

VA Premier CompleteCare

a Commonwealth Coordinated Care Plan

Virginia Premier CompleteCare Provider Resource Guide



Info in this Resource Guide

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- Checking Eligibility
- Getting an Authorization
- Claims Submission
- Getting Help with Claims
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Our Clearinghouses

We participate with:



- **Christina Chewning Phone: 813-363-5255**
- **christina.chewning@availity.com**



- **To Enroll Contact RelayHealth Support:**
- **RelayHealth Support**
- 877-684-9625, Option 1
DBQTSHInsuranceSupport@relayhealth.com

Our Clearinghouses

- Virginia Premier is pleased to be partnering with two of the largest clearinghouses in the industry to provide a full range of electronic capabilities for our CompleteCare providers and network partners.
- Please contact your clearing house to verify they work with one of these clearing houses.



- **Available Transactions:**

Claims – 837P and 837I, 835 remittances, 276/277 Claim Status
Eligibility – 270/271

- **Payer IDs:**

Institutional Claims: VPCCI
Professional Claims: VPCCP



- **Provider Must Check Eligibility Monthly**
- Establish a “Best Practice”
- Once you have determined the individual is enrolled with CCC, contact the MMP to speak with the Members Care Manager or Team.

Checking Eligibility

- A member's eligibility should be checked through DMAS and confirmed by Virginia Premier CompleteCare.
- If you have the Member's Medicaid Number, you may determine in which Health Plan the Member has enrolled through the DMAS website
- The VPCC Member Services call center can confirm a member's eligibility.
- You can reach us at **1-855-338-6467**.

Use our Provider Portal!

- Member's Eligibility can be confirmed through the VPCC Portal, **Premier**Connect.
- Follow the steps below to access the portal:
 - www.vapremier.com
 - Providers
 - CompleteCare(Medicare-Medicaid)
 - Provider Portals
 - Login
- If do not already have a portal account, please follow the steps below to have an account created for you:
 - www.vapremier.com
 - Providers
 - CompleteCare(Medicare-Medicaid)
 - Provider Portals
 - New Users

Getting an Authorization

Call us!

- Our Medical Management team is standing by to assist you with getting an authorization
- They can be reached at **1-888-251-3063**
- We also welcome your faxed authorization requests. The authorization form can be found on our website and the fax number is **1-877-739-1364**

There are three ways!

- You can enter your 1500 claim using our provider portal

www.vapremier.com/providers/completeca-re-overview/provider-portals/

- Or by using one of our clearinghouses – Availity or RelayHealth

Claims Submission

Paper Claims should be submitted to the following addresses:

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

Only claims submitted on official red and white **UB04 or CMS 1500 forms** will be accepted.
Paper claims must be electronically created.

Getting Help with Claims

Call us!

- Our Customer Service Team is standing by to assist you with any claim issues you may be having
- Call us at **1-855-338-6467**
- Your Provider Service Representative or your regional Long Term Services and Supports Manager can also help you with any issues that you may have
- You can reach them at vphpnetdev@vapremier.com or by calling our Provider Services line at **1-855-338-6467**

- **PaySpan-** Virginia Premier CompleteCare offers EFT services through PaySpan
- To receive EFT, you must register with PaySpan directly.
- To Register at <https://www.payspanhealth.com>
- If you need additional assistance or have questions, please contact PaySpan
 - Email: providersupport@payspanhealth.com
 - Call: Provider Services Team 1-877-331-7154, Option 1. They are available to assist Monday through Friday from 8am to 8pm, Eastern Time.

Scheduling Transportation

Call us!

- Please contact our Member Services call center to get help with scheduling transportation.
- You can reach us at 1-855-338-6467.
- **Routine Transportation requires 72 Hours Notice**

Our Call Centers

Member Services

- 1-855-338-6467

Claims Customer Service

- 1-855-338-6467

Organizational Determinations

- 1-888-251-3063

Provider Services

- 1-855-338-6467

Case Management

- 1-855-338-6467

Long Term Support Services



LTSS Providers

- Adult Day Health Care
- Personal Care
- Respite Care
- Personal Emergency Response Systems (PERS)
- Medication Monitoring
- Service Facilitators
- Skilled Nursing Facilities



- All LTSS services shall require prior authorization and approval of services is based on the DMAS screening tools and criteria and LOC assessment and score if applicable.
- The PAS team should send all screening documents (UAI, DMAS-97 and DMAS-96) to Virginia Premier CompleteCare. The pre-authorization process allows Virginia Premier CompleteCare to:
 - Verify the member's eligibility
 - Determine the services required to meet the Member's need
 - 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
 - Honor all prior authorizations or plans of care (POC)
 - Make sure that the chosen provider is in the Virginia Premier CompleteCare network
 - Evaluate the medical necessity criteria for the service
 - Update the members POC



Call a Care Manager (1-855-338-6467)

Fax Forms (1-877-739-1366)

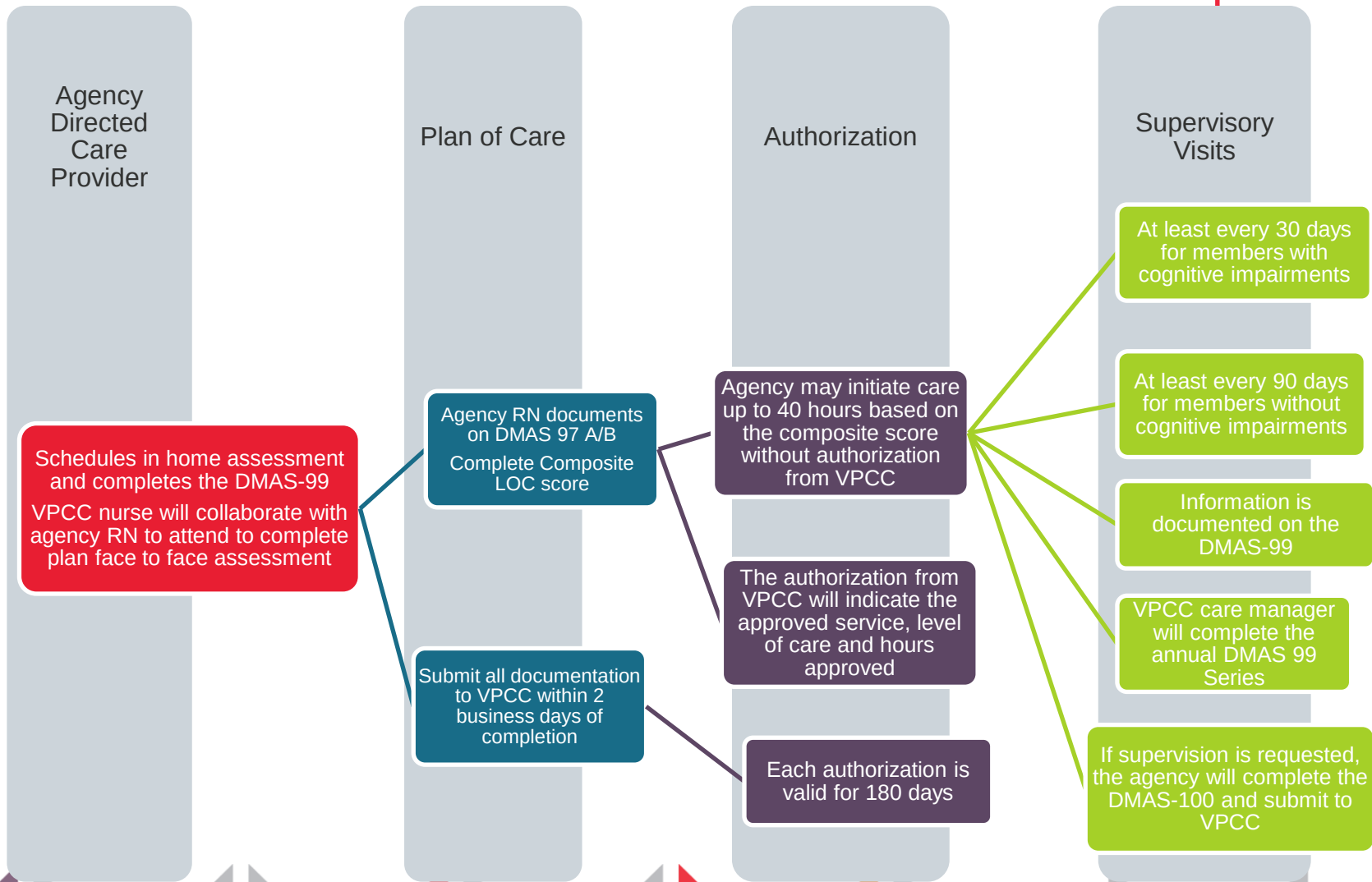
- Utilize current DMAS forms for submission of information to Care Manager for authorization and updates.
- The PAS team will complete the UAI, DMAS-97 and DMAS-96 to determine if the member meets nursing facility level of care criteria or EDCD enrollment. Once the PAS and member identify needed services, the member, family, caregivers or authorized representative will possibly choose the desired delivery model such as Adult Day Health Care

- If a provider for ADHC has not been selected by the member and family, our care manager will assist in selecting an ADHC provider and we will issue an authorization to the selected ADHC provider.
- You will complete the DMAS-301 (Adult Day Health Care Interdisciplinary Service Plan) and submit it to us.
- Goal oriented progress notes are required to be documented at least every 30 days. Our 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. Our care manager will also complete the annual DMAS 99 Series.

- If the member is referred directly to the ADHC, we will issue an authorization for up to five (5) visits upon receipt of the request. This allows time for the ADHC to develop the plan of care. The POC must be submitted to our Care Manager prior to the 5th visit for continuation of the authorization.
- Our Care Manager will authorize any increase in days of service, either at the time of enrollment or afterward. The ADHC Center will contact our Care Manager and provide the reason the increase in days of service is needed;

Note: If the Enrollee receives personal care under the ED CD Waiver, the ADHC Center must have the provider information for the personal care provider/Services Facilitator and must know how personal care services will be affected by the increase in the days of service.

Personal Care-Agency Directed (AD)



- If consumer directed care is selected, the Pre-Admission Screener (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.

- 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 previously 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 for up to 180 days
- 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 non routine, 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.

- 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 the criteria for PERS. A provider of the other EDCD services can complete the form and send it to a Virginia Premier CompleteCare 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 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.

- 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
- Virginia Premier's care manager will complete the annual DMAS 99 Series
- Authorizations are valid for 180 days
- Members may keep their service facilitator if out of network for 180 days of enrollment or until their authorization expires. Virginia Premier will work with the service facilitator and member to avoid any disruption in care

- The process to determine hours does not change with CCC - CompleteCare.
- Our Care Managers should not be increasing hours without communicating with the Service Facilitator
- If you encounter a discrepancy in authorized hours, please contact the member's Care Manager immediately. If resolution is not received please contact **Lisa Wheat**.
- Any revision of the Plan of Care should include the SF

- For Consumer Directed ED CD Members, **VPCC no longer requires the Service Facilitator authorizations.** These services will be included on the No Prior Authorization list.
- If for some reason the SF needs to exceed the allotted amount, they will then contact the member's Care Manager for authorization.
- **99509-service facilitation routine visit (allowed 8 per year)**
- **H2000-service facilitation initial comprehensive visit (allowed 1 per year)**
- **S5109-service facilitation consumer training visit (allowed 2 per year)**
- **S5116-service facilitation management training hours (allowed 2 per year)**
- **T1028-service facilitation reassessment visit (allowed 2 per year)**



Call VPCC Care Manager (8a-5p)
(855) 338-6467



Fax Requests/Forms
(877) 739-1366



To speak to a Care Manager after
Normal Business Hours for urgent
needs
(800) 256-1982



Uniform Pre-Authorization/Authorization Process between MMPs and Nursing

- There will be a clear identification of Commonwealth Coordinated Care (CCC) beneficiaries on the insurance card
- All MMPs will use the CMS criteria for the SNF admission as outlined in Chapter 8 of the CMS Benefits Policy Manual criteria
- Each MMP will provide a list of home health, DME companies that are participating with MMP. MMPs will keep this list current on their web portals.
- All MMPs agree to a 7 day authorization. The SNF/NF shall notify the appropriate MMP via fax or web submission on the day of admission. The MMP and the SNF/NF will begin to work collaboratively on the case during that 7 day period to determine ultimate disposition and plan for the beneficiary.

Referrals from Community/ED/Observation Stay/Inpatient Hospital Stay/Home Health

- Physician Order that beneficiary needs inpatient SNF stay
- The following is required when a member is referred from the Community/ED/Observation Stay:
 - Physician Order;
 - History and Physical;
 - MDS;
 - Medication List;
 - Prior Level of Function; and
 - Projected discharge plan.
- Providers must submit via Fax or Online notification through the MMP web portal that patient met criteria and has been admitted
- PT,OT, ST-Evaluation must be completed at center within 48 hours of admission
- All MMPs agree to a 7 day authorization. The SNF/NF shall notify the appropriate MMP via fax or web submission on the day of admission. The MMP and the SNF/NF will begin to work collaboratively on the case during that 7 day period to determine ultimate disposition and plan for the beneficiary.
- The MMPs will make patient information available to the SNF/NF via the web portal. At this time, the MMPs cannot commit to implementing an electronic interface with EMR systems currently in use by various facilities.

Uniform update/review period -

- The MMPs agree that after the initial 7 day authorization period, future decisions will be made based on medical necessity.
- The MMPs will notify the member beneficiary in the event of a non-coverage determination 48 hours prior to non-coverage. Facility is required to respond within 24 hours to requests for supporting documentation once an appeal has been initiated by the beneficiary. Coverage continues through denial or approval process.
- MMP and SNF must be in agreement on the discharge destination prior to 48-hour notice (patient has met goals and is safe to transition to the next setting)

Patients in the NF Receiving Long Stay Services That Require Skilled Care and Meet SNF Criteria

- The NFs must have a physician order that indicates the patient needs skilled services. This must be faxed or submitted online to notify the MMP; this must be done within 24 hours of the change in status.
- The MMPs agree to authorize all care at skilled rate until care is determined not to be medically necessary.
- MMPs agree that all future authorizations will be done based on medical necessity.

Referrals from Community/ED/Observation Stay to a NF for Long Stay Services

- The following is required when a member is referred from the Community/ED/Observation Stay to a NF for Long Stay Services:
 - Physician Order;
 - History and Physical;
 - MDS;
 - Medication List;
 - Prior Level of Function; and
 - Projected discharge plan.
- Providers must submit via Fax or Online notification through the MMP web portal that patient met criteria and has been admitted
- PT,OT, ST-Evaluation must be completed at center within 48 hours of admission
- All MMPs agree to a 30 day authorization given at admission. The SNF/NF shall notify the appropriate MMP via fax or web submission on the day of admission.
- 30-day authorization given at admission.
- Database available that would interface with NF electronic medical record that updates could be sent on line (different system may be developed for those NFs not utilizing EMRs)
- Recertification for NF services by the attending physician annually.

Patients no longer meeting Skilled Level of Care that are unable to be discharged safely into the community

- Consistent with current DMAS practice the MMP agrees to work with the SNF/NF to develop a safe discharge for patients that no longer meet nursing facility level of care criteria. If there is no safe alternative the MMPs agree to pay the NF at the established rate until discharge. Active discharge planning will be coordinated between the plan and SNF with weekly communication between the MMP and the NF to ensure that a safe discharge plan is following a reasonable timeline.

General footnote:

- Parties agree to revisit this process after January 1, 2015 to see if it is meeting both the clinical and administrative objectives of both parties and agree to work cooperatively to resolve any issues.

- 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 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

Intermediate/Long-term Facility Care

- The Pre-Admission Screener (PAS) or inpatient facility completes the UAI, DMAS 97 and DMAS 96 and submit 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.
- Virginia Premier will provide a thirty (30) day prior authorization for members who are discharged from an inpatient stay or ED after normal business hours and during weekends when there was not an opportunity to coordinate the discharge during normal business hours
- 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
- Members requiring skilled services while in custodial care will be authorized by Virginia Premier care manager upon notification

- 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



Call (Skilled Nursing
Authorization)
(888) 251-3063



Fax
(877) 739-1366 Custodial
(877) 739-1364 Skilled



To speak to a VPCC Care
Manager
(855) 338-6467



Behavioral Health Services



Virginia Premier CompleteCare has Partnered with Magellan Health Services!

- Effective October 6, 2014, all **behavioral health** and **substance abuse** service authorizations should be directed to Magellan Healthcare, Inc.
- Authorization request forms are available on the Virginia Premier CompleteCare website www.vapremier.com/providers/complecare-overview/provider-forms-library for the following services:

Mental Health Skill Building
Psychosocial Rehabilitation
Intensive Community Treatment

These forms should be faxed directly to Magellan at **1-866-354-8758**.

- Please call Magellan at **1-800-424-4971** for all other behavioral health or substance abuse service authorizations.
- More information about Magellan can be found on our website at:
<https://www.vapremier.com/providers/complecare-overview/behavioral-health-services>

Community Mental Health & Rehab Services

Service Title	Unit of Service	Authorization duration	Billing Code	Notes
Psychosocial Rehabilitation Assessment	1 unit of the service	Authorization not needed.	H0031	
Psychosocial Rehabilitation	One unit = 2 To 3.99 hours per day Two units = 4 to 6.99 hours per day Three units = 7 + hours per day	6 months	H2017	Prior Authorization Required Note: The assessment services does not require an authorization.
Mental Health Skill Building Assessment	1 unit of the service	Authorization not needed.	H0032-U8	
Mental Health Skill Building	1-2.99 hours per unit Time may be accumulated to reach a billable unit.	6 months	H0046	All services must be direct face-to-face contacts to be reimbursed Prior Authorization Required Note: The assessment services does not require an authorization.
Intensive Community Treatment Assessment	1 unit of the service	Authorization not needed.	H0032-U9	Each provider will be reimbursed for up to 2 assessments per member per fiscal year
Intensive Community Treatment	1 hour	26 weeks	H0039	Prior Authorization Required Note: The assessment services does not require an authorization.
Crisis Intervention	15 minutes	Authorization not required	H0036	Notification required at the start of services.
Crisis Stabilization	1 hour	Authorization not required	H2019	Notification required at the start of services.

Community Mental Health & Rehab Services

Service Title	Unit of Service	Authorization duration	Billing Code	Notes
Day Treatment/Partial Hospitalization Services	Sessions of two (2) or more consecutive hours per day are provided.	Prior Authorization required 30 days		The day treatment center could be attached to a psychiatric hospital or CSB clinic site.
Opioid Treatment	1 unit = 15 minutes	No Authorization Required	H0020	Opioid drugs may be billed separately as a Pharmacy Point of Service claim or by using the appropriate HCPCS code.
Residential Substance Abuse Treatment for Pregnant and Post Partum Women		Prior Authorization Required 60 days	H0018	No reimbursement for any other Community Mental Health/Mental Retardation/Substance Abuse rehabilitative services are available while the Enrollee is participating in the program. A unit of service is one day.
Substance Abuse Crisis Intervention	1 unit = 15 minutes	No Authorization Required	H0050	Notification required at the start of services.
Substance Abuse Day Treatment	1 unit = 15 minutes	Prior Authorization required 6 months	H0047	Substance abuse day treatment may not be provided concurrently with intensive outpatient opioid treatment services.

Community Mental Health & Rehab Services

Service Title	Unit of Service	Authorization duration	Billing Code	Notes
Substance Abuse Day Treatment for Pregnant and Post Partum Women	One unit = 2 to 3.99 hours per day Two units = 4 to 6.99 hours per day Three units = 7 + hours per day	Prior Authorization required 60 days	H0015	
Substance Abuse Intensive Outpatient Treatment	1 unit = 15 minutes	Prior Authorization required 6 months	H2016	The maximum number of service hours per week is nineteen (19) hours per week.
Substance Abuse Case Management	1 unit = 15 minutes	Prior Authorization Required. Authorization duration = 3 months (submission of ISP)	H0006	No other type of case management may be billed concurrently with substance abuse case management.
Targeted Case Management (TCM)				Carved out and continues to be reimbursed by DMAS. Virginia Premier CompleteCare Manager to coordinate with CSB TCM and include them in the ICT.

- Outpatient mental health and substance abuse services are provided in a practitioner's office, mental health clinic, individual's home or nursing facility
- Requires an active written treatment plan
- Medication management does not require an authorization



Call
(888) 251-3063



Fax to Magellan at
(866) 354-8758



To speak to a VPCC Care
Manager
(855) 338-6467

Home Health



- Evaluation assessment does not require authorization
- Continued home health visits require authorization
- Submit assessment notes or OASIS if complete for authorization of Episode
- OASIS reassessment due to VPCC every 60 days

- If sufficient clinical information is submitted prior to Start of Care, VPCC will authorize the episode.
- If sufficient information is not available prior to SOC, submit clinical information after initial assessment and OASIS within 72 hours of SOC
- Submit Recertification OASIS within 5 days from the end date of the current episode.

- Homebound status, when applicable must be noted in the clinical documentation.
- If member does not meet CMS Homebound Status Criteria, reimbursement will be paid per Medicaid FFS.
- Provider shall include the physician certification with the clinical documentation sent to Virginia Premier CompleteCare.

- Provider shall submit the POC with the OASIS.



Call (888) 251-3063



Fax

(877) 739-1364



To speak to a Care Manager

(855) 338-6467

Thank You!

VAPremier
CompleteCare

**Thank you for participating with
Virginia Premier CompleteCare!**

