in accordance with the POC. VPCC will coordinate access to these services for our members.

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 VPCC members.

Diagnostic Testing: Laboratory Services

VPCC has contracted with Lab Corporation of America (LabCorp) 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

VPCC 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 VPCC Medical Management 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 VPCC must be notified and those services pre-authorized.

Exceptions: If VPCC 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 Health Plan. Routine diagnostic radiological testing performed in the PCP or Specialist's office will be billed and reimbursed fee for service.

Outpatient Studies

Virginia Premier has partnered 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.

**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 Health Plan's Medical Management Department or will result in nonpayment of the claim.

Mammography Services

VPCC encourages women over the age of 40 to have breast exams and yearly mammograms. VPCC 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 will be documented in the member's POC.

Preventive Services

The following preventive screening tests and examinations are covered:

- Annual Wellness Visit;
- Initial Preventive Physical Examination (also known as the “Welcome to Medicare Visit”);
- 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; and
- Ultrasound screening for abdominal aortic aneurysm.

Mental Health Services

Community Mental Health Services

The following community mental health services are available through VPCC with an authorization. In the event that care must be initiated emergently or after hours, contact Virginia Premier’s medical management department on the next business for the authorization. Face-to-face provider assessments (H0032 & appropriate modifier) do not require authorization.

- **Crisis Intervention (H0036)**

Defined as immediate behavioral health care, available twenty-four (24) hours a day, seven (7) days a week, to assist Enrollees who are experiencing acute behavioral dysfunction requiring immediate clinical attention such as Enrollees who are a danger to themselves or others. This service’s objective is to prevent exacerbation of a condition, to prevent injury to the consumer or others, and to provide treatment in the context of the least restrictive setting. Crisis intervention includes assessing the crisis situation, providing short-term counseling designed to stabilize the Enrollee, providing access to further immediate assessment and follow-up, and linking the Enrollee and family unit with ongoing care to prevent future crises. Crisis intervention activities may include office visits, home visits, pre-admission screenings, telephone contacts, and other client-related activities for the prevention of institutionalization.

A maximum of 720 units of Crisis Intervention can be provided annually. The annual treatment year for all members is defined as the period July 1 through the following June 30. A unit of service is 15 minutes (**must provide a minimum of 15 minutes**). Billing should be per episode.

- **Crisis Stabilization (H2019)**

Is provided to non-hospitalized Enrollees experiencing an acute psychiatric crisis that may jeopardize their current community living situation. The goals are to avert hospitalization or re-hospitalization, provide normative environments with a high assurance of safety and security for crisis intervention, stabilize individuals in psychiatric crisis, and mobilize the resources of the community support system and family members and others for on-going maintenance and rehabilitation.

There is a limit of eight (8) hours a day for up to 15 consecutive days in each episode, up to 60 days annually. Treatment is based on a fiscal year which is from July 1 through June 30. A billing unit is one hour.

- **Day Treatment/Partial Hospitalization Services**

Sessions of two (2) or more consecutive hours per day are provided. Sessions may be scheduled multiple times per week, to groups of individuals in a nonresidential setting. These services include the major diagnostic, medical, psychiatric, psychological, and psycho-educational treatment modalities designed for Enrollees with serious behavioral disorders. The day treatment center could be attached to a psychiatric hospital or CSB clinic site. Services are for Enrollees with a serious behavioral health disorder and goal is to keep them out of a psychiatric hospital.

- **Intensive Community Treatment (H0039 – treatment; H0032 modifier U9 - assessment)**

An array of behavioral health services for adults with serious emotional illness who need intensive levels of support and service in their natural environment to permit or enhance functioning in the community. Intensive Community Treatment is provided through a designated multi-disciplinary team of behavioral health professionals. It is available twenty-four (24) hours per day.

The assessment (H0032) must document the eligibility and medical necessity for the service. Each provider will be reimbursed for up to 2 assessments per member per fiscal year. Treatment (H0039) is based on a fiscal year which is from July 1 through June 30. A maximum of 130 units of service may be authorized annually. A claim edit is in place that will cut back payment or deny claims for services beyond the maximum number of units allowed. A billing unit is one hour. Time may be accumulated to reach a billable unit.

- **Mental Health Skill Building Services (Previously Mental Health Support Services (H0046- treatment; H0032 modifier U8 - assessment)**

Training and supports to enable Enrollees to achieve and maintain community stability and independence in the most appropriate, least restrictive environment. Authorization is required for Virginia Premier reimbursement. The member must have a prior history of qualifying mental health treatment such as a psychiatric hospitalization, residential treatment, residential crisis stabilization, PACT or ICT

services, RTC-level C placement or a TDO evaluation due to mental health decompensation.

Mental Health Skill Building services may be authorized for six (6) consecutive months. All services must be direct face-to-face contacts to be reimbursed. This program shall provide the following services in order to be reimbursed by Virginia Premier: training in or reinforcement of functional skills and appropriate behavior related to the Enrollee's health and safety, ADLs, and use of community resources; assistance with medication management; and monitoring health, nutrition, and physical condition. Any service provided that is strictly vocational will not be billable such as job searches or filling out applications.

Each provider will be reimbursed for up to 2 assessments per member per fiscal year. For new client's the provider's service assessment must not occur prior to the Independent Clinical Assessment. A maximum of 372 units of services may be authorized per fiscal year. Treatment is based on a fiscal year which is from July 1 through June 30.

Only direct face-to-face contacts and services to the member are reimbursable.

- One unit = 1 to 2.99 hours per day
- Two units = 3 to 4.99 hours per day
- Three units = 5 to 6.99 hours per day
- Four units = 7+ hours per day

Time may be accumulated to reach a billable unit.

- **Opioid Treatment (H0020)**

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

The unit of service is 15 minutes. Billing rates are based on type of service provider and degree/credentials of the service provider. Opioid drugs may be billed separately as a Pharmacy Point of Service claim or by using the appropriate HCPCS code. Treatment is based on a fiscal year which is from July 1 through June 30. A maximum of 600 hours / 2400 units is allowed annually.

- **Psychosocial Rehabilitation (H2017-treatment; H0032 modifier U6- assessment)**

Services for the severely behaviorally ill. Psychosocial rehabilitation is provided in sessions of two (2) or more consecutive hours per day to groups of individuals in a nonresidential 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. Staff may observe medication being taken, watch and observe behaviors and note side effects of medications.

The assessment must document the eligibility and medical necessity for the service. Each provider will be reimbursed for up to 2 assessments per member per fiscal year. Treatment is based on a fiscal year which is from July 1 through June 30. A maximum of 936 units of service may be authorized annually.

For billing units of service calculated as follows:

- One unit = 2 to 3.99 hours per day
- Two units = 4 to 6.99 hours per day
- Three units = 7 + hours per day.

- **Residential Substance Abuse Treatment for Pregnant and Post Partum Women (H0018)**

Services are for pregnant and postpartum women with serious substance abuse problems for the purposes of improving the pregnancy outcome, treating the substance abuse disorder, strengthening the maternal relationship with existing children and the infant, and achieving and maintaining a sober and drug-free lifestyle. The Enrollee's care is supervised by a nurse care manager. The Enrollee must agree to actively participate in her care. Services provided are substance abuse rehabilitation, counseling, and treatment, pregnancy and fetal development education, symptom and behavior management, and personal health care training. No reimbursement for any other Community Mental Health/Mental Retardation/Substance Abuse rehabilitative services are available while the Enrollee is participating in the program.

There is a limit of 300 days per pregnancy, not to exceed 60 days postpartum. Treatment is based on a fiscal year which is from July 1 through June 30. A unit of service is one day.

- **Substance Abuse Crisis Intervention (H0050)**

Substance abuse treatment services, available twenty-four (24) hours a day, seven (7) days per week, to provide assistance to Enrollees experiencing acute dysfunction related to substance use which requires immediate clinical attention. The objectives are to prevent exacerbation of a condition; and injury to the Enrollee or others; and to provide treatment in the least restrictive setting. Crisis intervention services are provided following a marked reduction in the Enrollee's psychiatric, adaptive, or behavioral functioning or an extreme increase in personal distress related to the use of alcohol or other substances.

A unit of service is 15 minutes of Substance Abuse Crisis Intervention. A maximum of 720 units of Substance Abuse Crisis Intervention can be provided annually. Treatment is based on a fiscal year which is from July 1 through June 30.

- **Substance Abuse Day Treatment (H0047)**

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 abuse day treatment may not be provided concurrently with intensive outpatient or opioid treatment services.

The unit of service is 15 minutes. Billing rates are based on type of service provider and degree/credentials of the service provider. Treatment is based on a fiscal year which is from July 1 through June 30. A maximum of 1,300/5200 units hours is allowed annually.

- **Substance Abuse Day Treatment for Pregnant and Post-Partum Women (H0015)**

Comprehensive intensive services in a central location lasting two (2) or more consecutive hours per day, which may be scheduled multiple times per week for pregnant and postpartum women with serious substance abuse problems for the purposes of improving the pregnancy outcome, treating the substance abuse disorder, and achieving and maintaining a sober and drug-free lifestyle. Only behavioral health crisis intervention services or behavioral health crisis stabilization may be reimbursed for Enrollees of day treatment services. A billing unit is equal to a minimum of two (2) hours, but less than four (4) hours.

There is a limit of 400 units per pregnancy, not to exceed 60 days postpartum. Treatment is based on a fiscal year which is from July 1 through June 30.

- One unit = 2 to 3.99 hours per day
- Two units = 4 to 6.99 hours per day
- Three units = 7 + hours per day.

- **Substance Abuse Intensive Outpatient Treatment (H2016)**

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 Enrollees 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.

The unit of service is 15 minutes. Billing rates are based degree/credentials of the service provider. A maximum of 600 hours / 2400 units per treatment year is allowed. Treatment is based on a fiscal year which is from July 1 through June 30.

Targeted Case Management is not reimbursed through VPCC but continues to be available through DMAS. Virginia Premier's care manager will work closely with the CSB's Targeted Case Manager to coordinate care and will be included in the member's ICT.

Outpatient Mental Health and Substance Abuse Services

Outpatient mental health and substance abuse services are available through VPCC's network of participating mental health providers.

Outpatient mental health and substance abuse (SA) 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 abuse medication management requires a plan of care. A separate plan is required for outpatient psychiatric services and substance abuse 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.

Outpatient mental health and substance abuse services require service authorization after 26 units in the first year of treatment. During the first year of treatment, there may be an additional 26 units when authorized. The initial 26 units may be used within one year of the first date of service (anniversary date) and cannot be carried over into subsequent years. There is a limit of 26 units in subsequent years unless additional units are shown to be medically necessary, but these units require a service authorization. The 26-unit restriction does not apply to the psychiatric diagnostic interview examination. However, each provider may only bill one psychiatric diagnostic interview examination within a 12-month period. The examination must meet medical necessity criteria. 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 abuse treatment units. When medically necessary, there may be concurrent authorizations for mental health services and substance abuse services. For persons with co-occurring psychiatric and substance abuse conditions, providers are expected to integrate the treatment. The main focus of treatment, either mental health or substance abuse, requires service authorization after the initial 26 units.

Mental Health Specialist

Mental health specialists should contact VPCC's Behavioral Health Unit with clinical information to receive an initial authorization. A prior authorization is needed for out of network providers, neuropsychological testing, psychological testing, and electroconvulsive therapy. Authorization must be obtained before seeing patients or payment of services may be denied. Should a mental health specialist see a member on an ongoing basis, the mental health specialist must become a participating member of the ICT team.

Psychological Testing

A treatment plan must be submitted to VPCC's Behavioral Health Unit at the time of request. Psychological testing must be pre-authorized for outpatient services. The specific need for psychological testing must be identified to the Behavioral Health Unit

before initiation of any psychological testing procedures. Participating Providers must complete the Psychological Testing Form (**Exhibit F**) and submit for authorization prior to test being performed.

Inpatient Mental Health Services

Inpatient mental health services are available through VPCC's network of participating providers. Elective admissions require prior authorization. In the event of an emergency admission, VPCC must be notified within 24 hours or the next business day. All inpatient admissions will be documented in the member's POC.

Services provided to patients in an inpatient psychiatric 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 nurse will assign an appropriate length of stay. Inpatient mental health admissions are limited to twenty-one (21) days in a sixty (60) day period for the same or similar diagnosis for VPCC members.

The psychiatric benefit application (190 days) applies to freestanding psychiatric hospitals per 42 CFR 409.62. The 190-lifetime limitation does not apply to certified psychiatric distinct part units. Section 409.62 states, "There is a lifetime maximum of 190 days on inpatient psychiatric hospital services available to any member. Therefore, once an individual receives benefits for 190 days of care in a psychiatric hospital, no further benefits of that type are available to that individual."

Payment may not be made for more than a total of 190 days of inpatient psychiatric hospital services during the patient's lifetime. **This limitation applies only to services furnished in a psychiatric hospital.** This limitation does not apply to inpatient psychiatric services furnished in a distinct part psychiatric unit of an acute care hospital or CAH. The period spent in a psychiatric hospital prior to entitlement does not count against the patient's lifetime limitation, even though pre-entitlement days may have been counted against the 150 days of eligibility in the first benefit period.

During concurrent review, the UR nurse 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 hospitalizations do not require an authorization from Virginia Premier until after the custody hearing.

Free-standing Psychiatric Facility Admissions

Admission to a “free-standing” psychiatric facility 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

Inpatient Substance Abuse Services

Virginia Premier Health Plan does cover inpatient, residential or day treatment substance abuse services for VPCC members. VPCC will coordinate access to these services for our members.

Transportation

Transportation services are provided for VPCC member’s at no cost to the member. VPCC owns and operates its own fleet of vehicles that transports members to and from medical appointments. Ensuring members have adequate transportation is vital to ensuring the Plan of Care (POC) is being adhered to based on the care timelines identified. It allows members to have adequate access to medical services and provides an avenue for which the member can meet with members of their ICT team.

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 laundry. Referrals to the Pre-Admission Screening (PAS) team 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 include:

- Adult Day Health Care
- Personal Care
- Respite Care
- Personal Emergency Response Systems (PERS)
- Service Facilitator
- Skilled Nursing Facilities
- Transition Services

All LTSS services should be outlined in the POC for the member. The ICT will establish the POC at the onsite of the member's enrollment and determine if and how LTSS services will be utilized. Should a member's health status change, the POC can be updated to reflect the change.

LTSS Authorizations

All LTSS services shall require prior authorization and approval of services is based on the DMAS screening tools and LOC assessment and score if applicable. The PAS team should send all screening documents (UAI, DMAS-97 and DMAS-96) to VPCC within 2 business days of completion and member selection of a provider. The pre-authorization process allows VPCC 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 VPCC network.
- Evaluate the medical necessity criteria for the service.
- Enter the member into VPCC's Case or Disease Management program, if appropriate.
- Update the members POC.

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 manager will collaborate with the agency RN to attend this face-to-face assessment and incorporate information into Virginia Premier's initial member face-to-face assessment. The plan of care for LTSS services is developed by the agency RN with the member and Virginia Premier care manager 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 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. Virginia Premier's care manager 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. 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 manager 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 Virginia Premier's care manager. Virginia Premier's care manager will complete the annual DMAS 99 C.

If supervision is requested, the agency will complete the DMAS-100 (request for supervision) and submit to Virginia Premier's care manager for 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 screening process. 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 manager 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, Virginia Premier's care manager 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 Virginia Premier's care manager. Virginia Premier's care manager will complete the annual DMAS 99 C.

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 manager on the DMAS 97 A/B to be incorporated in their overall plan of care. Virginia Premier will render an authorization within 3 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 manager within 2 business days of completing the visit. This information will be used to update the plan of care and discussion in the member's ICT.

If respite services are needed and the member has consumer directed personal care, the plan of care 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 Virginia Premier's care manager within 2 business days of completing the visit. This information will be used to update the plan of care and discussion in the member's ICT.

Adult Day Health Care

Referrals to the Pre-Admission Screening (PAS) team 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 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 Virginia Premier care manager will use the information to update the overall plan of care and collaborate with the site to be a part of the member's ADHC Interdisciplinary Team meetings. The care manager will attend these meetings in person. Virginia Premier's care manager will complete the annual DMAS 99 C.

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 provider of the other EDCD services can complete the form and send to Virginia Premier's care manager for authorization of services. In addition, the care manager may complete this assessment as part of the plan of care if services are warranted.

Medication Monitoring

Medication monitoring units must be physician ordered and are not considered a stand-alone 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 manager and must be reauthorized every 6 months.

Skilled Nursing Facility (SNF)

VPCC covers semi-private rooms, meals, skilled nursing, rehabilitative services, long-term care and custodial care for member's. Virginia Premier has made the following modifications under the Commonwealth Coordinated Care program for Skilled Nursing Facility admissions:

- Virginia Premier will waive the requirement of a 3-day minimum medically necessary inpatient hospital stay for a related illness or injury prior to the member being admitted to the Skilled Nursing Facility.
- Virginia Premier will provide a seven (7) day prior authorization for members who are discharged from an inpatient stay after normal business hours and during weekends when there was not an opportunity to coordinate the discharge during normal business hours. All other admissions will require prior authorization. Virginia Premier will use InterQual skilled nursing criteria to determine medical necessity. Providers can contact Virginia Premier's medical management department with dates of admission, expected length of

stay and summary of treatment plan such as therapy, medications and/or wound care. In addition, the UAI, DMAS 97 and DMAS -96 should be sent to Virginia Premier at the time of the admission. These forms are requested in the event that the member is transitioned to intermediate or custodial care. Virginia Premier will authorize care for at least 14 days at each authorization unless the treatment plan requires less or more days. The Virginia Premier care manager will perform a face-to-face assessment with the member incorporating the information from the MDS. Virginia Premier's care manager will review the minimum data set (MDS) at the facility or through mutually agreed upon electronic mechanisms. A plan of care will be developed in collaboration with the nursing facility and the care manager will be a part of the facility's ICT meetings for the member. Virginia Premier's care manager 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 or no longer meets criteria for nursing facility care.

- Transportation will be provided to members during normal hours of operation. Members will only be transported to the Skilled Nursing Facility after-hours or on weekends when mutually agreed to by skilled nursing facility, hospital and Virginia Premier.

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 manager. Once received, the Virginia Premier care manager will authorize admission to the nursing facility for care. Services will require re-authorization at least every 6 months.

The Virginia Premier care manager 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 manager will be a part of the facility's ICT meetings for the member. Virginia Premier's care manager 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 or no longer meets criteria for nursing facility care.

PHARMACY SERVICES

Retail Pharmacy Benefits

Virginia Premier CompleteCare retail prescription drug services are administered through EnvisionRxOptions, www.envisionrx.com. All prescriptions must be filled at a participating pharmacy, unless a medical or FEMA declared emergency or an out-of-area situation exists. Prescriptions that require special authorization procedures shall have a response within 24 hours in most circumstances.

The formulary can be downloaded at the VPCC website at www.vapremier/cc for pharmacy and prescription related questions, please call Envision at 1-855-408-0010.

VPCC Medicare Transition of Coverage Process for Part D Drugs

The Centers for Medicare and Medicaid Services (CMS) require Part D Plan Sponsors, like Virginia Premier, to have a transition of coverage (TOC) process. Members who are taking Part D drugs that are not on the plan's formulary or that are subject to utilization management requirements can get a transition supply of their drug in certain circumstances. This gives members the opportunity to work with their doctor to complete a successful transition and avoid disruption in their treatment.

VPCC has established a TOC process in accordance with CMS requirements. This process has different sections and applies to new members, as well as current members who remain enrolled in their VPCC plan from one plan year to the next.

The following summary provides the key features of VPCC TOC process. If you have questions about the process or would like more details, please contact Envision at 1-855-408-0010 (TTY/TDD:711), 24 hours a day, 7 days a week..

Right to Transition Fill

If the member is a new member and is taking a Part D drug that is not on the VPCC formulary, or is subject to a utilization management requirement or limitation (such as step therapy, prior authorization, or a quantity limit), he/she is entitled to receive a 30-day supply of the Part D drug within the first 90 days of your enrollment (the period of time in which the member is entitled to receive the transition supply is called the "transition period").

If the member is an existing member who renews his/her VPCC coverage and is taking a Part D drug that is removed from the formulary, or is subject to a new utilization requirement or limitation at the beginning of the new plan year, he/she is entitled to receive the 30-day supply during your transition period. For existing members who renew their VPCC coverage from one year to the next, the transition period is the first 90 days of the new plan year. Whether the member is a new or renewing member, he/she can get multiple fills up to the 30-day supply within his/her transition period if his/her first fill is less than a 30-day supply.

In general, VPCC will determine the member's rights to a 30-day fill at the pharmacy when the member goes to fill his/her prescription. However, in some situations, we will

need to get additional information from the doctor before we can determine if the member is entitled to a transition 30-day fill.

If the member lives in a Long Term Care facility, and is entitled to a transition supply, we will cover a 31-day supply (unless your prescription is for fewer days) and will also honor refills up to a maximum of a cumulative 91-day supply during the transition period.

The member may also be eligible to receive a transition fill outside of the 91-day transition period. 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 isn't on the formulary). There are other situations where the member may be entitled to receive a temporary supply of a prescription drug. If you have questions about whether the member is entitled to a temporary supply of a drug in a particular situation, please call Envision Member Services or VPCC.

What you need to do

After the member gets a transition fill, he/she will receive a letter from Envision telling him/her what to do next. These are the steps he/she should follow to ensure that he/she is able to continue to get coverage for the prescription drug(s) he/she needs:

If your drug is not on the formulary

The member is recommended to speak to his/her doctor about whether he/she should change the drug he/she is currently taking or request an exception before the transition supply ends. The doctor can help determine if there's a different drug on the formulary that would be equally effective for the member's condition or the doctor may believe it's medically necessary for the member to continue taking his/her current medication. In that case, the doctor and/or member will need to ask us for an exception to receive coverage for the drug.

The member can make the request for a formulary exception or the doctor can make the request on the member's behalf. However, it may be easier to have the doctor submit the request for the member. We will need the doctor to give us a written statement with the medical reasons for the formulary exception requesting. We call this the "doctor's statement." The doctor can fax or mail the statement to Envision or the doctor can call us and follow up by faxing or mailing the signed statement.

To start the formulary exception process, the member, his/her authorized representative, or the doctor must call, fax or write to our Precertification Unit.

If the drug is subject to a utilization management requirement

The doctor can help if the prescription drug is subject to quantity limits, step therapy or prior authorization. These special requirements are developed by a team of doctors and pharmacists to help our members use drugs safely and in a cost effective manner.

Prior authorization refers to a requirement that, for certain medications, the member or the doctor has to provide us information regarding the reason the doctor prescribed the

drug so we can confirm its medically necessary. The doctor can help the member by providing clinical information needed for the prior authorization process.

Or the member may be required to try a different drug first, to see if it will work, before the drug he/she wants to take will be covered. This is called “step therapy.”

Or there might be limits on what amount of the drug (number of pills, etc.) is covered during a particular time period. This is called a “quantity limit.”

If the member and the doctor believe these restrictions should not apply, the member or the doctor can request an exception. It may be easier for the doctor to contact our Precertification Unit and request prior authorization or removal of a restriction. The doctor can get in touch with us using the contact information below.

How to contact our Precertification Unit

You can contact our Precertification Unit as follows:

EnvisionRxOptions
Attn: Coverage Determinations Dept.
2181 East Aurora Road
Twinsburg, OH 44087
Fax Number: 1-866-250-5178
Toll-Free Number: 1-855-408-0010
TTY Number: 711
Hours of Operation: 24 hours a day, 7 days a week

Once we receive the physician's statement, we must notify the member of our decision no later than 24 hours for an expedited request, or no later than 72 hours for a standard request. The request will be expedited if we determine, or the doctor 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 your request is denied?

If the request is denied, the member has the right to appeal by asking for a review of our decision. The doctor or the member must request this appeal within 60 calendar days from the date of our decision. If you want to file an expedited appeal, you can call or fax us. If you want to file a standard appeal, you must write or fax us.

For an Expedited Appeal, phone or fax:

Grievances and Appeals Phone Number: 1-800-727-7536
Grievances and Appeals Fax Number: 804-649-9647

For a Standard Appeal, write or fax:

Virginia Premier Health Plan, Inc.
Attn: Grievance & Appeals
PO Box 5244
Richmond, VA 23220

Grievances and Appeals Fax Number: 804-649-9647

If you need help requesting an exception, or would like more information about our transition policy (including alternate format or languages), please call Envision Member Services at 1-855-408-0010, 24 hours a day, 7 days a week. (TTY/TDD users should call 711).

Note: Members must use network pharmacies to access their prescription drug benefit, except under non-routine circumstances, and quantity limitations and restrictions may apply. For more information, please contact Envision at 1-855-408-0010 (TTY/TDD: 711), 24 hours a day, seven days a week.

Emergency supply

After the 90-day transition period expires, VPCC will also provide a 31-day transition supply to members who require an emergency supply of a non-formulary drug. The emergency supply will be granted while the member's exception or prior authorization is being processed.

Transition Policy

The transition policy applies to the following members:

- New members during the transition period.
- Newly eligible Medicare members from other coverage.
- Members who switch from one plan to another after the start of the contract year.
- Members residing in long-term care facilities.
- Members who change treatment settings due to a change in level of care.
- Current members affected by formulary changes from one contract year to the next.

The transition period begins on the member's effective date of coverage under the plan. Each member who receives a transition supply will be sent a written notice via first-class U.S. mail. The notice will be sent within three days of the temporary fill. The notice will include:

- An explanation of the temporary nature of the transition supply.
- Instructions for working with the member's prescriber and plan for identification of therapeutic alternatives that are on the formulary.
- An explanation of the member's right to request a formulary exception.
- A description of the procedures for requesting a formulary exception.

Formulary exception request forms will be available to members, appointed representatives and physicians via mail, fax, e-mail and our website.

To determine the proper course of action, Medical review of non-formulary drug requests may be required for members receiving a temporary supply of a Part D drug under this policy. VPCC will work with the member's physician to gather appropriate clinical history to facilitate the non-formulary drug request or the switch to a therapeutically appropriate formulary alternative.

Please note that our transition policy applies only to those drugs that are "Part D drugs" and bought at a network pharmacy. The transition policy can't be used to buy a non-Part D drug and/or at an out-of-network pharmacy, unless you qualify for out-of-network access.

Prior Authorization (for prescription drug coverage)

Process under which certain drugs require prior approval before members can get them as a covered benefit. The prior authorization program is 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. The doctor or other network provider should call VPCC and request coverage for these drugs. Providers should use generic drugs whenever possible when prescribing medication for our members. Please contact the Envision Pharmacy Customer Service line at 1-855-408-0010 for questions regarding drug products that require authorization or fax requests to 1-866-250-5178.

Step Therapy Drug Listing

To help make the use of prescription drugs safer and more affordable, VPCC uses a Step Therapy program. A Step Therapy program is the process where certain prescription drugs must be tried before the originally prescribed medication will be covered. Medications are grouped into two categories: Front Line Medications are recommended first, usually generic, Back-Up medications are brand name medications and only approved if a front-line medication doesn't work. The doctor can request an exception if it's medically necessary to use the originally prescribed medication.

Note: VPCC recommends that generic drugs which are indicated in the formulary as bio-equivalent and therapeutically equivalent be prescribed. The final decision regarding medications prescribed to an individual member is left to the physician's professional judgment.

Pharmacy Co-Pay

Copays are listed by tiers. Tiers are groups of drugs with the same copay.

- Tier 1 drugs are generic drugs. The copay will be \$0.00 (LTC members), \$1.20 (LIS-Level2) or \$2.55 (LIS-Level1), depending on your level of Commonwealth Coordinated Care eligibility.
- Tier 2 drugs are brand name drugs. The copay will be \$0.00(LTC members), \$3.60 (LIS-Level2) or \$6.35 (LIS-Level1), depending on your level of Commonwealth Coordinated Care eligibility.
- Tier 3 drugs are Non-Medicare Rx/OTC drugs and the copay will be \$0.00.

Medication Therapy Management (MTM)

Our MTM program is offered only to members who meet the specified pharmacy criteria per CMS requirements. Members eligible for the MTM program (MTMP) will be identified on a quarterly basis. The identification process uses the prior three months prescription claims data to identify the appropriate drug spend, number of diseases and

number of Part D covered drugs. After identification for participation in the MTMP, all members newly identified for the quarter will receive a cover letter indicating the member is eligible for and enrolled in the MTM program along with a personal medication record (PMR). The PMR contains the drugs that the member received in the previous 4 months from the prescription drug paid claims file. In the cover letter accompanying the PMR, members will be offered a telephonic comprehensive medication review (CMR) with a pharmacist. In the event the member is unable to accept the offer to participate in a CMR, the CMR may be performed with the member's prescriber, caregiver, or other authorized individual. In order to increase participation in the CMR program, telephonic outreach to members will occur after the cover letter and PMR have been mailed.

During the CMR, the personal medication record mailed initially to the member will be verified and all OTC, dietary supplements, and herbal products used by the member will be obtained. This information will be collected in order to aid in assessing medication therapies to identify medication related problems, develop a prioritized list of medication related problems, and create an action plan and recommendation list for the member and/or caregiver. In addition, the goal is to increase members' knowledge of their prescriptions, OTC medications, herbal therapies and dietary supplements and address any concerns that the member might have while optimizing patient outcomes. Upon completion of the CMR, an individualized written summary in the CMS standardized format will be provided to the member or if the member cannot participate, their prescriber, caregiver, or other authorized representative by mail or fax.

All MTM members will receive follow-up mailings on a quarterly basis to remind members of their opportunity for the CMR and to provide general member education materials. This includes members who were enrolled in the MTMP during the previous contract year that continue to meet the criteria for the current contract year. Prescribing providers (and primary care providers, if available) will receive a member medication list along with any identified potential therapy care gaps for that member as identified in the applicable quarter. Prescribers will be re-notified regarding any unresolved therapy care gaps no more frequently than every 6 months. Medication Therapy Management (MTM) programs are aimed at helping members safely and effectively take medications prescribed by their physicians.

Mail Order Pharmacy

Pharmacy Mail order is available for up to a 90-day supply and orders are fulfilled by Costco Pharmacy.

802 134th Street SW

Suite 140

Everett, WA 98204-7314

Phone: 1-800-607-6861

Generic substitution is mandatory if available.

Note: A 90-day supply is also available at all of our retail providers for mail order pharmacy upon request.

Over-the-Counter Medications

Medicaid Wrap Drugs

There are specific drug classes that, by law, are not covered under the Medicare Part D program but are covered by Medicaid. VPCC covers these medications in accordance with existing Medicaid policy. The drug classes that Medicare does not cover, but that are covered by Virginia Medicaid (or known in this document as Medicaid wrap drugs) for Medicare Medicaid members include:

- i. Select medications for weight loss (service/prior authorization required);
- ii. Select legend and non-legend medications for symptomatic relief of cough and colds;
- iii. Select prescription vitamins and mineral products (except prenatal vitamins and fluoride preparations);
- iv. Select FDA approved over-the-counter medications (prescriptions are required);

VPCC shall also cover compounded prescription drug products for Part D members that contain: (1) all Part D drug product components; (2) some Part D drug product components; or (3) drug components covered by Virginia Medicaid (i.e., drugs listed above, i-iv).

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.

People 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, state benefits, regulations, contracts and medical judgment.

All pre-authorizations for specialty drugs are administered by **Envision at 1-855 408-0010**, however actual Specialty Pharmacy services are provided by preferred specialty pharmacy vendors.

Once prior authorization is obtained, providers will be informed about the available options on the specialty drugs; using the preferred Specialty vendor, using office stock or when appropriate, home health nursing services. All Specialty pharmacy order forms can be located at the Virginia Premier website, www.vapremier/cc.

ADDITIONAL ANCILLARY SERVICES

Physical and Occupational Therapy

Physical and Occupational Therapies are rehabilitative services available to VPCC members. Services require prior authorization and medical necessity must be demonstrated based on InterQual criteria. Virginia Premier will authorize an evaluation visit and 2 treatment visits until the therapist submits the treatment plan to Virginia Premier. The therapist must then submit a treatment plan to VPCC for prior authorization of additional services beyond the evaluation and 2 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.

Audiology and Speech Pathology Services

Inpatient and outpatient services for speech, language and hearing disorders are covered services. All services require prior authorization from VPCC.

Vision Services

Medically necessary services associated with eye surgeries are covered under VPCC.

Home Health Services

Home health services are available to VPCC members. These services must be provided by a participating home health agency and provided to a VPCC 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. Contact Virginia Premier's VPCC Utilization Review (UR) nurse to authorize home health services. Virginia Premier will authorize an evaluation visit and 2 treatment visits upon request until the provider submits the treatment plan to Virginia Premier for additional visits.

Virginia Premier's care manager will assess the member for further needs, progress or potential referral for LTSS. All information will be incorporated into the plan of care and discussed during the ICT. The home health provider will be involved in the member's ICT.

Home health benefits include:

- Nursing, social work evaluations, and home health aid services
- Occupational and physical therapy
- Speech, hearing and language disorder services
- Infusion therapy
- Durable medical equipment and supplies
- Homemaker services for prenatal patients only

Durable Medical Equipment (DME), Prosthetic Devices and Supplies

VPCC will cover all medically necessary equipment and supplies for rental or purchase when ordered by a contracted VPCC 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 [Medicare.gov/publications](https://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 **(Exhibit B)** can be accessed and downloaded at www.vapremier.com. 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

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

WIC (Women, Infants and Children)

VPCC will work 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 retrieved for gifts at local grocery stores or baby stores.

GENERAL LIMITATIONS AND EXCLUSIONS

Non-Covered Services

VPCC 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 Medical Management Department. Non-covered services include:

- Private duty nursing services are not covered by VPCC;
- Infertility treatments are not covered by VPCC;
- Services of Christian Science nurses are not covered by VPCC;
- Experimental or investigational procedures are not covered by VPCC but will be evaluated on an individual basis for medical necessity and exhaustion of other viable treatments;
- Inpatient mental health services rendered in a State Psychiatric Hospital are not covered by VPCC;
- Dental services;
- Services and supplies that are not medically reasonable and necessary;
- Excluded items and services;
- 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.

Exclusions from VPCC Enrollment

If a VPCC member receives any of the following services, that member shall meet the criteria for exclusion from the VPCC Program.

- Services for members with mental retardation and related conditions, including case management
- Inpatient mental health services rendered in a State psychiatric hospital
- Hospice services

MEDICAL MANAGEMENT PROGRAMS

Medical Outreach

While visiting with the member, the Medical Outreach Representative will assess the home environment and elicit from the member specific health and social service needs. A HealthCare assessment will 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 social service resources as necessary.

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

Disease Management

Virginia Premier's VPCC disease management programs are designed to help members manage their chronic conditions. Our programs are based on nationally accepted guidelines, support the physician-patient relationship and are available at no additional cost to the members.

VPCC provides disease management programs for the following chronic conditions: Asthma, Heart Disease, COPD, Bipolar Disorder/Schizophrenia, Childhood Weight and Nutrition Management and Diabetes. All programs are coordinated with the member's care manager as part of the ICT. If the member has a targeted case manager (TCM) through the CSB, the disease manager will work with the TCM to coordinate care through the ICT.

Program components include:

- Educational materials
- VPCC education classes
- Referrals to community classes and resources
- Case management
- 24-Hour Nurse Advice line
- Special monitoring equipment (peak flows, glucose meters)

We also have a prenatal program, Healthy Heartbeats™ that provides general and targeted interventions based on the members' level of risk. Call Medical Management for referrals or comments about our programs. We are staffed by registered nurses Monday-Friday, 8:00 a.m. to 6:00 p.m. (except holidays). Please encourage your patients to participate in the programs and call us if you have any questions or concerns.

Care Management

VPCC offers an intensive Integrated Care Management Program for all members. The Care Management Team works closely with the member, family, care-giver, members PCP, ICT and providers to coordinate healthcare services across the continuum of care. Care Managers may also intervene when patients that demonstrate non-adherence to

their treatment plan. Circumstances that warrant referral to the Care Management Team include:

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

The care management program includes the following services:

- Support of the PCP's treatment plan
- Coordination of services
- Education on disease/illness and benefits
- Referral to community resources

All members will have an assigned care manager at Virginia Premier. To speak with a member's care manager, call Medical Management:

- 1-800-727-7536 in the Central Virginia / NOVA Area
- 1-800-828-7989 in the Tidewater Area
- 1-888-338-4579 in the Roanoke / Western Area

Or, utilize our [Online Care Management Request Form](https://www.vapremier.com), which can be located at www.vapremier.com and located under the "Providers" tab.

After hours, members may contact VPCC's Case Management Hotline at 1-800-256-1982.

Preventive Health and Wellness Programs

VPCC 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. VPCC's Health Education Department works closely with Member Outreach Representatives to assist with identification of members for health education services. Member outreach surveys include questions on health status and interest in health education classes or information. These surveys are then shared with the health educator and case manager to develop an individualized approach to presenting information to the member.

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

- Aerobic exercise (water, chair and regular)
- Diabetes
- Hypertension
- Family Planning
- Member Support
- Pre-natal/Parenting Skills

- Asthma
- Nutrition and Weight Loss
- Women's Wellness
- Smoking Cessation

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 VPCC's health education services, call our Member Services Department.

Quality Program Description

All practitioners are required to cooperate with the VPCC Quality Activities.

The primary goal of VPCC's Quality Program (QP) is to ensure the delivery of high quality, appropriate, efficient, cost-effective healthcare to its members. This goal is achieved by the design and implementation of a continuous process to objectively measure, monitor, evaluate, and improve the quality of clinical care and services delivered to members.

The objective of continuously improving the quality of care provided is to improve the overall health status of our members. Improvement of health status is measured by focusing on health outcomes. In addition, VPCC is committed to improving the communities where our members live through participation in public health initiatives on both the national and local levels and achievement of public health goals.

VPCC strives to provide cost effective services of exceptional quality, in the most appropriate setting. Our QP tracks and monitors all aspects of care to the members with timely feedback to providers. This program is a population-based plan that acts as a road map in addressing common medical problems identified within our population. The QP is integrated within clinical and non-clinical services provided for VPCC members. It addresses the availability, accessibility, coordination, continuity and overall quality of care as supported by VPCC staff. Key areas include: Member Services, Provider Services, Contracting, Credentialing, Care Team Management, Medical Management, Interdisciplinary Care Team and clinical performance measurement functions. This also includes monitoring of community-focused programs that encompass transportation and health education activities. The VPCC Board of Directors provides oversight to the QP, working closely with the Continuous Quality Committee to underscore VPCC's commitment to quality.

The goals and objectives of the Quality Plan are to:

- Improve the health status of the populations that we serve
- Institute healthcare programs that will improve the health status of our members through member and provider education
- Focus studies on illnesses which frequently affect our members
- Continuously monitor and measure activities to demonstrate effective outcomes

Given our focus on the dual eligible population, VPCC uses a quality improvement process that monitors activities that may have a deleterious effect on this unique population, and we have developed programs to address these specific concerns.

Accessibility Standards

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

Examples of VPCC's Quality Program at Work

Prenatal Care

VPCC is committed to increasing the percentage of pregnant members receiving appropriate pre-natal care. A number of different 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 pre-natal examinations as well as the creation of a Maternal Child Health Coordinator position dedicated to working with our expectant members. Our Healthy Heartbeats™ program emphasizes outreach activities, prenatal visits and patient education. This program has reduced neonatal intensive care unit admissions by 50%. Correspondingly, the number of co-morbid conditions associated with this high-risk group has also been significantly reduced.

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. VPCC annually announces the outstanding practitioner through the Provider and Member newsletter. Practitioners as well as members are encouraged to nominate a practitioner to be recognized by VPCC. The nomination form can be accessed at: www.vapremier.com.

Questions to Ask Your Physician

"Questions to Ask Your Physician" is established to encourage members to become proactive in their healthcare 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,)
- Medical Test (how test is performed, benefits/risks)
- 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 safe clinical practice. This information can be downloaded at www.vapremier.com.

20 Tips to Prevent Medical Errors:

The "20 Tips to Prevent Medical Errors" is intended to provide awareness and prevention of Medical Errors. VPCC takes pride in preventive measures to provide positive outcomes. Members are encouraged to ask questions regarding:

- Medications (be sure pharmacist fills what the Doctor prescribe)
- Hospital Stays (Be sure healthcare 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.vapremier.com.

Access to Care

All members are notified within 30 days of notification from a practitioner that a practitioner is not or will no longer be contracted with VPCC. VPCC 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 through the current period of active treatment or up to 90 calendar days. If the member is in the second or third trimester of pregnancy, VPCC will allow the member to continue to see the non-par practitioner through the postpartum period.

Standards for access and availability to care are established and monitored by VPCC's Quality department. Performance against the standards is monitored by provider on-site surveys to evaluate appointment availability, provider audits and random telephone calls, member satisfaction surveys, member complaints/grievances, and encounter reports which identify members' access patterns and identify members who have not received care within 90 days of enrollment. VPCC 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 Healthcare Quality Utilization Management Committee (HQUM) for the development of Quality initiatives. Through our QP, this information is incorporated into corrective action plans that are implemented and monitored for effectiveness.

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.

Model of Care (MOC) – Overview

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. The MOC consists of:

- a. Specific target populations
- b. Measurable goals
- c. Interdisciplinary Care Team
- d. Provider network with expertise and use of clinical practice guidelines
- e. Health risk assessment
- f. Individualized care plans
- g. Communication of network
- h. Care management of the most vulnerable subpopulations
- i. Performance and health outcomes measures

a. Specific Target Populations

The first key piece of information, with regards to the MOC, is to understand the specific targeted population covered within the VPCC program. These individuals include:

- a. The Elderly or Disabled with Consumer Direction waiver recipients
- b. Intellectual/developmental disabilities
- c. Cognitive or memory problems
- d. Physical or sensory disabilities
- e. Members residing in nursing facilities
- f. Serious and persistent mental illnesses
- g. End Stage Renal Disease (ESRD)
- h. Complex or multiple chronic conditions
- i. Anticipated long-term service and support needs in the future

b. Measurable Goals

The purpose of the MOC is to improve the care and services provided to members. The MOC works to ensure:

- a. Access to essential services
- b. Access to affordable care
- c. Coordination of care through an identified point of contact (gatekeeper)
- d. Seamless transitions of care across healthcare settings, providers, and health services
- e. Access to preventative health services
- f. Member health outcomes
- g. Assuring appropriate utilization of services

c. Interdisciplinary Care Team (ICT)

The ICT is a member centered group that discusses the care plan, health status and current / possible interventions for the member. It is a team of professionals that collaborate, either in person or through other means, with the Member to develop and implement a Plan of Care that meets their medical, behavioral, long term care and supports and social needs. The ICT is responsible for ensuring the POC is adhered to and follows the timeline specified. The ICT composition will vary depending on the members needs but will be made up of some, if not all, of the individuals below:

- 1. Member**
- 2. Family members and / or caregiver or legal representation**
- 3. Medical Directors and Pharmacy Director (Chief Medical Officer as needed)
- 4. The Care and / or Disease Manager**
- 5. The member's Primary Care Physician**
- 6. Targeted Case Management (members with Mental Health/Substance Abuse Needs)**
- 7. Specialists
- 8. Social Worker**
- 9. Medical Outreach Worker

10. Health Educator

****Core composition of the ICT team for all members**

The frequency of the ICT meeting is dependent on the complexity and needs of the member.

Level 1: The ICT will meet yearly at a minimum and more often if the member's needs change

Level 2: The ICT will meet at a minimum of every three months and more often should the member's status change

Level 3: The ICT will meet monthly and more often if warranted by the member's situation

The Care Manager will arrange for ICT meetings at the member's and/or member's representative's availability. ICT's may occur by phone or in person. Access to the plan of care and pertinent member health records will be made available to the ICT with permission from the member or member's authorized representative. ICT members will have access by fax, secure email or case management consumer portal.

d. Provider network with expertise and use of clinical practice guidelines

The provider network is comprised of Primary Care Physicians (PCP), Medical Specialists, Skilled Nursing and Long Term Care Facilities, Inpatient Acute Care Facilities, Ambulatory Surgery Centers, Outpatient Diagnostic Facilities, Behavioral Health providers, Laboratory, Dialysis, Home Health, Social Workers, Pharmacists and other provider specialties. All providers and facilities are credentialed prior to entering the VPCC network.

Clinical Practice Guidelines:

VPCC conducts a welcome call with each new member to initiate a health risk assessment (HRA) screening. The HRA determines the medical, psychological and environmental needs of the member. It is also used to determine the level of care management the member will require. Should a member be categorized as a level 2 or level 3, a care manager will conduct a comprehensive assessment which will determine the member's needs and the Plan of Care (POC).

Care Manager. Is a Registered Nurse or Social Worker with a bachelor's or Master's degree who provides intensive case management services to the member and member's family. The Care Manager conducts a comprehensive assessment of the member's health and psychosocial needs in collaboration with the member, family, providers, social agents, and other members of the care team.

Care Managers Will:

- Conduct in-depth assessments to determine the services the member will need. Members who are in the EDCD waiver and NF will have a face-to-face in depth assessment.
- Develop the interdisciplinary care team (ICT).

- Employ an approach based on each member's strengths, needs and preferences through involvement of the member, their family, their caregiver(s), members of the VPCC care team and a network of community-based supports in the care planning and care delivery process.
- Develop an individualized Plan of Care (POC) with a member, their family and caregivers coordinated by the Interdisciplinary Care Team (ICT) to fully address and adhere to the members' strengths, needs and preferences.
- Utilize community-based resources as available to help support the member's needs and preferences.
- Promote the member's ability to actively exercise their rights and responsibilities.
- Offer disease management services for individuals with chronic conditions to obtain disease-specific education and support.
- Educate members regarding the importance of self-care, prevention and maintain or improve health.

e. Health Risk Assessment (HRA)

The HRA is a tool used to evaluate a member's physical condition, cognitive functioning, behavioral health, frailty and functional needs. It is administered within the first sixty (60) days for members who come onto VPCC under the Elderly and Disabled with Consumer Direction (EDCD) waiver and within ninety (90) days of enrollment for all other new members. Once the initial HRA has been facilitated, it is conducted on an ongoing basis annually. The Patient Care Coordinators (PCC) are the intake screeners and are primarily responsible for completing the HRA.

The HRA stratifies members into risk levels: Low, Moderate and High. The risk level determines the type of intervention provided. The HRA also identifies the potential need for specific case / disease management and potential care management needs based on medical or psychosocial issues.

The HRA assesses the following:

- Member's perception of health status
- History of hospital and ER utilization
- History of surgical procedures
- ESRD / Dialysis
- Pain Level
- Chronic medical conditions
- Number of medications taken
- Fall screening and mobility limitations
- Special Care Needs: DME / Home Health / Social Work
- ADL's and IADL's
- Behavioral screenings

f. Individualized Care Plan

The plan of care (POC) is personalized to meet the member's specific needs and identifies, but is not limited to, the following:

- Prioritized goals (member and caregiver preferences)
- Time frame for evaluation of the goals, interventions and resolution of problems
- Resources to be utilized
- Planning for continuity of and transition of care
- Collaborative approaches
- Self-management plan
- Measure outcomes
- Social / community service needs
- Condition specific educational needs

The POC can vary depending on the complexity of the member. For members who score in the high range of the HRA, the care manager will complete the In-Person Comprehensive Assessment (IPCA) and utilize data from the HRA and other sources to gather a holistic picture of the member and to identify areas of need to develop an individualized plan.

g. Communication of Network

The MOC must include effective and in some cases enhanced and technologically advanced communication methods. VPCC utilizes many different methods when communicating with members and providers.

Member Communication:

- Member Services Call Center
- Newsletters
- Brochures
- Reminder Mailings
- Website
- Member Meetings
- Focus Groups

Provider Communication:

- Provider Visits
- HEDIS Education Classes
- Provider Training
- Peer Review Committees
- Provider Meetings
- Provider Services Call Center
- Newsletters
- Website
- Personalized faxes

- Face-to-face meetings

h. Care Management of the most Vulnerable Subpopulations

VPCC identifies the vulnerable subpopulations through many avenues available, including:

- Enrollment reports
- DMAS medical transition data
- Internal/external referrals
- Virginia Premier's reports and processes
- Predictive modeling
- Pharmacy reviews
- High dollar claims
- Daily referrals from Utilization

Some of the services offered to the vulnerable subpopulations are: Care coordination and complex care management, long-term care integration, long-term support services, behavioral health coordination, transition management, medication therapy management, transportation, vision services and glasses, member outreach services and dedicated twenty-four (24) hour service.

i. Performance and Health Outcome Measures

HEDIS is a primary component to the measurement of the VPCC MOC. Utilizing HEDIS measures allows VPCC to observe and report changes year over year. This also allows VPCC to understand the quality of care delivered to the members and the care model's effectiveness.

PROVIDER REIMBURSEMENT AND CLAIMS

Claim Filing Guidelines

Providers participating with VPCC are required by their participation agreement to submit claims in the required format for all services rendered. For outpatient services, a CMS-1500 claim form must be used for physician, ancillary or other provider type services. For hospital or facility, a UB04 claim form must be submitted. When submitting claims, a provider should refer to the most recent version of the following Professional resources for coding accuracy: including: the American Medical Association Physicians' Current Procedural Terminology (AMA/CPT Book), International Classification of Diseases, Revised Edition, Clinical Modification (ICD-9-CM) and HCPCS Level II Medicare Codes manuals.

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

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

VPCC requires that all claims be submitted within the timeframes established in the provider contract. Please refer to your VPCC 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. Paper Claim Submissions

Paper claims should be submitted to the following address:

Primary Care Providers VPCC P.O. Box 4468 Richmond, VA 23220-0207	Specialty Providers VPCC P.O. Box 4468 Richmond, VA 23220-0208
Hospital Claims VPCC P.O. Box 4468 Richmond, VA 23220-0120	Claims Appeals VPCC P.O. Box 4468 Richmond, VA 23220-0307
Transportation Claims VPCC P. O. Box 4468 Richmond, Virginia 23220-5287	

Electronic Filing Clearinghouses

Electronic claims can be filed with VPCC by utilizing one of the following Clearing Houses:

Availity	800-282-4548
McKesson (Relay Health)	800-981-8601

VPCC strongly encourages providers to consider filing claims electronically which will reduce claims submission timeframes and increase account receivables payment for services rendered. Providers who wish to submit claims electronically must complete all necessary documents related to the process. A listing of participating clearinghouses along with enrollment forms can be accessed at www.vapremier.com. Please allow at least thirty (30) business days to complete this process. Providers are encouraged to contact their claims clearinghouses to confirm they are set-up to submit claims electronically. Submitting claims electronically without full clearance will cause claims processing delays.

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

API Provider Claim Submission

Providers participating with VPCC who require the ability to create and submit claims through our direct data entry portal will be required to contact Rick Gordon at rgordon@vapremier.com in the Network Development department prior to submitting their first claim.

Network Development will assist API providers in creating a claims submission account. Providers will be asked to provide the following in order to create an account:

- First Name and Last Name of the user
- Email address of the user (this will be used as the user name they log on with)
- Group or Provider Name
- API
- Tax ID
- We will set their password (note: You will NOT be prompted to change your password, but can optionally change the password if you don't like the one we set up)

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

VPCC recognizes the important role that our primary care providers play in managing the healthcare of our members. Primary Care Physicians (PCP) are reimbursed on a fee for service basis.

Primary Care Fee for Service

Primary Care Physicians will be paid according to their VPCC contract on a fee-for-service basis. If the PCP's billed charges are less than the VPCC allowable, the PCP will be paid their billed charges. All claims are to be filed on a CMS 1500 claim form or electronically.

Encounter Reporting

Encounter reporting is used to determine levels of service and to assist in the coordination of benefits. VPCC also uses encounter information to monitor, evaluate and report utilization.

Panel Report

Primary care providers will receive a monthly report that will itemize their assigned member panel.

Recoupment/Recovery Policy

In accordance to 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 in appropriate Medicaid payments. VPCC will recoup/recover payments that are identified by our auditing and monitoring programs.

Member Hold Harmless Policy

Providers may not charge Members or VPCC for any service that:

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

Providers may not bill a VPCC member for medically necessary services covered under the VPCC contract and provided during the member's period of enrollment. This provision shall continue to be in effect even if VPCC becomes insolvent. However, if a member agrees in advance of receiving a non-covered service and this agreement is in writing, then the Provider may bill the member for those non-covered services. Balanced Billing is prohibited under the Commonwealth Coordinated Care Program.

Denied Claims/Reconsiderations

All denied claims, in whole or in part, must be appealed in writing to VPCC. 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.

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

Virginia Premier CompleteCare
Attention: Appeals Department
PO Box 4468
Richmond, Virginia 23220

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

Virginia Premier CompleteCare
Attention: Medical Management Department
P. O. Box 4388
Richmond, Virginia 23220-0244

Appeals for denied claims must be sent to VPCC within sixty (60) days of the original date of denial. The Appeal Claims form can be accessed at www.vapremier.com.

Filing of Specific Claim Types

Inpatient Rounding

VPCC 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 VPCC’s Medical Director. PCPs are reimbursed fee for service if they provide attending physician, “inpatient care” or discharge management services.

Global OB Method

Providers who bill VPCC for OB services 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 VPCC 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.

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. VPCC follows the use of modifiers as outlined in the CPT (Current Procedural Terminology). VPCC accepts all AMA approved modifiers.

- VPCC requires that bilateral procedures billed on one claim line with the modifier 50 and 2 units should be indicated for us to properly reimburse you for a bilateral procedure.

Collection of Charges from Third Parties

VPCC 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 VPCC. If the recipient is enrolled in and receives services through VPCC and is subsequently discovered to have another source of health insurance, VPCC 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 VPCC's enrollment, VPCC will be responsible for providing covered services as set forth in our contract with CMS and DMAS.

Payment amounts will be determined by a review of the primary carriers EOB and VPCC's allowable rate.

Reimbursement of Physician Assistants and Nurse Practitioners

VPCC 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 VPCC provider shall be reimbursed to the credentialed provider.

If a nurse practitioner (family or nurse midwife) wants to bill directly for their services, they must submit a VPCC provider application, complete the credentialing process and be a participating practitioner with Medicaid.

Virginia Premier does not credential Physician Assistant's. However VPCC 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.

DME Individual Consideration Request Submission

DME Individual Consideration (IC) Item: HCPCS codes that do not have a corresponding reimbursement rate. The provider/DME supplier must submit Certification of Medical Necessity (CMN) Form for DME requests to the 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**. Items will be reimbursed in accordance to VPCC fee schedule.

Long Term Services and Supports (LTSS)

LTSS providers are not required to have a National Provider Identifier (NPI) and instead may use an Atypical Provider Identifier (API). VPCC will review providers who do not have either a NPI or an API on a case by case basis.

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 RESPONSIBILITIES

Members of Virginia Premier Health Plan are entitled to all the benefits outlined in their Member Handbook/Evidence of Coverage. With VPCC 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.

Member Rights

VPCC members have the right to:

- Timely access to their PCP and referrals to specialists when medically necessary or as needed and timely access to all covered services, both clinical and non-clinical.
- Not be balanced billed by any provider for any reason for covered services or Flexible Benefits.
- Not be discriminated against due to; medical conditions, including physical and mental illness, Claims experience, Receipt of healthcare and Medical history.
- Treatment with quality care, respect and dignity regardless of their race, physical or mental ability, ethnicity, gender, sexual orientation, creed, age, religion or their national origin, cultural or educational background, economic or health status, English proficiency, reading skills or source of payment for your care.
- Have healthcare services twenty-four (24) hours a day, three hundred and sixty-five (365) days a year, including urgent, emergency and post stabilization services.
- Choose their personal VPCC doctor/Primary Care Physician (PCP).
- Change their personal VPCC doctor and choose another one from VPCC's Provider Directory (included in the enrollment/membership package).
- Make their own doctor/PCP appointments to be seen in their private office at their convenience.
- Not to be treated against their will.
- To see their doctor/PCP, get covered services; get their prescriptions filled within a reasonable period of time. They should not be afraid to ask their doctor/PCP questions.
- Call Member Services to file a complaint/grievance about VPCC or file an appeal if they are not happy with the answer to their inquiry (question), complaint/grievance, or care given.
- To privacy and to have your medical records and personal health information kept private unless they sign a permission form.
- Have timely access to their medical records in accordance with applicable State and Federal laws. They may be required to sign for release of those records.
- Participate with their doctor in making decisions about their health care, give their consent for all care, and make decisions to accept or refuse medical care to the extent permitted by law and be made aware of the medical consequences of such action.
- Have their doctor tell them about all treatment options and alternatives, presented in a manner that can be easily understood, regardless of the cost or benefit coverage. They can also receive a second opinion from VPCC's network of providers.

- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, as specified in Federal regulations on the use of restraints and seclusion.
- Free exercise of rights and the exercise of those rights that does not adversely affect the way VPCC and its providers treat their members
- Receive information about VPCC, its services, costs, providers, network pharmacies, drugs, and Members' Rights and Responsibilities.
- To know the names and qualifications of the physicians and healthcare professionals involved in their medical treatment.
- Make suggestions regarding VPCC's Member Rights and Responsibilities statement, which is found in the member handbook.
- Rights to reasonable accommodations
- To use Advance Directives (such as a Living Will or a Power of Attorney).
- VPCC will 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
- A right to a copy of the Privacy Notice annually or when requested

Supplemental Member Rights

VPCC members also have the right to:

- 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.
- Get emergency care and family planning services in or out of network without prior authorization. Family planning services, preventive services, and basic prenatal care do not need preauthorization, but the member should get care from an in network doctor/provider.
- To obtain care from a doctor/provider acting within the lawful scope of practice. VPCC may not prohibit, or otherwise restrict, a member's doctor/provider from advising or advocating on behalf of a member who is his/her patient related to the member's health condition, medical care or treatment choices, including any other treatment that may be self-administered.
- Have the doctor 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 contact Va. Premier staff that has been trained on advance directives and asks questions, if needed.
- File any type of grievance, including those related to advance directives, with Va. Premier by calling the toll free line at 1-855-338-6467, the Department of Medical Assistance Services, the Bureau of Insurance and the Department of Health.
- Give female members direct access (no referral needed) to a woman's health doctor/provider in the network for covered routine and preventive care services. This is in addition to the member's assigned primary care doctor/provider if that person is not a women's health doctor/provider.

- Have his/her healthcare needs and information discussed and given to the doctors/providers they want. The member is advised to sign a release form with their current provider in order to have the information released.
- Confidentiality when coordinating care including medical records, member information and appointment records for the treatment of sexually transmitted diseases.
- To be held harmless (not responsible for the bill or extra costs), if out of network services are given to a member for emergency care or care that has been preauthorized.
- To see in network doctors/providers with the same office hours as those for other patients who may not have Medicaid like private commercial insurance members and or other types of Medicaid members (fee for service), if the doctor/provider sees only Medicaid members.
- To see a doctor of his/her choice based on language and/or race and one who is sensitive to the member's cultural needs, including those who cannot speak English well and those with different cultural and racial backgrounds.
- To 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 have any service that has been stopped reactivated, if a member's location is known.

Member Responsibilities

- Choose a VPCC Primary Care Physician (PCP) from the provider directory. Work with their PCP to help establish a proper patient/physician relationship.
- Get their healthcare from a participating PCP, hospital or other health care provider.
- Keep their doctor's appointments or call to cancel them at least twenty-four (24) hours ahead of time.
- Carry their Member Identification Card with them at all times.
- Inform VPCC if they have other health insurance coverage
- Tell the doctor that they are a member of VPCC at the time that they speak with their doctor's office.
- Give their PCP and other providers honest and complete information they need about their health to care for them.
- Learn the difference between emergency and urgent care. Know:
 - What an emergency is
 - How to keep one from happening
 - What to do if one happens
- Follow plans and instructions for care given by their physician.
- Understand their health problems and discuss and/or agree upon a treatment plan with their physician.
- Advise their PCP of visits to other doctors so that he can be kept informed about the care that they are receiving.
- Act in a way that supports the care given to other patients and helps the smooth running of their doctor's office, hospitals and other offices.

- Let VPCC know if they have any problems, concerns or suggestions on how we can work better for them.
- Take into advisement the recommendations of the Case Managers and other healthcare professionals at VPCC.

Advance Directives (Patient Self-determination)

An Advance Directive is posted at www.vapremier.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 members' medical record. This even includes if the member states "No, I do not wish to complete an advance directive." VPCC 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.

The Patient Self-Determination Act requires that a "provider of services" document in the individual's medical record whether or not an advance directive has been executed. As a VPCC participating provider, you play an important role in helping your patient make a decision concerning advance directives. Information about advance directives will be provided to members upon enrollment and re-enrollment through our Member Handbook. Additional information will be provided to physician offices upon request. Physician compliance will be audited as part of ongoing medical record reviews. On our website you will also find information pertaining to "Virginia Health Care Decision Act" and applicable sub-attachments pertaining to this Act. Official Virginia Code, see <http://leg1.state.va.us/lis.htm>. If you have questions concerning Advance Directives, please call our Medical Management Department.

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 healthcare decisions on their behalf, should they be unable to do so.

Grievance and Appeals Procedures

VPCC is committed to providing high quality healthcare and service to its members. To ensure an open dialogue with our members, VPCC 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 VPCC 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 grievance and appeals quality improvements
- To ensure monitoring and oversight of activities for the effectiveness of such corrective measures

VPCC provides information about the grievance and appeals process and procedures to all plan members at the time of enrollment, upon voluntary disenrollment, and at least annually thereafter. The Member Handbook explains how member complaints and grievances can be initiated. 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 Program Integrity Department for investigation and prompt resolution.

If a member is denied authorization for treatment, VPCC initially sends written notification to the member indicating receipt of the grievance or appeal request. The member or member representative has sixty (60) calendar days from the decision to file an appeal regarding any coverage for service adverse decision. The grievance or appeal is investigated by the Program Integrity Department and a final decision is made. The member is notified of this decision in writing and clearly explains to the member their appeal rights, including how to file an appeal for the next level if desired. All member issues or concerns are addressed and a written response is sent to the member within thirty (30) days of initial receipt, stating that the inquiry/concern has been addressed. Member letters also include information (address and phone numbers) for further appeals.

External appeals filed or auto-forwarded to the Medicare external appeal process shall be heard under currently existing Medicare appeal timelines. External appeals shall be resolved or a decision issued within ninety (90) calendar days of the date of filing the appeal for the first year of the Demonstration (as defined in Figure 6-1 in Appendix 6), and within seventy-five (75) days of the date of filing the appeal for the second year of the Demonstration, and within thirty (30) days of the date of filing the appeal for subsequent years thereafter.

VPCC's Continuous Quality Improvement Committee (CQIC) oversees the grievance and appeal review process. Administrative reviews are the responsibility of the Member Services Department. Quality of care/service reviews are the responsibility of the Program Integrity Department.

Appeals and Grievances 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 Environs: 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 VPCC 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 VPCC representatives, problems with transportation services, etc.

Filing an appeal

Initiating Medicare/Medicaid Appeal

Appeal time frames

Members, their authorized representatives, and/or providers who are authorized by the member, will have sixty (60) calendar days from the date of notice of action (denial letter) to file an appeal in writing related to coverage. This matches the current sixty (60) day time-frame for requesting an appeal related to benefits under Medicare, and exceeds the current thirty (30) day time-frame for requesting appeal related to benefits under Medicaid. Members have the option of filing an expedited appeal by telephone as currently allowed for under Medicare. If the request for an expedited appeal is granted, VPCC completes the review process and renders a decision within 72 hours. If the appeal request is processed using standard time frames, VPCC completes the review process and renders a decision within thirty (30) calendar days. The time-frame

may be extended up to 14 days by VPCC if there is evidence that the delay is in the best interest of the member.

All VPCC internal appeals regarding coverage decisions must be resolved within thirty (30) calendar days of filing for standard appeals and within 72 hours or as expeditiously as the Member's condition requires for appeals qualifying as expedited appeals. This excludes Part D appeals, which are resolved in accordance with existing rules.

Appeal levels

Initial appeals are filed with VPCC. The filing of an internal appeal and exhaustion of the VPCC internal appeal process is a prerequisite to filing an external appeal (additional levels of appeal).

If the VPCC internal appeals process renders an adverse decision (upholds the denial), for Medicare traditional Part A and B services, the case file is automatically forwarded to the Medicare Independent Review Entity (IRE) at:

MAXIMUS Federal Services
Medicare Managed Care & PACE Reconsideration Project
3750 Monroe Avenue, Suite 702
Pittsford, NY 14534-1302
Phone: 585-348-3300

The appeal request is submitted by mail, commercial delivery service, or personal delivery to the IRE (electronic and fax submissions are not permitted).

If the IRE review renders an adverse decision (upholds the denial) and the AIC is > \$140, VPCC will notify the IRE Maximus of the next level appeal request. Upon request of the member for next level of appeal, the IRE Maximus will submit the case file to the Administrative Law Judge (ALJ) Hearing for Review. The IRE is responsible for compiling the reconsideration file and forwarding it to the ALJ Hearing office.

If the ALJ Hearing renders an adverse decision (upholds the denial), the member or provider has the right to appeal to the Medicare Appeals Council (MAC) directly by submitting appeal request to:

Department of Health and Human Services
Department Appeals Board, MS 6127
Medicare Appeals Council
330 Independence Avenue, SW
Cohen Building, Room G-644
Washington, DC 20201

If the MAC Review renders an adverse decision (upholds the denial) and the AIC is > \$1400, the member or provider has the right to appeal for Judicial Review by filing a motion with the Federal District Court. The request should be initiated in the District where the Member lives or where VPCC has its primary business, or the District of Columbia.

There is no statutory time limit for processing ALJ Hearings, MAC Reviews, or Judicial Reviews.

State Fair Hearing Process

For all Medicaid-based adverse decisions, subsequent appeal levels are available with Department of Medical Assistance's State Fair Hearing at:

Department of Medical Assistance Services
600 E. Broad Street
Richmond, Virginia 23219
(804) 371-8488

Appeal/review requests may also be faxed to:
(804) 371-8491

Continuation of Benefits Pending an Appeal

VPCC provides continuing Medicare and Medicaid benefits for all prior approved non-Medicare Part D benefits that are terminated or modified pending internal VPCC appeals. This means that such benefits will continue to be provided by providers to member's, and that VPCC continues to pay providers for providing such services pending an internal VPCC appeal. This right to aid pending an appeal currently exists in Medicaid, but is generally not currently available in Medicare. Existing Medicaid rules concerning benefits pending an appeal will not change.

Integrated Notice

VPCC Members are notified of all applicable Demonstration, Medicare and Medicaid appeal rights, including whether an individual may receive benefits pending the appeal, through a single notice.

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 three-way contract between VPCC, The Centers for Medicare and Medicaid Services (CMS) and the Department of Medical Assistance Services (DMAS). Responsibilities include, but are not limited to, the following:

- Providing care and services to VPCC members without discrimination or regard for the member's race, creed, national origin, sex, age, religion, health status, source of payment, disability, English proficiency or frequency of utilization of covered services.
- Physicians must be participating Medicare and/or Medicaid providers.
- Providers must comply with provider access standards as set forth in the terms of the Agreement to ensure that VPCC members have appropriate access to routine, urgent and emergent care.
- Providers must submit timely utilization data in a format that will allow VPCC to comply with CMS and DMAS reporting requirements.
- Providers must comply with all record keeping, record retention and special reporting requirements as set for the in the provider contract.
- Providers agree to allow authorized VPCC 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 Agreement.
- Providers must comply with VPCC's Medical Management procedures and must clearly specify referral approval requirements to any subcontracted providers.
- Providers agree not to charge eligible VPCC members for medically necessary covered services. Providers may only bill if the member has consented in writing to pay for a non- covered service prior to receiving the services.
- Providers agree to cooperate with any external review organization contracted by CMS, DMAS or VPCC to perform quality studies.
- Providers agree to assist VPCC members with special needs. This may range from assistance with understanding managed care and the role of their PCP to referring members to community resources.
- 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.

Provider Availability

PCPs and Specialists must provide coverage for their practice twenty-four (24) hours a day, seven (7) days a week. PCP's and Specialist offices must also have a published after hours telephone number. The member must be able to reach someone after hours. A voicemail alone after hours is not acceptable. All Providers must offer hours of

operation that are no less than the hours of operation offered to persons who are not VPCC members or their commercially insured or public fee-for-service insured individuals.

Credentialing and Re-credentialing Program Description

Overview of Program

The Credentialing Program of VPCC shall be comprehensive to ensure that its practitioners and providers meet the standards of professional licensure and certification. The process enables VPCC 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 recredentialing cycles, and it emphasizes and supports a practitioner's and provider's ability to successfully manage the healthcare of network members in a cost-effective manner.

VPCC 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 as well as 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 & Activities

The Chief Medical Officer 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 VPCC's internal staff.

The activities of the Credentialing Committee include:

- Receive and review the credentials of all practitioners being credentialed or recredentialed 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 give thoughtful consideration to the credentialing elements before making recommendations about a practitioner's ability to deliver care.
- Establish implement, monitor, and revise policies and procedures for VPCC credentialing and re-credentialing.
- 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 VPCC at an outpatient setting. An independent relationship exists when VPCC 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.
- Non-physician practitioners who have an independent relationship with VPCC as defined above, and who provide care under the organization's medical benefits.
- Long Term Services and Supports providers
- Hospital based practitioners who have an independent relationship with VPCC and an outpatient setting:
- Anesthesiologists with pain-management practices
- Cardiologists
- University faculty who are hospital based and who also have private practices
- Non-physician practitioners who may have an independent relationship with VPCC and provide care under VPCC'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 Chiropractors (DC)
 - o Osteopaths (DO)
 - o Podiatrists (DPM)
 - o Nurse Practitioners (NP, PNP, ANP, FNP)
- Behavioral health practitioners:
 - o Psychiatrists and other physicians
 - o Addiction medicine specialists
 - o Doctoral or master's-level psychologists who are state certified or licensed
 - o Master's-level clinical social workers who are state certified or licensed

- o Master's-level clinical nurse specialists or psychiatric nurse practitioners who are nationally or state certified or licensed
- o Other behavioral healthcare specialists who are licensed, certified or registered by the state to practice independently

Process and Requirements

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

Each practitioner must submit a legible and completed application, a consent form that is signed and dated, a confidentiality form that is signed and dated, and any other required documentation. Practitioners may also submit their applications and/or information to the Center for Affordable Quality Healthcare (CAQH). Upon notification from the prospective practitioner that his/her application is filed with CAQH, VPCC'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 VPCC application or CAQH Application number
- 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 VPCC credentialing staff will conduct primary source verification as required by the most current and applicable VPCC CMS, DMAS, and/or NCQA guidelines. VPCC 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 VPCC office site and medical record standards are met. The Quality Department is responsible for conducting office 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 VPCC 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 Senior Medical Director 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 Senior Medical Director 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:** VPCC’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 within 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

VPCC conducts an annual review of the credentialing process to assess compliance with policies and procedures in accordance with VPCC standards, CMS standards, DMAS standards, the standards set forth by the National Committee for Quality Assurance (NCQA) and other applicable regulatory bodies. Additionally, VPCC conducts annual reviews on delegated vendors to assure that they are in compliance with VPCC, 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 VPCC. A Member Services Representative will obtain the information from the Credentialing Department or another appropriate source and provide it to the member. The member could also be directed to the VPCC's website at: www.vapremier.com or the Virginia Board of Health Professions website at: <http://www.vahealthprovider.com/>

Provider Sanctions

VPCC 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. VPCC 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 VPCC members:

Service	VPCC Standard
Appointment for health assessment, general physical exams, first examinations (preventive care)	Scheduled within 30 days of request.

Appointment for Routine primary care & specialty care (non-urgent care for symptomatic conditions)	Scheduled within 14 calendar days of request.
Routine primary care	Scheduled within 30 calendar days of the member's request. Excludes appointments for routine physicals, regularly scheduled visit to monitor a chronic condition if the schedule calls for visits less frequently than once every 30 days, for routine specialty care like dermatology, allergy care, etc.
Average wait time in PCP office	No more than 30 minutes following appointment time.
Specialist appointment (non-urgent referral)	Scheduled within 30 calendar days or sooner of the request.
Initial assessments for pregnant women or persons desiring family planning	Scheduled within 10 days.
Maternity Care – First Trimester Maternity Care – Second Trimester Maternity Care – Third Trimester High Risk Appointments	Scheduled within 14 calendar days. Scheduled within 7 calendar days. Scheduled within 3 business days. Scheduled within 3 business days.
Urgent appointments	Provided within 24 hours of member's request.
Emergent appointments	Immediately and/or referred to emergency facility.
Access to after-hours care	Answering service/machine provides instructions on how to access care.
Appointment for Behavioral Health/Substance Abuse Services	i. Care for non-life threatening emergency within 6 hours. ii. Urgent Care within 48 hours. iii. Routine visits within 10 business days. iv. Follow-up visit after inpatient admission within seven (7) calendar days.
Answering Telephone Hold Time	Within two (2) to (4) four rings 30 seconds or less
VPCC 24 Hours Medical Help Line	Practitioners shall advise members to contact VPCC Nurse Advice Line for medical concerns prior to seeking services at the emergency room.

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 VPCC 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 plan of care should be referred to Case Management at 804-819-5151 or 1-800-727-7536 (Central Virginia/Fredericksburg/Western), 757-461-0064 or 1-800-828-7989 (Tidewater) and 540-344-8838 or 1-888-338-4579 (Southwest). A VPCC Outreach Worker will contact the member and work with them directly to facilitate compliance.

Note: VPCC members cannot be billed for a missed appointment.

Medical Record Keeping Policies

Participating physicians are required to maintain adequate medical records and documentation relating to the care and services provided to VPCC members. All communications and records pertaining to our member's healthcare must be treated as confidential. No records may be released without the written consent of the member or their designated caregiver. 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:
 - o Accurate and legible
 - o Safeguarded against loss, destruction or unauthorized use
 - o 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
 - o Readily available for VPCC's Medical Management staff with adequate clinical data to support utilization management activities
 - o Comprehensive with adequate information to allow record transfer procedures to provide continuity of care when members are treated by more than one provider

VPCC has established standards for medical record documentation and maintenance. These standards address medical record content, organization, confidentiality and maintenance. VPCC 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 VPCC employees
- Credentialing Department ongoing monitoring process
- Other Quality Initiatives

The VPCC Medical Record Standards are as follows:

- I. Medical Records Keeping Requirements:
 - A. Confidentiality of medical records must be maintained by:
 1. Medical records being stored securely (i.e., confidential filing system, etc.)
 2. Only authorized personnel having access to medical records
 3. Conducting training on confidentiality related to member information periodically, and as needed
- II. Medical record documentation standards will be utilized.
 - A. Each medical record must include the following:
 1. History and physical
 2. Allergies and adverse reactions
 3. Problem list
 4. Medications
 5. Documentation of clinical findings and evaluation for each visit
 6. Preventive services/risk screening
- III. 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 VPCC members for ten (10) years or longer if required under applicable state law.

VPCC 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 VPCC'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
- Sentinel Events
- Practice specific member surveys
- Reports from VPCC employees
- Credentialing Department ongoing monitoring process
- Other Quality related initiatives

The purpose of the review is to ensure practitioners meet VPCC regulatory and accreditation site standards for quality, safety and accessibility.

VPCC 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

Practitioners who do not meet VPCC's 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 Senior Medical Director and/or the Credentialing Committee to begin a review process with the practitioner.

COMPLIANCE AND PROGRAM INTEGRITY

The Program Integrity Department was established to support Virginia Premier's commitment to the highest standards of conduct, honesty, integrity and reliability in our business practices. Program Integrity is about **"Doing the right thing"** for the right reasons.

The Program Integrity program is designed to assist the organization to uphold our continued commitment in making proper and ethical decisions. The compliance and integrity program applies to officers, directors, employees and affiliated associates such as providers, vendors, and subcontractors. It consists of the following: policies and procedures, Code of Conduct, compliance oversight, education and training, monitoring and auditing, enforcement and discipline, and detection and prevention of fraud, waste, and abuse.

If you have questions or concerns related to:

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

Call the Compliance Helpline:

1-800-620-1438, or go on-line to:

<https://www.compliancehelpline.com/WelcomePageVCUHS.jsp>

24 hours a day, 7 days a week. You may remain anonymous.

If you have any questions regarding Compliance or HIPAA, you may also contact our Program Integrity Department at (800) 727-7536.

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 and 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 Corporate Compliance 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 member 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 remuneration 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 Corporate Compliance Officer of any instances of non-Compliance and cooperate with all investigation efforts by Virginia Premier and other state and federal agencies

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 healthcare clearinghouses to take greater care in use and disclosure of protected health information (PHI).

Who is impacted by HIPAA? Health Plans, providers and healthcare 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 healthcare operations. Here are simple steps you can use to protect the privacy and security of patient health information:

1. Post your Notice of Privacy Practices in patient common areas
2. Make sure every patient reads and signs the Notice of Privacy Statement
3. Keep medical records in a restricted area and locked file cabinet
4. Make sure PHI is safely filed away at the end of each workday
5. Make sure computers are logged off or shut down according to company policy

6. Encourage staff to shred documents that are not part of patient record that contains protected health information
7. Use a fax coversheet and confirm fax numbers when faxing patient health information
8. Place the fax machine in a secure location away from public viewing
9. Conduct staff training on HIPAA policies and procedures
10. Designate a staff member to handle compliance and/or HIPAA concerns for your office
11. Establish a policy and procedure for computer and Internet usage
12. Establish a policy and procedure for release of medical records
13. Immediately terminate access for computer systems and obtain keys from terminated employees
14. Establish a policy to ensure all visitors check in at the front desk
15. Ensure computers are backed up daily
16. Ensure anti-virus software for computers is updated on a regular basis
17. Ensure computer passwords are changed at a minimum, every 90 days
18. 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 healthcare provider, health plan, employer, or healthcare 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 Member
- Medical Record
- Biometric identifier

Uses and Disclosures of PHI

Providers are not required to obtain a member's approval to use or disclose protected health information for Treatment, Payment and healthcare Operations (TPO).

Treatment – Provision, coordination, or management of health care and related services

Payment – Reimbursement for healthcare services, including billing and claim management

Healthcare Operations – Business activities of the organization such as quality assessments & improvement activities, training programs, accreditation, licensing, credentialing, premium rating, legal services, business management and general administrative activities.

Other Permitted and Required Uses and Disclosures That 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 healthcare 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 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 Health Information Technology for Economic & Clinical Health (HITECH) Act

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 DRA's 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 Health Plan.

Failure to report overpayments within the 60 day time requirement constitutes an obligation under the False Claims Act and could create a 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 healthcare services or prescriptions
- ☑ "Doctor shopping" and excessive trips to the ER for control 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. VPCC 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.

VPCC 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; 45 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 healthcare 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 <http://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 healthcare 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 healthcare 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

VPCC 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.

MARKETING GUIDELINES

Virginia Premier is responsible for including certain CMS Medicare Marketing Guidelines in the policies and procedures distributed to our providers. For purposes of this manual, the term “Medicare Marketing” includes any information, whether oral or in writing, that is intended to promote or educate prospective or current VPCC members about Virginia Premier or its VPCC plan, products or services. This includes, but is not limited to, any and all promotional materials used at Provider-sponsored activities, such as open houses, health fairs and grand openings. Examples of promotional materials include letters, advertisements, invitations, and announcements, which use Virginia Premier’s name.

Medicare Marketing must be approved through the Virginia Premier Corporate Review Process prior to a Provider conducting any Medicare Marketing activity. Our review process includes review by our Strategic Planning & Business Development and Program Integrity departments and filing through CMS for approval (as applicable), in accordance with CMS’ guidelines.

To obtain approved Medicare Marketing materials or to arrange for a Provider-sponsored activity, contact the Communications Manager at 800-727-7536, ext. 55449. Any misrepresentation of Virginia Premier or VPCC, intentional or not, is a serious violation of Virginia Premier’s agreements with DMAS and CMS.

Specific Medicare-Medicaid Plan Marketing Requirements

Providers must remain neutral when assisting with enrollment decisions and may not:

- Offer scope of appointment forms;
- Accept Medicare enrollment applications;
- Make phone calls or direct, urge or attempt to persuade member’s to enroll in a specific Plan based on financial or any other interests of the Provider;
- Mail marketing materials on behalf of Plan/Part D sponsors;
- Offer anything of value to induce Plan members to select them as their Provider;
- Offer inducements to persuade member’s to enroll in a particular Plan or organization;
- Conduct health screening as a marketing activity;
- Accept compensation directly or indirectly from the Plan for member enrollment activities; or
- Distribute materials/applications within an exam room setting.

Providers may

- Provide the names of Plan sponsors with which they contract and/or participate;
- Make available and/or distribute Plan marketing materials (as long as all Plans with which the provider participates are allowed the same courtesy);
- Refer patients to other sources of information, such as SHIPs, their state Medicaid office, local Social Security office, CMS’ website at <http://www.medicare.gov/> or 1-800-MEDICARE; and/or
- Share information with patients from CMS’ website, including the “Medicare and You” handbook or “Medicare Options Compare” (from <http://www.medicare.gov/>), or other documents that were written by or previously approved by CMS.

Provider Affiliations

Virginia Premier's contracted providers may announce new or continuing affiliations for specific Plans/Part D Sponsors through general advertising, (e.g., radio, television, websites). Also, providers can make new affiliation announcements within the first 30 days of the new contract agreement. An announcement to patients of a new affiliation which names only one MMP/VPCC Plan may occur only once when such announcement is conveyed through direct mail, email or phone. Additional direct mail and/or email communications from Providers to their patients regarding affiliations must include a list of all plan sponsors with which the Provider contracts. Any affiliation communication materials that describe Plans in any way, (e.g., benefits, formularies, or comparisons to other plans) must be approved by Virginia Premier, DMAS and CMS.

GLOSSARY

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.
Appeal	A request from a member, attending physician, provider or facility to reconsider a decision made by VPCC to reduce or deny covered services.
Authorization	The process of obtaining prior approval from the health plan before rendering specified services or procedures to a member.
CCC By Virginia Premier	VPCC is a Medicare-Medicaid Plan contracted with the Centers for Medicare and Medicaid Services and the Department of Medical Assistance Services to provide healthcare services for dual eligible members in the Central Virginia/Fredericksburg & Surrounding Counties, Tidewater/Rural Tidewater, Western and Southwestern areas of the state.
Centers for Services (CMS) Medicare & Medicaid	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.
Claim	An itemized statement of services rendered by healthcare providers (such as hospitals, physicians, dentists, etc). billed electronically or on HCFA 1500 UB 04.
Clean Claim	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.
Complaint	Any oral or written communication made by or on behalf of a member expressing dissatisfaction with any aspect of the Health Plan's, providers, or State's operation, activities or behavior regardless of whether a remedial action is requested.
Co-payment	The member's portion of the payment due at the time of service.

DMAS	Department of Medical Assistance Services (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).
DSS	Department of Social Services (DSS).
Emergency	A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent lay-person who 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.
Member	A member who is enrolled with VPCC to receive healthcare services.
Enrollment Broker	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 and may include recipient marketing and outreach.
Fee for Service	The traditional healthcare 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.
Fraud	Intentional deception or misrepresentation made by a person or entity with the knowledge that the deception could result in payment of an unauthorized benefit.
Grievance	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 VPCC Continuous Quality Improvement Committee (CQIC) and are related to the availability, delivery or quality of healthcare services

including the utilization review decisions that are adverse to the member or the payment or reimbursement of healthcare service claims.

HMO	Health Maintenance Organization (HMO). A medical care organization to deliver and finance healthcare 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.
Health Risk Assessment (HRA)	A comprehensive assessment of an Member's medical, psychosocial, cognitive, and functional status in order to determine their medical, behavioral health, LTSS and social needs
Interdisciplinary Care Team (ICT)	A team of professionals that collaborate, either in person or through other means, with the Member to develop and implement a Plan of Care that meets their medical, behavioral, long term care and supports and social needs. ICTs may include physicians, physician assistants, long-term care providers, nurses, specialists, pharmacists, behavior health specialists, and/or social workers appropriate for the Member's medical diagnoses and health condition, co-morbidities, and community support needs. ICTs employ both medical and social models of care.
Managed Care	Use of a planned and coordinated approach to provide healthcare with the goal of quality care at a lower cost. Usually emphasizes preventive care and often associated with an HMO.
Medicare-Medicaid Plan (MMP)	A product offered by Virginia Premier who has entered into a contract with CMS and DMAS to participate in the CCC by Virginia Premier program.
Medicaid	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.
Medical Necessity	Services sufficient in amount, duration, scope and environment to improve health status.
Medicare	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 member's with the option of receiving Part A and Part B services through a private health plan. Medicare Part D provides outpatient prescription drug benefits.

Member	An individual who is eligible for Medicaid/FAMIS Plus and who is currently enrolled with VPCC. All members are assigned a PCP to provide and/or coordinate all healthcare services.
Minimum Data Set	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.
Model of Care (MOC)	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.
NCQA	National Committee on Quality Assurance. A not-for-profit organization performing accreditation review of managed care plans.
Network Provider	The healthcare entity or healthcare professional that has a contract with VPCC or its subcontractor to render covered services to members.
Non-par Provider	Non-participating Provider – a healthcare entity or healthcare provider who is not contracted with VPCC to provide services to members. Often referred to as an “out of network” provider.
Options	One of three managed care programs administered by DMAS. Options are 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.
PCP	Primary Care Physician (PCP) - 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.

**Plan of Care
(POC)**

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.

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.