

Provider Manual

2015-2016

Corporate Office

600 East Broad Street
Suite 400
Richmond, VA 23219

Tidewater

825 Greenbrier Circle
Suite 200
Chesapeake, VA 23320

Roanoke

5060 Valley View Boulevard NW
Roanoke, VA 24012

Bristol

105 Village Circle
Bristol, VA 24209



Dear Provider:

Thank you for agreeing to become a participating provider for Virginia Premier Health Plan, Inc (VPHP). Attached is the 2015-2016 Virginia Premier Provider Manual with the information you need to answer questions related to pre-authorizations, claims, appeals and grievances, credentialing/re-credentialing, quality and utilization management programs, 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	Utilization Management Program Description
Exhibit I	Credentialing Program Description
Exhibit J	Practitioner Golden Globe Award
Exhibit K	Questions to Ask Your Doctor
Exhibit L	20 Tips to Prevent Medical Errors
Exhibit M	Bereavement Program
Exhibit N	Virginia Health Care Decisions Act
Exhibit O	Clinical Practice Guidelines

To request a hard copy of the manual or to receive additional provider training, please contact your Provider Services Representative. Should you have questions, concerning the manual, please contact your Provider Services Representative at the numbers listed below:

Central Virginia	(800) 727-7536
Roanoke	(888) 344-8838
Tidewater	(800) 828-7989
Bristol	(276) 619-0963

Thank you,

Network Development

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

Central Virginia	(800) 727-7536
Roanoke	(888) 344-8838
Tidewater	(800) 828-7989
Bristol	(866) 285-8963



Introduction and Welcome

Virginia Premier Health Plan, Inc. (VPHP) is pleased to welcome you to its participating provider network. At Virginia Premier, our sole mission is to improve the health care status of the Medicaid and Family Access to Medical Insurance Security Plan (FAMIS) population in the Commonwealth of Virginia. We believe these under-served populations are entitled to the same quality health care as commercially insured populations, but require a focused approach that is specifically designed to meet the needs of these unique populations.

Our Mission

Virginia Premier Health Plan, a managed care organization partnered with Virginia Commonwealth University Health System, 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 Health Plan will:

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

How to Reach Us

Virginia Premier Health Plan Directory

Contact	Central Virginia/ Fredericksburg/Western	Tidewater
Physical Address	Virginia Premier Health Plan, Inc. 600 East Broad Street, Suite 400 Richmond, Virginia 23219-1800	Virginia Premier Health Plan, Inc. 825 Greenbrier Circle Suite 200 Chesapeake, VA 23320
Mailing Address	Virginia Premier Health Plan, Inc. P.O. Box 5307 Richmond, Virginia 23220- 0307	Virginia Premier Health Plan, Inc. P.O. Box 62347 Virginia Beach, VA 23466-2347
Phone Numbers	(804) 819-5151 (800) 727-7536	(757) 461-0064 (800) 828-7989
Fax Numbers	(804) 819-5187	(757) 459-2230
Medical Management (Referrals and Authorizations) Phone Numbers	(804) 819-5151, press 3 (888) 251-3063	(757) 461-0064, press 3 (888) 251-3063
Medical Management (Referrals and Authorizations) Fax Numbers	(804) 819-5186 (866) 284-1057 <u>Behavioral Health</u> (804) 819-1727 (877) 689-2276	FAX (757) 466-1133
After Hours Nurse Advice Line	(800) 256-1982	(800) 256-1982
Provider Services	(804) 819-5151, press 6	(757) 461-0064, press 6
Member Services Toll Free Number	(804) 819-5151, press 1 (800) 289-4970, press 1	(757) 461-0064, press 1(800) 828-7953, press 1
VPHP Eligibility Verification	(804) 819-5151, press 1 (800) 289-4970, press 1	(757) 461-0064, press 1 (800) 828-7953, press 1
DMAS AVRS Line (Automatic Voice Response System)	(800) 884-9730	(800) 884-9730
Transportation	(804) 819-5151, press 2 (800) 727-7536, press 2	(757) 461-0064, press 2 (800) 828-7953, press 2
Claims Inquiries	(804) 819-5151, press 4 (800) 727-7536, press 4	(804) 819-5151, press 4 (800) 727-7536, press 4

Contact	Western	Roanoke
Physical Address	N/A	Virginia Premier Health Plan, Inc. 5060 Valley View Blvd. NW Roanoke, Virginia 24012 P.O. Box 1751
Phone Numbers	(804) 819-5151 (800) 727-7536	(540) 344-8838 (888) 338-4579
Fax Number	540-344-6007	(540) 344-4484
Medical Management (Referrals and Authorizations)	(804) 819-5151, press 3 (888) 251-3063 Fax (804) 819-5186 or (866) 284-1057	(540) 344-8838, press 3 (888) 338-4579 Fax (540) 344-8007 or (800) 827-7192
After Hours Nurse Advice Line	(800) 256-1982	(800) 256-1982
Provider Services	(804) 819-5151, press 6	(540) 344-8838, press 6 (540) 432-8783 Fax
Member Services	(804) 819-5151, press 1	(540) 344-8838, press 1
Toll Free Number	(800) 289-4970, press 1	(888) 338-4579
VPHP Eligibility Verification	(804) 819-5151, press 1 (800) 289-4970, press 1	(540) 344-8838, press 1 (888) 338-4579
DMAS AVRS Line (Automatic Voice Response System)	(800) 884-9730	(800) 884-9730
Transportation	(804) 819-5151, press 2 (800) 727-7536, press 2	(804) 819-5151, press 2 (800) 727-7536, press 2
Contracting	(804) 819-5151 (800) 727-7536	(804) 819-5151 (800) 727-7536
Claims Inquiries	(804) 819-5151, press 4 (800) 727-7536, press 4	(804) 819-5151, press 4 (800) 727-7536

Contact	Far SW/Abingdon
Physical Address	Virginia Premier Health Plan, Inc. 105 Village Circle Bristol, VA 24209
Phone Numbers	(276) 619-0963 (800) 727-7536
Fax Number	(276) 619-0967
Medical Management (Referrals and Authorizations)	(800) 727-7536, press 3 Fax (804) 819-5186 or (866) 284-1057
After Hours Nurse Advice Line	(800) 256-1982
Provider Services	(276) 619-0963 (866) 285-8963 option 6
Member Services	(804) 819-5151, press 1
Toll Free Number	(800) 727-7536
VPHP Eligibility Verification	(800) 727-7536, press 1
DMAS AVRS Line (Automatic Voice Response System)	(800) 884-9730
Transportation	(800) 727-7536, press 2
Contracting	(804) 819-5151 (800) 727-7536 press 6
Claims Inquiries	(800) 727-7536, press 4

Service Regions

Central Virginia		
Amelia	Hanover	Petersburg
Brunswick	Henrico	Powhatan
Charles City	Hopewell	Prince Edward
Chesterfield	King William	Prince George
Colonial Heights	Lunenburg	Richmond City
Cumberland	Mecklenburg	
Dinwiddie	New Kent	
Goochland	Nottoway	
Far Southwest		
Bland	Grayson	Smyth
Bristol	Lee	Tazewell
Buchanan	Norton	Washington
Dickenson	Russell	Wise
Galax	Scott	
Fredericksburg		
Fredericksburg	Spotsylvania	Westmoreland
King George	Stafford	
Roanoke		
Amherst	Danville	Patrick
Appomattox	Floyd	Pittsylvania
Bedford City/County	Franklin County	Pulaski
Blacksburg City	Giles	Radford
Botetourt	Halifax	Roanoke City/County
Buena Vista	Henry	Rockbridge
Campbell	Lexington	Salem
Carroll	Lynchburg City	Wythe
Charlotte	Martinsville	
Christiansburg City	Montgomery	
Tidewater		
Accomack	Isle of Wight	Suffolk
Chesapeake	Newport News	Surry
Emporia	Norfolk	Sussex
Franklin County	Northampton	Virginia Beach
Greensville	Portsmouth	
Hampton	Southampton	
Western Virginia		
Albemarle	Covington	Nelson
Alleghany	Fluvanna	Page
Augusta	Frederick	Rockingham
Bath	Greene	Shenandoah
Buckingham	Harrisonburg	Staunton
Charlottesville	Highland	Waynesboro
Clarke	Louisa	Winchester City

Transportation Services

Virginia Premier Health Plan, Inc. owns and operates its own transportation service for our members. Our vans will transport patients 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 caseworker for re-certification. This service is offered to VPHP members free of charge.

To arrange for transportation services call:

(804) 819-5151 (press 2) or 1-800-727-7536
(Richmond/Central Virginia/Fredericksburg/Western)

(540) 344-8838 or 1-888-338-4579 (Roanoke)

(757) 461-0064 (press 2) or 1-800-828-7953 (Tidewater/Rural Tidewater)

(800) 727-7536 option 2 (Bristol Area)

To schedule transportation for an appointment members are required to call the VPHP Member Services Department at least 72 business hours prior to their scheduled medical appointment time. The Member Operations Representative will verify the member's eligibility and obtain the member's name, address, telephone number, date, time, and location of the appointment as well as 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 VPHP'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 be coordinated through the VPHP Transportation department.

Private or "911" ambulance service is available for members whose medical condition precludes the use of VPHP's regular van service. Transportation that requires non-emergent ambulance transfer should be coordinated with VPHP's Transportation department.

**Non-emergent transportation is NOT covered for FAMIS recipient.*

ID Cards and Eligibility

New Member Information

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

- Welcome Letter
- Member Handbook Evidence of Coverage which details about:
 - Your Primary Care Physician
 - How to make appointments
 - When you need a specialist
 - After hours care
 - Appropriate use of the Emergency Room
 - Benefits Summary
 - Member Services
 - Member Identification Card
 - Health Education Materials
 - Transportation Information

Eligibility Verification

Each new member enrolled in Virginia Premier Health Plan, Inc. 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 VPHP directly.

VPHP 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 VPHP members you may utilize the IVR or speak with a representative by calling:

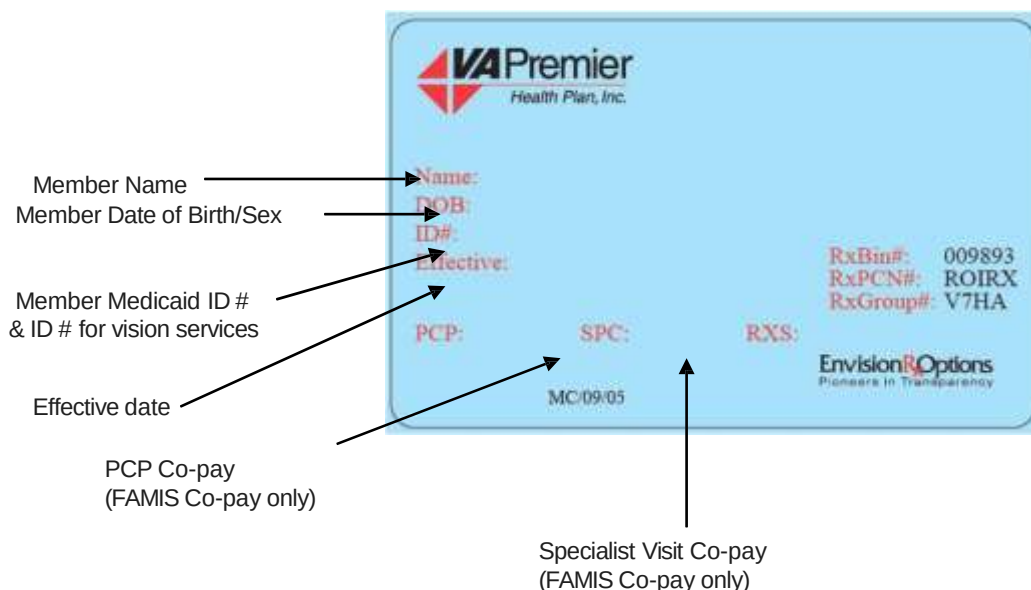
Richmond/Western	(804) 819-5151 press 1 (800) 289-4970
Tidewater	(757) 461-0064 press 1 (800) 828-7953
Roanoke	(540) 344-8838 press 1 (888) 338-4579
Bristol	(800) 727-7536 press 1
DMAS AVRS Line	(800) 884-9730
NaviNet	www.Navinet.net

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. There are three identification cards:

Blue = Medallion	Pink = FAMIS (Co-pays are applicable)	White = FAMIS MOMS
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Front of Member Identification Card



Back of Member Identification Card

The back of the member identification card contains helpful reminders to our member along with instructions on how to reach us.

Members:

1. If medical assistance is needed when your doctor's office is closed, please call: **VPHN Nurseline 1-800-256-1982**
2. Do not let anyone else use this card. Call VA Premier to report a lost or stolen card. **If you lose your eligibility for health benefits, this card is no longer valid.**
3. If you have questions, call the Member Services Department, Monday - Friday, 8:00a.m. - 5:00p.m. **Richmond: (804-819-5151)** or (1-800-289-4970)
Tidewater (757-461-0064) or (1-800-828-7953) **Roanoke (540-344-8838)** or (1-888-338-4579).
4. **If you have questions about your prescriptions or pharmacies, please call EnvisionRxOptions at 1-855-872-0005**

Call at least 72 hours in advance for medical transportation Mon. - Fri., 8:00a.m. - 5:00p.m.

Providers: For Authorizations, please contact our UM Department
1-888-251-3063. Pharmacies may call 1-855-872-0005.

HMO Claims Address:

Virginia Premier Health Plan Inc. P.O. Box 5207 • Richmond, VA 23220-0208

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, applicable co-payment amount and medication 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;
- PCP should check their member enrollment listing;
- Refer patients to in-network specialist for services. If referrals are being made to a non-participating specialist, call VPHP to obtain an authorization prior to specialty services being rendered;
- Specialist should check to make sure an appropriate authorization is on file prior to rendering services (if applicable); and
- Submit claims in accordance to timely filing guidelines with correct coding and diagnosis to ensure you are reimbursed for services.

Co-payments and Coinsurance

VPHP FAMIS Plus/Medallion 3.0 members have no co-payments or coinsurance.

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

Primary Care Physicians

Role of the Primary Care Physician

Primary Care Physicians (PCPs) in the VPHP network include Board Certified or Board Eligible practitioners in the fields of Internal Medicine, General Practice, Family Practice and Pediatrics. Each VPHP member chooses a PCP who assumes responsibility for the management of our member's health care needs. An Obstetrician may assume care for members during pregnancy, but generally will refer back to the PCP for health care issues unrelated to the pregnancy.

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

- Maintain and provide to VPHP, medical and other such records and information to 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;
- Performing 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;
- Generating referrals to in-network specialist when services cannot be performed by the PCP;
- Contacting VPHP to obtain necessary prior authorization for designated services (e.g. out of network referrals, specified diagnostic tests); and
- Complying with all established VPHP policies and procedures as documented in this provider manual.

Nurse Advice Line

The Primary Care Physician is the primary source of medical care for our members and acts as the health care 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. After hours, in non-emergent situations, members may contact the Nurse Advice Line at: **(800) 256-1982**

The responding nurse will give self-care instructions, or direct the member to a physician or facilities for routine, urgent or emergency care.

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. Please refer to this list 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 VPHP participating PCP whose panel is open to accepting new members and who matches the member's age category.
- If the member does not select a PCP, VPHP 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, age category, language requirements, as well as geographic proximity to the provider.
- VPHP 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 VPHP members paneled to that provider.

Members may request a change to their PCP assignment at any time. Changes received during the current month will be made effective for the following month. PCP's who are not on a capitated reimbursement model will still receive reimbursement for services rendered to VPHP members regardless if the PCP's name is printed on the member's card or not.

Member/Provider Incompatibility

VPHP recognizes that the physician-patient relationship is a personal one and may become unsatisfactory to either party. VPHP 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 VPHP 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. Both the member and the provider will receive written notification of PCP transfers. The notification will include the effective date of the transfer.
- The new PCP is responsible for contacting the member's former PCP to arrange for the transfer of any medical records in order to ensure continuity of care.
- Capitation adjustments, member listings, and payment adjustments 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 VPHP'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 PCP's Request:

Primary Care Physicians have the right to request that a member be transferred to another participating PCP. Requests for member transfer may be initiated by telephone, but must also be submitted in writing to VPHP'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 until that the transfer to another PCP has taken place. Mail or Fax your request to:

Central Virginia / Western

Virginia Premier Health Plan, Inc
Member Services Department
P.O. Box 5307
Richmond, Virginia 23220-0307
FAX (804) 819-5187

Tidewater / Rural Tidewater

Virginia Premier Health Plan, Inc.
Member Services Department
P.O. Box 62347
Virginia Beach, VA 23466-2347
FAX (757) 459-2230

Roanoke / Bristol

Virginia Premier Health Plan, Inc.
Member Services Department
105 Village Circle
Bristol, VA 24209 FAX (276)
619-0967

Change in Member Status

VPHP members may be dis-enrolled from VPHP by the Department of Medical Assistance Services (DMAS) if the member no longer meets DMAS' eligibility requirements for HMO enrollment. PCPs are responsible for notifying VPHP's Member Services Department if they know of a member's change in eligibility status, e.g. admission to an extended care facility.

Sample Member Listing Report

Enrollee by Primary Care Provider

Group= eligibility category:
Aid to Dependent Children (ADC), Aged, Blind, Disabled (ABD) or FAMIS

10/09/99

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

Page 1

PCP	Name	POL#	Eff Date	Term Date	Status	Cont Type	Member Type	MedP	Employer Group	Plan	PCP	HMO
Welby MD, Marcus A	#9998											
	ADAMS, PATIENT	760100000000	12/01/98		ACTIV	NAP	SELF	MRP	XXVAC	ADC	VA Premier	MAW
	ARNOLD, PATIENT	760100000000	10/01/99		ACTIV	NAP	SELF	MRP	XXVAC	ADC	VA Premier	MAW
	BAKER, PATIENT	041100000000	04/01/99		ACTIV	NAP	SELF	MRP	XXVAC	ADC	VA Premier	MAW
	BROOKS, PATIENT	087100000000	09/01/99		ACTIV	NAP	SELF	MRP	XXVAC	DISAB	VA Premier	MAW
	CARTER, PATIENT	760100000000	07/01/96		ACTIV	NAP	SELF	MRP	XXVAC	ADC	VA Premier	MAW
	DAVIS, PATIENT	760100000000	12/01/98		ACTIV	NAP	SELF	MRP	XXVAC	ADC	VA Premier	MAW
	JONES, PATIENT	760100000000	10/01/99		ACTIV	NAP	SELF	MRP	XXVAC	FAMIS	VA Premier	MAW
	LEWIS, PATIENT	041100000000	04/01/99		ACTIV	NAP	SELF	MRP	XXVAC	ADC	VA Premier	MAW
	OBRIEN, PATIENT	087100000000	09/01/99		ACTIV	NAP	SELF	MRP	XXVAC	DISAB	VA Premier	MAW
	PARKER, PATIENT	760100000000	10/01/96		ACTIV	NAP	SELF	MRP	XXVAC	ADC	VA Premier	MAW
	ROGERS, PATIENT	760100000000	10/01/99	10/30/99	ACTIV	NAP	SELF	MRP	XXVAC	ADC	VA Premier	MAW
	WILSON, PATIENT	041100000000	04/01/99		ACTIV	NAP	SELF	MRP	XXVAC	ADC	VA Premier	MAW
TOTAL: 11												

PCP Enrollment Totals

Effective Date

Termination Date

Immunizations

Primary Care Physicians are responsible for administering routine childhood immunizations to age appropriate VPHP members. Immunizations must be administered according to the recommended childhood immunization periodicity schedule. VPHP recommends administration of immunizations according to the Advisory Committee on Immunization Practices (ACIP). PCP compliance with immunization standards will be monitored through VPHP's provider office and medical record review. PCPs that provide services to adolescents and adults are also responsible for documenting and/or updating members' immunization status.

- For Medicaid/FAMIS Plus eligible members up to the age of 19 years, serums should be obtained through the Virginia Department of Health Vaccines for Children (VFC) program. The appropriate code for the vaccine administered should be used for billing. VPHP will reimburse providers the contractual allowable for each vaccine administered. These encounters must be submitted on a CMS 1500 claim form.
- If the member is 19 years of age or older, or if the member is eligible through the Family Access to Medical Insurance Security (FAMIS), they are not eligible for the Virginia Department of Health Vaccines For Children (VFC) program. Vaccines should be administered from the physician's stock and providers should bill VPHP using the appropriate CPT code for the vaccine or toxoid administered and any applicable vaccine administration codes. The provider will be reimbursed at the contracted fee.

"Catch-up" immunizations should be billed using a CPT code and will be reimbursed at the contracted rate for the vaccine and administration.

More information on the Virginia VFC program can be found at www.vdh.virginia.gov.

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) for pediatric vaccines or go www.vdh.state.va.us.

Early Periodic Screening, Diagnosis and Treatment (EPSDT)

EPSDT is the program designed to facilitate early identification of health problems through periodic well-child assessment; immunization and follow-through care to resolve any identified health problems. VPHP's EPSDT preventive health program targets members from birth up to age twenty-one (21) years.

EPSDT services are administered as part of the member's regular check-ups and include the following services as appropriate for the age and sex of the child:

- Complete unclothed physical examination
- Complete health history
- Developmental review
- Vision, hearing and dental review
- Measurements, blood pressure and vital signs
- Nutritional review
- Laboratory procedures including lead screening
- Immunizations
- Age appropriate counseling
- When a child arrives for an EPSDT screening appointment, ask to see the current VPHP ID card. A photocopy of this card should be made for your records. It will be necessary for PCPs to submit a CMS 1500 form for each encounter.
- Screen the child according to the procedures outlined in the periodicity chart and bill using the standard CMS 1500 claim form with appropriate CPT codes. These procedures are intended to provide an indication of the scope and depth of the EPSDT screening component and the frequency with which these services should

be performed. These procedures are minimum requirements and are not intended to restrict the physician's judgment as to the kinds of additional services required under individual circumstances. The need for additional services must be specifically documented in the child's chart.

- Screening results should be discussed with the parent(s) or guardian, explaining in detail the findings and any recommendations for diagnosis and treatment. Anticipatory guidance relevant to age and risk factors should also be given.
- If the child needs further diagnosis and/or treatment, a referral for the appropriate follow-up care should be made. Progress notes must clearly indicate which course was taken.
- Members under age 21 should be treated according to the recommended schedule of preventive health care. This information should be retained as part of the patient's medical record. The member's evaluation should include all age appropriate required components including the scheduling of the next appointment if possible. For state reporting requirements, please utilize appropriate CPT codes on page 64 when your encounter data is reporting preventive screening and treatment services for members under age 21.
- The PCP is required to monitor and communicate scheduling of EPSDT screening appointments. VPHP, as a part of member education, will reinforce the need for these services.
- If a treatment or service is needed to correct, improve a problem that is found during an EPSDT check-up, or prevent a problem from getting worse, please make appropriate referrals or call VPHP Case Management for assistance.

Medical Management

Utilization Management Program

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

Virginia Premier Health Plan, Inc. (VPH) is prohibited from providing incentives for denying, limiting, or discontinuing medical services for its enrollees inclusive of practitioners and VPH Staff. Utilization management decisions are based on appropriateness of care and service and existence of coverage for the enrollee. VPH does not discriminate against particular practitioners that serve high-risk populations or specialize in conditions that require costly treatment. Additional information pertaining to VPH Utilization Management Program (Exhibit H) can be accessed at www.virginiapremier.com.

Referrals

Primary Care Physicians (PCPs) in the VPH network include Board Certified or Board Eligible practitioners in the fields of Internal Medicine, General Practice, Family Practice and Pediatrics. Each VPH member chooses a PCP who assumes responsibility for the management of our member’s health care needs. An Obstetrician may assume care for members during pregnancy, but generally will refer back to the PCP for health care issues unrelated to the pregnancy. If a PCP determines that a member requires the services of a specialist or other treatment that they are unable to provide, then the PCP must make a recommendation to the appropriate specialist for the services, however VPH does not require a referral from the PCP in order for the member to obtain specialist services

PCP shall 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 and coordinate further care for the Member. If a Member requires Specialist services and a Participating Specialist is not available, PCP shall obtain authorization from VPH to refer to a non-participating specialist. Any approval by VPH for a course of treatment or referral services does not release the PCP from his/her obligation to verify Member Eligibility at the time Covered Services are rendered.

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

- VPH’s contracted providers are unable to provide the specialty service required for the member’s medical care.
- VPH does not have a provider in the network with appropriate training or experience.

- Services are prior authorized by another HMO or Medallion prior to enrollment with VPHP to avoid interruption of care.

Tidewater

Address	Virginia Premier Health Plan, Inc. 825 Greenbrier Circle Suite, 200 Chesapeake, VA 23320
Phone	(757) 461-0064, press 4 1-888-251-3063
Fax	(757) 466-1133

Central Virginia / Fredericksburg / Western

Address	Virginia Premier Health Plan, Inc. 600 East Broad Street, Suite 400 Richmond, Virginia 23219-1800
Phone	(804) 819-5151, press 3 1-888-251-3063
Fax	(804) 819-5186 (866) 284-1057

Roanoke/Far Southwest Virginia

Address	Virginia Premier Health Plan, Inc. 5060 Valley View Blvd. NW Roanoke, Virginia 24012
Phone	(540) 344-8838 1-888-338-4579
Fax	(540) 344-8007 (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.
- 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 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. If the referral is not approved by the VPHP, the PCP will be notified and provided with alternative recommendations. The PCP has the right to appeal the denial and may discuss medical indications with the Medical Director.

- When VPHP 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.

Pre-Authorization

- The PCP is responsible for providing and/or managing all health care services for the VPHP member. However, some services also require pre-authorization from the health plan. The pre-authorization process allows Virginia Premier Health Plan, Inc. 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 VPHP network
- Evaluate the medical necessity criteria for the service
- Enter the member into VPHP's Case or Disease Management program if appropriate

To pre-authorize services, contact VPHP'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.

Procedures Requiring Pre-Authorization

(The full listing of services can be found at www.virginiapremier.com, Medical Management, Utilization Management)

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 (This is a FAMIS Benefit Only)
- Cosmetic Surgery (e.g. Keloid & Scar Revisions, Varicose Veins, Mammoplasty, Reduction and Augmentation)
- Durable Medical Equipment (DME)(Includes Orthotics and Prosthetics when applicable*)
- Enteral Nutrition and Total Parenteral Nutrition Only Available*
- 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)
- 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

* Age Requirements

Note: If a provider has any questions pertaining to prior authorization, please contact VPHP's Medical Management Department or check our No Prior Authorization (NPA) list on our website 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 VPHP’s Referral Coordinator of the planned admission. If this is an emergency admission, VPHP 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.
- 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 codes are determined using ICD-9 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 VPHP 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 VPHP to verify status of approval.

Medical Management Staff Availability

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

Medical Management Offices are open from 8:00 a.m. to 5:00 p.m. daily. After hours and on weekends a confidential answering machine will receive your call. Please leave detailed information and a VPHP 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, VPHP will determine if the admission was medically necessary. Pending availability of clinical data, determinations will be made within 24 hours of VPHP's notification with subsequent notification to providers within 24 hours of making the decision.

Concurrent or continued stay reviews are performed on all non DRG all 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. No letters are generated for concurrent review certifications. Letters are only generated for non-certification and include instructions on submitting an appeal. The facility, attending physician and member are notified in writing of the non-certification decision within 3 business days of making the decision.

Case Management Services

As part of the concurrent review process, VPHP's Medical Management team will screen each patient for discharge planning and case management needs. VPHP offers an intensive Case Management Program for all members that are high risk and who require complex medical interventions. The Case Management Team works closely with the member's PCP to coordinate healthcare services across the continuum of care. Case Management is provided by Registered Nurses. Case 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

To refer a patient for Case Management Services, call Medical Management on page 2 or 3.

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). 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 VPHP'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 VPHP has denied.***

If the patient/family member insists upon continued hospitalization (even though both the attending physician and VPHP 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 VPHP 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 non-certification decision by VPHP. Appeals will be considered if received within thirty (30) days of the decision.

NOTE: A non-certification decision made by VPHP 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 VPHP approved medical policy, Interqual[®] criteria, 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

VPHP uses McKesson Interqual[®] criteria, nationally recognized clinical practice guidelines/standards and approved VPHP 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

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

**Virginia Premier Health Plan, Inc.
Medical Management**

600 E. Broad Street Suite 400 Richmond, VA 23219 (800) 727-7536	825 Greenbrier Circle Suite 200 Chesapeake, VA 23320 (800) 828-7989	5060 Valley View Blvd NW Roanoke, VA 24012 (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.

Expedited Medical Necessity Appeal

Expedited appeals may be requested when a non-certification decision is made by VPHP prior to, or during the course of treatment. If the member or physician/provider believes that VPHP's decision is not acceptable, a request to appeal should be faxed to VPHP's Medical Management Department. Once the appeal is received, VPHP will select a physician of the same or related specialty to review the case. This physician will be responsible for returning a decision within three (3) calendar days of receiving the information required for the expedited appeal. A member may appeal to VPHP and/or DMAS. FAMIS members and providers must appeal to VPHP prior to appealing to the next level.

Standard Medical Necessity Appeal

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

VPHP will provide in writing, clinical rationale for the non-certification decision to the member, physician/provider, or the facility. All medical information and appeals for reconsideration of prior authorization/notification or appeals of medical necessity should be sent to:

**Virginia Premier Health Plan, Inc.
Medical Management/ Appeals
P.O. Box 5244
Richmond, VA 23220-0244
(800) 727-7536
(804) 649-9647 Fax**

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

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

Emergency Services/Urgent Care Services

In the case of sudden onset of an unexpected medical condition and time permits, VPHP 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 VPHP so the claim can be paid without retrospective review. All visits authorized by the PCP or Nurse Advice Line will be paid regardless of whether or not the visit meets the prudent layperson definition of an emergency.

VPHP 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. Emergency Room services that do not meet the Prudent Layperson standard will be reimbursed for a medical screening or "triage fee" only. 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), VPHP members should seek immediate medical treatment from the nearest emergency room. Members should notify their PCP or VPHP within 24 hours (or the next business day) of receiving services.

Medical Services

Gynecology and Obstetrical Services

All female Virginia Premier Health Plan members, age 13 years and older, have direct access to in-network OB/GYN for annual and routine visits and all necessary follow-up care without a referral. If the VPHP 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 VPHP. Services can be coordinated through VPHP’s Medical Management Department for obstetric patients that require additional specialist visits. OB/GYN services include:

- Prenatal, labor and delivery, and post-partum care
- Nurse and Midwife Services
- Specialty gynecological care
- Care and Services for Miscarriage
- Family planning services in or out of network
- Preventive Care, Exams, Tests and Education
- HIV testing, counseling, and treatment
- 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.
- This form is used to identify pregnant members early and to assist with the care coordination. VPHP 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 VPHP’s Case Management Department for assistance with prenatal care and enrollment in the Healthy Heartbeats™ program.

Virginia Premier Health Plan, Inc.
Medical Management Dept.
P.O. Box 5307
Richmond, Virginia 23220
Phone: (800) 727-7536
Fax: (804) 819-5186

Virginia Premier Health Plan, Inc.
Medical Management Dept.
P.O. Box 62347
Virginia Beach, VA 23466
Phone: (800) 828-7989
Fax: (757) 466-1133

Virginia Premier Health Plan, Inc.
Medical Management Dept.
P.O. Box 1751
Roanoke, VA 24008-1751
Phone: (888) 338-4579
Fax: (540) 344-8007

Length of Stay Policy

For routine vaginal delivery, VPHP 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 VPHP 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.

Gynecology Services: Direct Access Legislation

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

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

Family Planning

Family planning services are covered benefits for Virginia Premier Health Plan members. Family planning can be provided in or out of network and services include the following:

- Counseling services and patient education
- 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.
- Treatment for sexually transmitted diseases

Sterilization Services

Sterilization services (tubal ligation and vasectomy) are covered services for VPHP members 21 years of age or older. VPHP 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.

Healthy Heartbeats™

To meet the needs of routine and high-risk pregnant women, Virginia Premier Health Plan, Inc. developed 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 not only cared for by their physician, but are also closely monitored and lead through the program by a multidisciplinary 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). VPHP 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 and community referrals. Program goals include:

- Identifying and addressing any medical/social problems that may adversely impact the pregnancy outcome.
- Transitioning each newborn into VPHP's EPSDT Program (if applicable).
- Developing partnerships with providers and members to improve outcomes and compliance with the medical care plan

Substance Abuse Services for Obstetric Patients

Virginia Premier Health Plan does not cover inpatient residential or day treatment substance abuse services for pregnant women. However, these services are available when requested and coordinated through DMAS. Authorization and reimbursement need

to be arranged through DMAS. VPHP will coordinate access to these services for our members.

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

Abortions

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

Infertility Services

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

Diagnostic Testing: Laboratory Services

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

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

To find the nearest LabCorp site visit www.labcorp.com.

To find the nearest Solstas site visit www.solstas.com

CLIA Waived Tests

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

Pre-Operative Lab Testing

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

If this is not possible due to time constraints of the scheduled admission, the lab work can be done by the admitting hospital. In order for these labs to be reimbursed, the hospital must call the Virginia Premier 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 SolstasLabs 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 VPHP must be notified and those services pre-authorized.

Exceptions: If VPHP 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 web-site 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

Virginia Premier Health Plan encourages women over the age of 40 to have breast exams and yearly mammograms. No referral or authorization is required for screening mammograms. Additional, mammograms ordered as a result of breast abnormalities are covered regardless of age. These diagnostic mammograms require prior authorization.

Mental Health Services

Outpatient Mental Health Services

Outpatient mental health services are available through VPHP's network of participating mental health providers.

Mental Health Specialist

Mental health specialists should contact VPHP'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.

Psychological Testing

A treatment plan must be submitted to VPHP's Behavioral Health Unit at the time of request. Psychological testing must be pre-authorized for outpatient services after the member has exceeded 8 hours. 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.

Outpatient Substance Abuse Benefits

Members may self-refer for outpatient substance abuse services.

- Opioid drugs prescribed and filled through an independent pharmacy are the responsibility of VPHP
- Opioid drugs administered and obtained by the provider are not covered through VPHP – must contact DMAS

Inpatient Mental Health Services

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

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).

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.

Free-standing Psychiatric Facility Admissions

Admission to a "free-standing" psychiatric facility is permitted under the following circumstances:

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

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

Inpatient Substance Abuse Services

Virginia Premier Health Plan does not cover inpatient, residential or day treatment substance abuse services for Medicaid or FAMIS Plus. However, residential or day treatment services are available for pregnant members when requested and coordinated through DMAS. Authorization and reimbursement will be arranged through DMAS. VPHP will coordinate access to these services for our members.

FAMIS Restrictions: Inpatient substance abuse services in a substance abuse treatment facility are covered for up to 90 days per enrollee. (Maximum lifetime benefit)

Pharmacy Services

Retail Pharmacy Benefits

Virginia Premier Health Plan's retail prescription drug services are administered through EnvisionRxOptions, www.envisionrx.com. All prescriptions must be filled at a participating pharmacy, unless a medical emergency or an out-of-area situation exists. Drugs dispensed by a physician's office will not be reimbursed by VPHP. Prescriptions that require special authorization procedures shall have a response within 24 hours in most circumstances. If the drug is prescribed for an emergency medical condition, VPHP will pay for at least a five (5) day supply of the drug, until a final determination can be made.

The formulary can be downloaded at the Virginia Premier website at www.vapremier.com. For pharmacy and prescription related questions, please call Envision at 1-855-872-0005.

Pharmacy Plan Prior Authorization Guidelines

Providers must use generic drugs whenever possible when prescribing medication for our members. Please contact the Envision Pharmacy Customer Service line at 1-855-872-0005 for questions regarding drug products that require authorization or fax requests to 1-877-503-7231.

If a prescription is received by a participating pharmacy for a non-formulary drug, the pharmacist will attempt to contact the prescribing physician to request a change to a formulary product. If the physician is unavailable or unwilling to change the prescription or if there is no formulary alternative, then prior authorization from VPHP is required. The member will be given a five (5) day temporary supply of the drug until a prior authorization can be obtained. A Prescription Prior Authorization Form (**Exhibit C**) can be accessed at www.vapremier.com.

Step Therapy Drug Listing

To help make the use of prescription drugs safer and more affordable, VPHP uses a Step Therapy program. 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.

Note: VPHP requires 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

There is no co-payment for prescription drugs for Medallion II members. FAMIS members have co-payments which is located on the members VPHP ID card.

Non-covered Prescription Drugs

- Over the counter drugs that are not prescribed the member's physician or that are not listed in the covered benefits section.
- All anorectic drugs (amphetamine and amphetamine-like) usually used for dieting or decreasing a person's desire for food, are covered only when authorized by VPHP.
- Fertility drugs are not covered.
- Experimental or investigational drugs (not approved by the FDA) are not covered.
- Erectile dysfunction drugs are not covered.

Mail Order Pharmacy

Pharmacy Mail order is available for up to a 90 day supply and orders are fulfilled by Costco Pharmacy. Mail order pharmacy is only available to FAMIS members. Generic substitution is mandatory if available.

Over-the-Counter Medications

VPHP covers the following over-the-counter drugs and supplies when they are prescribed in writing by a participating provider: **(Covered benefit for Medallion 3.0 members only).**

Covered Over the Counter Medications by Therapy Class (Generic Only)
Cough and cold products
Antacids
Antidiarrheals
Antifungals - topical & vaginal
Antihistamine/decongestant
Antihistamines
Antiulcer
Calcium supplements, calcium with Vitamin D
Decongestants
Ferrous sulfate
Glucosamine/Chondroitin
Ketotifen
Laxatives and Cathartics
Niacin
Nicotine gum and lozenge
Nicotine patch
NSAID
Oral analgesics/antipyretics
Prenatal Vitamins
Proton Pump Inhibitors
Salicylates and related drugs
Scabicides and pediculicides
Topical corticosteroid
Vitamins and Minerals

IUD Distribution

To obtain IUDs or implantable contraceptive devices for Virginia Premier members you may either contact Envision at 855-872-0005 or contact the contracted specialty vendor as directed below:

Mirena, contact Orchard Pharmacy (877) 437-9012

Implanon, contact CVS/ Caremark (866) 638-8321

Paragard, contact ICS Distribution at 1-877-Paragard

Providers may also choose to utilize office stock and may bill VPHP directly for the device as well as for the insertion of the device using the appropriate CPT codes. Should you have any questions regarding this change please contact your local Provider Services Representative or EnvisionRxOptions at 1-855-872-0005. IUD order forms can be accessed at www.vapremier.com

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 RxOptions at 855-872-0005**, however actual Specialty Pharmacy services are provided by multiple 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 VPHP website and are located under the Medical Management tab.

Additional Ancillary Services

Physical and Occupational Therapy

Physical and Occupational Therapies are rehabilitative services available to VPHP members. Services require prior authorization and medical necessity must be demonstrated. The therapist must then submit a treatment plan to VPHP for prior authorization of services. 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.

Audiology and Speech Pathology Services

Inpatient and outpatient services for speech, language and hearing disorders are covered for children under twenty-one (21) years of age. All services require prior authorization from VPHP. School based speech therapy is not a covered benefit and is reimbursed by the Department of Medical Assistance Services (DMAS).

Dental Services

Dental services are provided by the DMAS Smiles for Children program. The toll free number for Smiles for Children is 888-912-3456.

Dental treatment for adults is covered under certain circumstances through the DMAS dental program, Smiles for Children. Adult dental services are limited to medically necessary oral surgery and associated diagnostic services such as x-rays and surgical extractions. Preventative, restorative, endodontics, prosthetic services, cleanings, fillings, root canals, and dentures are not covered for adults. Dental conditions that may apply for reimbursement are ones compromising a patient's general health and such conditions must be documented by the dentist or medical provider.

Vision Services

VPHP has contracted with Vision Service Plan (VSP) to provide routine vision care for eligible members. All Diabetic members are encouraged to have an annual dilated examination. This exam can be completed by a VSP contracted optometrist or ophthalmologist.

Vision Plan Guidelines

Members may self-refer for routine vision services to a participating VSP optometrist without obtaining a referral from their PCP. Members may select a provider of their choice from VPHP's Provider Directory or they may call the Member Services Department for assistance in selecting a provider. Members may also contact VSP Customer Service at **1-800-877-7195**.

Routine eye exams are covered for adults and children. Members with vision pathology (not acuity related) that require treatment and/or consultation by an ophthalmologist must be recommended by their PCP to one of VPHP's participating ophthalmologists.

Vision Benefits (Under 21)	• Eyeglass frames are covered in full from a designated selection of frames. • Lenses are covered in full, every 24 months or sooner if prescription changes. • Contact lenses are covered in full if medically necessary with prior authorization through VSP at 1-800-877-7195.
Vision Benefits (age 21 and over)	• Members may choose to receive eyeglasses or contact lenses. If the member chooses eyeglasses, single vision and bifocal lenses are covered in full. Trifocals

	are not covered. • Members have \$100 retail allowance for contact lenses in lieu of glasses, every 24 months. • Members may be balance billed for the difference between the charges and the VPHP allowance.
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Home Health Services

Home health services are available to VPHP members. These services must be provided by a participating home health agency and provided to a VPHP 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 VPHP's Utilization Review (UR) nurse to arrange for home health services.

- Home health benefits include:
- Nursing, social work evaluations, and home health aid services
- Occupational and physical therapy
- Speech, hearing and language disorder services (members under 21 yrs)
- Infusion therapy
- Durable medical equipment and supplies
- Homemaker services for prenatal patients only

Durable Medical Equipment (DME), Prosthetic Devices and Supplies

- VPHP will cover all medically necessary equipment and supplies for rental or purchase when ordered by a contracted VPHP participating provider. DME services must be pre-authorized by VPHP. Please refer to DMAS Appendix B (Medicaid) for item covered under the Medicaid Plan. The certificate medical necessity (CMN) form (**Exhibit B**) can be accessed and downloaded at www.vapremier.com. Examples of covered items include (but not limited too):
- 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
- Artificial arms, legs and their necessary supportive devices for members under 21 years of age when medically necessary, to include orthotics when part of an approved rehabilitative program

Nutrition Services

VPHP will cover all medically necessary visits to dieticians 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 VPHP Case Manager. These services do require authorization from VPHP.

WIC (Women, Infants and Children)

Virginia Premier Health Plan 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.

Exclusions

Individuals with Disabilities Education Act Early Intervention Services (IDEA-EIS)

Virginia Premier Health Plan will work closely with Primary Care Providers to identify any infant or toddler with a disability in any one or more of the following areas:

- Physical
- Cognitive
- Communication
- Social
- Emotional
- Adaptive Development

Such children may be eligible for the IDEA program administered by the Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services. VPHP will refer members who are potentially eligible for the Early Intervention Services to local interagency councils and will make that listing available to qualified enrollees.

General Limitations and Exclusions

Non-Covered Services

VPHP 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:

- Services rendered by a chiropractor (covered for FAMIS recipients) are not covered by VPHP, except as medically necessary for EPSDT services, which must be approved by VPHP prior to services being rendered.
- Private duty nursing services are not covered by VPHP, except for medically necessary EPSDT services, which must be authorized by VPHP prior to services being rendered.
- Infertility treatments are not covered by VPHP.
- Services of Christian Science nurses are not covered by VPHP.
- Personal Care services (covered under Medicaid Waiver)
- Experimental or investigational procedures are not covered by VPHP.

- Regular assisted living services provided to residents of adult care residences are not covered by VPHP.
- Inpatient mental health services rendered in a State Psychiatric Hospital are not covered by VPHP.

Medallion 3.0 Carved-Out Services

As a Medicaid contractor, it is important to note that some services are carved out and excluded from the HMO contract. These services are covered through DMAS and are defined through Medicaid memos, Federal and State laws and regulations, and Medicaid manuals. The following services are Medallion 3.0 carved-out services:

- Community mental health rehabilitative services, emergency services (crisis), intensive outpatient, day treatment and substance abuse case management services for Medicaid/FAMIS Plus enrollees.
- Inpatient substance abuse treatment
- School health services
- Targeted case management services to the elderly and members receiving community mental health and mental retardation services as set forth in 12 VAC §§ 30-50-420 through 470.
- Regular assisted living provided to residents of adult care residences.
- Lead contamination investigations (screenings are reimbursed by VPHP through LabCorp/Solstas)
- Abortions as set forth in 12 VAC 30-50-180 and 42 CFR §441.203 and §441.206
- Dental services as set forth in 12 VAC 30-50-190.
- Specialized infant formula and medical foods for individual under age 21.
- Private Duty Nursing when provided through HCBS waivers covered in 12 VAC 30-50-170, 12 VAC 30-120-10 through 30-120-259
- Personal care services.
- Hospice services.
- Services provided under home and community-based Medicaid waivers.

Exclusions from HMO Enrollment

If a VPHP member receives any of the following services, that member shall meet the criteria for exclusion from the Medallion 3.0 Program.

Services for enrollees with mental retardation and related conditions, including case management

Inpatient mental health services rendered in a State psychiatric hospital

- Hospice services
- Skilled nursing facility care
- Private duty nursing services
- Personal care services in an enrollee's home

FAMIS recipients with commercial insurance will be excluded from Virginia Premier Health Plan enrollment.

FAMIS Carved-Out Services

Virginia Premier is pleased to offer an array of health benefits. However, there are a few services that are not covered by our Plan and are carved out to DMAS. If you have any questions about covered benefits, please contact our Medical Management Department. Non-covered services include:

- Dental Services
- School Health Services for special education students that include physical therapy occupational therapy, speech language pathology
- Skilled Nursing Services
- Specialized Infant Formula
- Community Mental Health Rehabilitation Services (CMHRS) and Mental Retardation Services, including intensive in-home services, case management services, day treatment, and 24-hour emergency response.

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 Health Care 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

VPHP’s 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.

VPHP provides disease management programs for the following chronic conditions: Asthma, Heart Disease COPD, Bipolar Disorder/Schizophrenia, Childhood Weight and Nutrition Management, Prenatal and Diabetes.

Program components include:

- Educational materials
- VPHP 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 5:00 p.m. (except holidays). Please encourage your patients to participate in the programs and call us if you have any questions or concerns.

Case Management

VPHP offers an intensive Integrated Case Management Program for all members that are high risk and who require complex medical interventions. The Case Management Team works closely with the member's PCP to coordinate healthcare services across the continuum of care. Case Managers may also intervene when patients that demonstrate non-adherence to their treatment plan. Circumstances that warrant referral to the Case 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
- Children with Special Health Care Needs
- Multiple hospitalizations or emergency room visits

The case 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

To refer a patient for VPHP's Case Management Services, call Medical Management:

- 800-727-7536 in the Central Virginia Area
- 800-828-7989 in the Tidewater Area
- 888-338-4579 in the Roanoke Area
- 800-727-7536 in the Far SW Virginia Area

Or, utilize our [Online Care Management Request Form](#) which can be located at www.vapremier.com and located under the Medical Management tab.

Preventive Health and Wellness Programs

VPHP 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. VPHP'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.

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

- Aerobic exercise (water, chair and regular)
- Diabetes
- Hypertension
- Family Planning
- Member Support
- Pre-natal/Parenting Skills
- Well Child Care
- 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 VPHP's health education services call our Member Services Department.

Quality Program Description

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

The primary goal of VPHP's Quality Program (QP) is to ensure the delivery of high quality, appropriate, efficient, cost-effective health care 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 **(Exhibit G)**.

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, VPHP 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.

VPHP strives to provide cost effective services of exceptional quality, delivered 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 VPHP members. It addresses the availability, accessibility, coordination, continuity and overall quality of care as supported by VPHP staff. Key areas include: Member Services, Provider Services, Contracting, Credentialing, Care Team Management, Medical Management and clinical performance measurement functions. This also includes monitoring of community-focused programs that encompass transportation and health education activities. The

VPHP Board of Directors provides oversight to the QP, working closely with the Continuous Quality Committee to underscore VPHP'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 health care programs that will improve the health status of our member through member and provider education
- Focus studies on illnesses which frequently affect our members
- Continuously monitor and measure activities to demonstrate effective outcomes

VPHP is unique among Medicaid HMOs as our plan specializes in Medicaid/FAMIS Plus/FAMIS managed care. Given our singular focus, VPHP 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. Among our many quality initiatives, our QP has identified three significant quality objectives that impact our members. They are immunizations, pre-natal care, and enrollee access to care.

Examples of VPHP's Quality Program at Work

Immunizations

A major objective of VPHP is to increase the percentage of children who are adequately immunized against preventable illnesses. VPHP's EPSDT program addresses member's preventive health screenings and immunizations from birth through age twenty (20). The objectives of the program are consistent with the Center for Disease Control and Prevention's Healthy People 2000's goals which include:

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

Using an integrated care management approach, VPHP's implements the program with oversight provided by the Medical Officer and the Director of Medical Management. The care management team is comprised of case managers, health educators, outreach workers and social workers. This team will work closely with the pediatrician and parent/member in developing a plan of care and monitoring outcomes. During each outreach visit to the member's home, information on immunization screening will be provided.

VPHP monitors immunizations through its encounter/claims system and through medical record review. Data is extracted quarterly and cross referenced with each PCP's panel to ensure screenings and immunizations for children are occurring according to the EPSDT periodicity schedule. This information is provided to the PCP so that appropriate medical care can be arranged. The case manager, in conjunction with health education and medical outreach, contacts members by phone, mail or home visit if they have not

accessed care within the first sixty days of enrollment. The VPHP outreach worker will identify members who are out of compliance and will assist the member with obtaining the next available appointment with their PCP. Follow up occurs to ensure the child is seen and that they received the immunizations as scheduled.

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

Pre-natal Care

VPHP 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, pre-natal 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. VPHP 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 Virginia Premier. 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 health care team. Members should engage in meaningful communication with their Doctor (and vice versa), to ask questions regarding:

- Treatment/Procedure (type of treatment; less invasive etc.)
- Medications (dosage, selection,)
- 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. VPHP 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 VPHP. VPHP 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, VPHP 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 VPHP'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. VPHP 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, initiated in 2008, 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.

Provider Reimbursement and Claims

Claim Filing Guidelines

Providers participating with Virginia Premier Health Plan, Inc. 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.

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.**

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

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

Paper Claim Submissions

Paper claims should be submitted to the following address:

Primary Care Providers Virginia Premier Health Plan, Inc. P.O. Box 5207 Richmond, VA 23220-0207	Specialty Providers Virginia Premier Health Plan, Inc. P.O. Box 5208 Richmond, VA 23220-0208
Hospital Claims Virginia Premier Health Plan, Inc. P.O. Box 5120 Richmond, VA 23220-0120	Claims Appeals Virginia Premier Health Plan, Inc. P.O. Box 5286 Richmond, VA 23220-0307
Transportation Claims Virginia Premier Health Plan, Inc. P. O. Box 5287 Richmond, Virginia 23220-5287	

Electronic Filing Clearinghouses

Electronic claims can be filed with Virginia Premier Health Plan, Inc. by utilizing one of the following Clearing Houses:

Allscripts	800-654-0889
Benchmark	800-779-0902
Claims Logic	866-252-4656
Gateway	800-969-3666
McKesson (Relay Health)	800-981-8601
Med Assets (Xactimed)	866-323-6332
Noteworthy Medical Systems	877-891-8777
SSI Group	800-881-2739
Emdeon	877-363-3666
Zirned	877-494-7633

Virginia Premier Health Plan, Inc. 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 relating 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 Health Plan, Inc.
Attention: EDI Enrollment Team
Fax: 804-819-5174

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

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

Primary Care Fee for Service

Primary Care Physicians who elect to be reimbursed on a fee for service basis will be paid according to the VPHP fee schedule. If the PCP’s billed charges are less than the VPHP fee schedule, the PCP will be paid their billed charges. All claims are to be filed on a CMS 1500 claim form or electronically.

Encounter Reporting

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

Panel Report:

Primary care providers will receive a monthly capitation report that will itemize their assigned member panel. It also reflects the dollar amount calculated for reimbursement for primary care services associated with each member.

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. Virginia Premier Health Plan, Inc. (VPHP) will recoup/recover payments that are identified by our auditing and monitoring programs.

Member Hold Harmless Policy

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

Denied Claims / Reconsiderations

All denied claims must be appealed in writing to Virginia Premier. 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 Health Plan, Inc.
Attention Appeals Department
PO Box 5286
Richmond, Virginia 23220

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

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

Appeals for denied claims must be sent to VPHP 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

Newborns

Newborn’s permanent Medicaid Identification numbers are usually unavailable immediately after their birth. Virginia Premier Health Plan (VPHP) creates a temporary number to enroll newborns.

VPHP covers newborns, whose mothers are actively enrolled in VPHP’s Medallion 3.0 and FAMIS programs, for birth month plus two (2) months. The baby’s temporary contract number is the first nine digits of the mother’s Medicaid Identification number followed by three zeros for the first newborn. These newborn numbers are incremental for each child born to the mother, for example, the second child’s contract number will end in 001 instead of 000. Contact VPHP to determine which number to use if you are unsure.

If the child has not been named when we enroll them, we will enroll the newborn based on gender under the mother’s last and first name. For example; Johnson, (mother’s last name), BB or BG (gender) Mary (mother’s first name). BB=Baby Boy and BG=Baby Girl.

Upon receipt of the permanent Medicaid Identification number, VPHP will terminate the temporary Medicaid Identification number contract and generate a new contract with the permanent Medicaid Identification number. The contract effective date of the new Medicaid Identification number reflects the month in which the permanent number is received from the Department of Medical Assistance Services (DMAS). For example, if the child was born on 4/15/08 and we receive the permanent Medicaid Identification number on 5/20/08, the child is effective under the temporary number from 4/1/08 to 5/31/08 and

effective with the permanent number beginning on 6/1/08.

We will instruct the member to disregard the old card with the temporary number and mail them a new member ID card with the permanent identification number.

Inpatient Rounding

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

Obstetric Services Reimbursement Schedule

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

OB Unbundled Method

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

CPT codes to be utilized with unbundled method

Description of Service	CPT Code
New patient, OB Visit	99201- 99205
Established Patient, OB Visit or antepartum visits 1-3	99211- 99215
Antepartum care, visits 4, 5, and 6	59425
Antepartum care, visits 7 or more	59426
Delivery- Vaginal	59409, 59612
Delivery- Cesarean	59514, 59620
Postpartum Visit	59430

Global OB Method

Providers who bill VPHP for OB services globally should follow the AMA guidelines. The Global (bundled) delivery method includes: all antepartum visits, delivery (to include all services associated with the admission and discharge), and postpartum visits. If a

provider provides prenatal services but does not perform the delivery then visits should be billed to VPHP 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.

Vaccines

- For Medicaid/FAMIS Plus eligible members up to the age of 19 years, serums must be obtained through the Vaccines for Children (VFC) program. Providers are advised to bill VPHP for each vaccine CPT code administered. VPHP will reimburse providers an administration fee for each vaccine CPT code billed. All vaccine encounters must be submitted on a CMS 1500 claim form.
- For members covered through FAMIS (Family Access to Medical Insurance Security) or who are 19 years of age or older, providers must administer office stock and these members are not eligible for the VFC program. Providers should bill VPHP for each vaccine administered as well as any associated immunization administration codes.

Medicaid Product	VFC Eligible	How to Bill VPHP
Medallion 3.0 (FAMIS Plus) age 0-18	Yes *	Bill VPHP for each vaccine CPT code that was administered to the member. An administration fee will be made to providers on each vaccine CPT code submitted to VPHP. VPHP will <u>not</u> make additional reimbursement on vaccine administration CPT codes.
FAMIS age 0-18	No	Bill VPHP for each vaccine CPT code that was administered to the member and any applicable vaccine administration codes. VPHP will reimburse providers the contracted allowable for each vaccine plus applicable vaccine administration codes.
Medallion 3.0 age 19 or older	No	Bill VPHP for each vaccine CPT code that was administered to the member and any applicable vaccine administration codes. VPHP will reimburse providers the contracted allowable for each vaccine plus applicable vaccine administration codes.

** Note: Providers will not be reimbursed more than the administration allowable in the event that they provide non-VFC obtained serums to members.*

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

- VPHP 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 to a bilateral procedure.

Collection of Charges from Third Parties

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

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

Reimbursement of Physician Assistants and Nurse Practitioners

VPHP 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 VPHP provider shall be reimbursed to the credentialed provider.

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

Virginia Premier does not credential Physician Assistant’s. However VPHP 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 VPHP members.

Durable Medical Equipment Individual Consideration Request Submission

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

The provider/DME supplier must submit Certification Medical Necessity (CMN) Form for DME requests to Medical Management Department for authorization. When submitting a claim for IC request, the vendor **must** attach to the claim the wholesale (cost) invoice and retail invoice

including description for all items, and HCPCS codes. Without both the wholesale and retail invoices, the claims will be **denied**. Please refer to DMAS Appendix B (Medicaid) for item listed as IC or UCC. Items will be reimbursed in accordance to VPHP fee schedule.

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 VPHP support, each member must learn the plan guidelines, follow proper procedures and seek services from our network of participating providers.

Member Rights

Virginia Premier Health Plan members have the right to:

- All covered services.
- Treatments with quality care, respect, dignity and right to privacy.
- Have healthcare services 24 hours a day, 365 days a year, including urgent, emergency and post stabilization services.
- Choose their own VPHP doctor/Primary Care Physician (PCP).
- Change their own VPHP doctor and choose another one from VPHP's Provider Directory (included in the enrollment/membership package).
- Make their own doctor/PCP appointments to be seen in the physician private office at their convenience.
- Not be treated against their will.
- Ask his/her doctor/PCP questions.
- Call Member Services to file a complaint/grievance about VPHP or file an appeal if they are not happy with the answer to their inquiry (question), complaint/grievance, or care given. Requests for a State Fair Hearing may be submitted to DMAS at the same time that an appeal is submitted to Virginia Premier; or, after exhausting the Virginia Premier appeal's process; or, instead of appealing to Virginia Premier.
- Have their and/or their child's medical records kept private unless they sign a permission form.
- Participate with their physician in making decisions about their health care.
- Have their and/or their child's doctor tell you about any treatment choices they may have, no matter what the cost or benefit coverage as well as received a second opinion from VPHP'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 other 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 VPHP and its providers treat the enrollee.
- Receive information about VPHP, its services, providers and member's rights and responsibilities.
- Make suggestions regarding VPHP's member rights and responsibilities statement, which is found in the member handbook.

Supplemental Member Rights

Virginia Premier Health Plan members also have the right:

- 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. Va. Premier may not prohibit, or otherwise restrict, a member's doctor/provider from advising or advocating on behalf of a member who is his/her patient related to the member's health condition, medical care or treatment choices, including any other treatment that may be self-administered.
- Have the doctor 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 1-866-287-5314, 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 health care needs and information discussed and given to the doctors/providers they want. The member can call Member Services and ask that Va. Premier have the information sent to their doctor.
- 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

- Members have the responsibility to:

- Choose their and/or their child's VPHP PCP from the list of our doctors. (See Provider Directory)
- Obtain their and/or their child's healthcare through our list of PCP's and hospitals and other health care providers.
- Keep doctor's appointments or call to cancel them at least 24 hours ahead of time.
- Carry their and/or their child's VPHP Member ID Card with them at all times.
- Tell the doctor that their and/or their child is a Member of Virginia Premier Health Plan at the time that they speak with the doctor's office.
- Give honest information about their and/or their child's health.
- Learn the difference between emergency and urgent care.
- What constitutes an emergency, how to keep one from happening, and what to do if one happens.
- Follow plans and instructions for care given by their and/or their child's physician.
- Understand their health problems and discuss and/or agree upon treatment plans with their and/or their child's physician.
- Get permission from their and/or their child's PCP or VPHP before they see another physician.
- Let VPHP know how we can work better for them.

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 member's medical record. This even includes if the member states "No, I do not wish to complete an advance directive." VPHP 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 VPHP 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

VPHP is committed to providing high quality health care and service to its members. To ensure an open dialogue with our members, VPHP has processes in place to fully investigate and address member complaints, grievances and appeals and to incorporate this information into the continuous Quality process. Complaint and grievance system processes have been established with the following objectives:

- To promote member satisfaction with the care and services VPHP 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 logging of all complaints, grievances and appeals into a database
- To perform regular and periodic analysis of issues identified in this database and to categorize opportunities for improvement related to quality of care and service rendered to our members
- To develop an action plan for implementation of identified quality improvements
- To ensure monitoring of activities for the effectiveness of such corrective measures

VPHP does provide information about the grievance and appeals procedures to all plan members at the time of enrollment. The Member Handbook will explain how member complaints and grievances can be initiated. Administrative concerns (such as receipt of ID cards, transportation issues) will be handled through Member Services. If a quality of care complaint is identified, the issue will be forwarded to the Quality Department for investigation and prompt resolution. If a member is denied authorization for treatment, VPHP sends written notification to the member. This letter contains information concerning the denial and clearly explains to the member their appeal rights, including how to file an appeal. For all written concerns or inquiries, VPHP will send a letter of acknowledgement to the Member within five (5) calendar days of receipt. All member issues or concerns will be addressed and a written response will be sent to the member within 30 days of initial receipt, stating that the inquiry/concern has been addressed. Member letters also will include information (address, phone number, e-mail) for further appeals to the Department of Medical Assistance Services (DMAS) or External Quality Review Organization.

VPHP's Continuous Quality Improvement Committee (CQIC) oversees the grievance and appeal review process. Administrative reviews will be the responsibility of the Member Services Department. Quality of care/service reviews will be the responsibility of the Quality Department.

Appeals and Grievances Issues

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 VPHP 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 VPHP representatives, problems with transportation services, etc.

Filing an appeal

Initiating a Medicaid/FAMIS Plus Appeal

The Appeals Process is a mechanism through which a practitioner/provider can request a review of a Virginia Premier Health Plan, Inc. (VPHP) adverse action. An adverse action is the denial of a service authorization request, the reduction, suspension, or termination of a previously authorized service and/or denial in whole or in part of a payment for a covered service. Such a request may be made to VPHP. Upon exhaustion of VPHP's appeal process, the practitioner or provider may appeal to the Department of Medical Assistance Services (DMAS) after a letter is sent informing them of the action. The appeal can also be requested at the time the decision is verbally given over the telephone or in person. VPHP and DMAS will consider all requests for appeals, when the request for an appeal is made within thirty (30) days of notification of the decision.

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

Virginia Premier Health Plan, Inc.
Program and Integrity Department
Grievances and Appeals
PO Box 5244
Richmond, Virginia 23220-0244
Telephone (800) 727-7536
Fax (804) 649-9647
TTY/TDD: 800-828-1120/800-828-1140

Expedited Appeal (Only Urgent Requests on Behalf of Member):

Expedited Appeals may be requested telephonically or in writing for any urgent care requests. This applies to requests concerning admissions, continued stay or other health care services that:

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

A member or member's authorized representative may request an expedited appeal of Virginia Premier Health Plan, Inc. by telephoning or faxing the attached form to the numbers listed below. Once the request is received, Virginia Premier will select an appeal practitioner of the same or similar specialty as typically manages the condition, procedure or treatment in question, to review the case. Virginia Premier will return a decision in writing to the requestor within seventy-two (72) hours of receiving the expedited appeal.

Standard Appeal:

The practitioner/provider may request a standard appeal telephonically or in writing within **thirty days (30)** of the date of the adverse action letter. All oral requests must be followed by a written appeal request. This type of appeal applies to requests for non-urgent pre-service or post-services. The practitioner/provider may submit written comments, documents, records and other information relevant to the appeal. Appeals that involve clinical issues will be reviewed by a practitioner that was not involved in the initial denial that is of the same or similar specialty of the treating practitioner. An appointed VPHP staff member that was not involved in the initial adverse decision will review non-clinical appeals such as benefit determinations. The practitioner/provider will be notified of the appeal decision in writing within thirty (30) calendar days of the appeal request.

The practitioner or provider may appeal to DMAS upon exhaustion of VPHP's appeals process by notifying DMAS in writing at the address below within 30 days of notification of VPHP's appeal decision.

Department of Medical Assistance Services
Appeals Division
600 East Broad Street
Richmond, Virginia 23219
(804) 371-8488

Initiating A FAMIS Appeal

The Appeals Process is a mechanism through which a member, member's representative, attending physician/provider or facility can request a review of a VPHP's (VPHP) adverse action. An adverse action is the denial of a service authorization request, the reduction, suspension, or termination of a previously authorized service and/or denial in whole or in part of a payment for a covered service. Such a request may be made to VPHP after a letter is sent informing the member or representative of the adverse action. The appeal can also be requested at the time the decision is verbally given over the telephone or in person. All verbal requests must be followed by a written, signed, appeal using the attached form. VPHP will consider all requests for appeals, when the request for an appeal is made within thirty (30) days of the decision.

The member or a representative authorized by the member may appeal this decision. The member must give written consent for a person to act on their behalf. The treating practitioner can act on behalf of the member for urgent care requests without the member's written consent.

VPHP offers two types of Appeals: the **Expedited Appeal** and the **Standard Appeal**.

Expedited Appeal

Expedited Appeals may be requested telephonically or in writing for any urgent care requests. This applies to requests concerning admissions, continued stay or other health care services that:

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

A member or member's authorized representative may request an expedited appeal of Virginia Premier Health Plan, Inc. by telephoning or faxing the attached form to the numbers listed below. Once the request is received, Virginia Premier will select an appeal practitioner of the same or similar specialty as typically manages the condition, procedure or treatment in question, to review the case. Virginia Premier will return a decision in writing to the requestor within seventy-two (72) hours of receiving the expedited appeal.

Standard Appeal

The member or member's authorized representative may request a standard appeal in writing within **thirty days (30)** of the date of this letter. This type of appeal applies to requests for services that Virginia Premier must pre-approve or services that have already been received by the member. The member or member's representative may submit in writing or in person, comments, documents, records and other information relevant to the appeal. Appeals that involve clinical issues will be reviewed by a practitioner that was not involved in the initial denial that is of the same or similar specialty of the treating practitioner. An appointed Virginia Premier staff member that was not involved in the initial adverse decision will review non-clinical appeals such as benefit determinations. The

member and/or authorized representative will be notified of the appeal decision in writing within thirty (30) calendar days of the appeal request.

Virginia Premier Health Plan, Inc.

Medical Management Appeals

PO Box 5244

Richmond, Virginia 23220-0244

Telephone (800) 727-7536

Fax (804) 649-9647

External Review

You or your authorized representative may submit a request for an external review directly to the Department of Medical Assistance Services (DMAS). Requests for an External Review may be submitted to DMAS **after** exhausting the Virginia Premier appeal's process. External Review requests must be submitted to DMAS in writing. Written requests to DMAS must be sent within **thirty (30)** days of the date of the last denial notice. Michigan Peer Review Organization (MPRO), an external independent review organization, will complete the review of the appeal request.

The practitioner, provider member or member's representative may appeal to DMAS upon exhaustion of VPHP's appeals process by notifying DMAS in writing at the address below within 30 days of notification of VPHP's appeal decision

Submit your written request for external review to:

Department of Medical Assistance Services

600 East Broad Street

Richmond, VA 23219

Fax: (804) 786-5799

Filing a Grievance

The Grievance Process is a mechanism through which a Member and/or a Member's representative may request a review of a matter that has caused the Member dissatisfaction with Virginia Premier Health Plan, Inc.'s (VPHP). A grievance is an expression of dissatisfaction about any matter other than an action (i.e. denial, suspension or termination of services) taken by VPHP. Possible subjects for grievances include, but are not limited to, the quality of care or services provided and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the Member's rights. A Member can request a grievance by telephone or in writing. VPHP will resolve and respond to all grievances within thirty- (30) days from the date of initial receipt of the grievance. Only written grievance requests will be responded to in writing, unless the Member requests a written response to a verbal grievance.

When the grievance is of a healthcare nature, individuals at VPHP with appropriate clinical expertise in treating the Member's condition or disease will make decisions on grievances.

Whenever a Member, Member's Representative, or Provider is not satisfied with the resolution of a grievance, the Member, Member's Representative, or Provider has the right to appeal the outcome of the grievance.

VPHP will answer any questions regarding the Grievance and/or Appeal's Process during normal business hours, Monday through Friday 8:00 a.m. to 5:00 p.m. by contacting VPHP's Medical Management Department.

Virginia Premier Health Plan, Inc.
Attention: Grievances and Appeals Coordinator
P.O. Box 5244
Richmond, Virginia 23220-0244
Fax (804) 819-5171 - Tel. (800) 727-7536, Ext 5724

Appeals to the State Medicaid Program:

VPHP Medallion 3.0 members can write directly to the State Medicaid Program to file a grievance or to file an appeal if they disagree with their health plan's decision. Letters should be addressed to:

Department of Medical Assistance Services
Appeals Division
600 East Broad Street
Richmond, Virginia 23219

Providers may also appeal to the State Medicaid Program after exhausting appeals with VPHP. FAMIS members may request an External Review through DMAS after exhausting appeals with VPHP.

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

- Know that he/she may have to pay for the cost of the benefits if the state hearing decision is the same as VPHP's decision, to deny the benefits. If the final decision of the appeal is to deny the benefits, VPHP may bill the member for the cost of all services or benefits that were pending during the appeal process.
- Have benefits continue pending the outcome of the appeal and/or state hearing. The member can request continued benefits by writing a letter stating "please continue benefits during my appeal" and forwarding it to VPHP, or by calling the Grievances and Appeals Toll Free Line at 1-800-727-7536, ext 5724.
- Ask for an extension, orally or in writing, up to 14 calendar days, while the appeal is going on, if the extension is best for the member.
- To be contacted by Va. Premier, in writing, of the appeal extension reason like "the appeal needs to be extended for additional information" and how the delay is best for the member.
- Look at all documents before and during the appeal, by writing to VPHP with the request. The member can call the Grievances and Appeals Toll Free Line at 1-800-727-7536, ext 5724 for help.
- To include, as parties to the appeal, the legal representative of a deceased member's estate.

Grievance/Appeal Request Form

First Name of Member:	Middle Name:	Last Name:
Street or Post Office Box:		
City and State:	Zip Code:	Contact Telephone#:
Virginia Premier ID#:	Social Security#:	Other Telephone#:
() I am appealing the action of Virginia Premier Health Plan, Inc.(VPH) The date on the letter that I was told about the VPHP decision is: / / ____ The person who spoke or wrote to me telling me about the action that I am appealing is: Name: _____ Title: _____		
Virginia Premier Health Plan, Inc. <i>(check the appropriate space):</i> () Denial or limited authorization of a service authorization request () Reduction, suspension, or termination of a previously authorized service () Denial in whole or part of a payment for a covered service () Other <i>(please specify)</i> _____		
IMPORTANT <i>Please send a copy of the notice or letter about the action you are appealing or submitting as a grievance.</i>		
I have a representative (It is not necessary to have a representative): Name: _____ Address: _____ _____ <i>(Name, Address, and Telephone Number of Representative)</i>		
Signature of the Appellant: _____ Date: _____		
I am requesting a grievance review/appeal because: _____ _____		

Provider Participation Information

General Guidelines:

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

- Providing care and services to VPHP members without discrimination or regard for the member's race, creed, national origin, sex, age, religion, health status, source of payment or frequency of utilization of covered services.
- Physicians must be participating Medicaid providers.
- Providers must comply with provider access standards as set forth in the terms of the Medicaid Agreement to ensure that VPHP members have appropriate access to routine, urgent and emergent care.
- Providers must submit timely utilization data in a format that will allow VPHP to comply with DMAS reporting requirements. This includes information to demonstrate compliance with provision of EPSDT services.
- Providers must comply with all record keeping, record retention and special reporting requirements as set for the in the provider contract.
- Providers agree to allow authorized VPHP representatives access to conduct office site reviews, with appropriate access to member's medical records. Additionally, the provider agrees to preserve the full confidentiality of all medical records as stated in their contract.
- Providers agree to ensure the confidentiality of all patient records, including family planning services in accordance with the Medicaid Agreement.
- Providers must comply with the VPHP's Medical Management procedures and must clearly specify referral approval requirements to any subcontracted providers.
- Providers agree not to charge eligible VPHP members for medically necessary covered services under the DMAS contract. Providers may only bill if the member has consented in writing to pay for a non-Medicaid covered service prior to receiving the services.
- Providers agree to cooperate with any external review organization contracted by DMAS to perform quality studies.
- Providers agree to assist VPHP enrollees with special needs. This may range from assistance with understanding managed care and the role of their PCP to referring members to community resources or Early Intervention Services.
- Providers agree to provide appropriate written notice regarding any operational changes related to their practice. These may include address or phone number changes as well as panel status changes.

Credentialing and Re-credentialing Program Description

Overview of Program

The Credentialing Program of Virginia Premier Health Plan, Inc. (VPHP) shall be comprehensive to ensure that its practitioners and providers meet the standards of professional licensure and certification. The process enables VPHP 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 health care of network members in a cost-effective manner.

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

Credentialing Committee Structure & Activities

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

- Receive and review the credentials of all practitioners being credentialed or recredentialled 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 VPHP 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 VPHP at an outpatient setting. An independent relationship exists when VPHP selects and directs its members to see a specific practitioner or group of practitioners. An independent relationship is not synonymous with an independent contract. NCQA does not require the organization to credential some practitioners with whom it holds independent contracts.
- ❑ Practitioners who see members outside the inpatient hospital setting or outside freestanding, ambulatory facilities.
- ❑ Dentists who provide care under VPHP's medical benefits.
- ❑ Non-physician practitioners who have an independent relationship with VPHP, as defined above, and who provide care under the organization's medical benefits.
- ❑ Hospital based practitioners who have an independent relationship with VPHP and an outpatient setting:
 - Anesthesiologists with pain-management practices
 - Cardiologists
 - University faculty who are hospital based and who also have private practices
- ❑ Dentists providing care under medical benefits:
 - Endodontists
 - Oral surgeons
 - Periodontists
- ❑ Non-physician practitioners who may have an independent relationship with VPHP and provide care under VPHP's medical benefits:
 - Behavioral health practitioners
 - Nurse practitioners
 - Nurse midwives
 - Optometrists
 - Physical therapists
 - Occupational therapists
 - Vision Services providers providing care under medical benefits
 - Speech and language therapists

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

- ❑ Medical practitioners:
 - Medical doctors (MD)
 - Dentists (DDS/DMD)
 - Chiropractors (DC)-only applicable to FAMIS Members under the Medicaid line of business
 - Osteopaths (DO)
 - Podiatrists (DPM)
 - Nurse Practitioners (NP, PNP, ANP)
- ❑ Behavioral health practitioners:
 - Psychiatrists and other physicians
 - Addiction medicine specialists

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

Process and Requirements:

VPHP credentials all practitioners prior to being admitted into the VPHP 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, VPHP'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 VPHP application
- Copy of the unrestricted (*no limitations*), current and valid license or license number for the participating practitioner
- Copy of the unrestricted (*no limitations*), current DEA Certificate, if applicable
- Copy of the medical malpractice policy face sheet
- Copy of the board certificate or highest level of education; proof of education, training and competency
- Copy of the current Curriculum Vitae, which must include work history (*gaps or interruptions in work history 6 months or greater must be explained*)
- Quality measures (*initial credentialing site visit and medical record keeping practices*)
- Primary Source Verification of associated credentialing documentation
- The Office of the Inspector General and the CMS Exclusions List will be checked monthly to ensure practitioners meet the specifications of CMS and are eligible for participation.
- The Credentialing Committee's final decision (*The practitioner shall be notified within 60 calendar days of the Committee's decision*)

Primary Source Verification

The VPHP credentialing staff will conduct primary source verification as required by the most current and applicable VPHP, DMAS, and/or NCQA guidelines. VPHP 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 VPHP 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 VPHP 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:** VPHP's credentialing process is nondiscriminatory. It is the plan's policy to not discriminate based solely on an applicant's race, ethnic/national identity, gender, age, sexual orientation or the types of procedures performed or patients treated. Please be aware that this does not preclude the plan from including in its network practitioners who meet certain demographic or specialty needs. It does not preclude the plan from denying participation to a provider, if the network is adequate.
- **Right to be informed of Credentialing Outcomes:** Credentialing decisions will be communicated to providers, in writing, within 60 calendar days from the plan's final decision.
- **Right to a Timely Application Process:** Applications will be processed with in accreditation and/or regulatory guidelines. The Plan will make every attempt to process applications within 90 calendar days of receipt in the Credentialing Department.

Annual Reviews

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

Request for a Practitioner's Professional Qualifications

Please be aware that if a member request information related to a practitioner's professional qualifications, such as the specialty, board certification information, etc., the member can contact VPHP. 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 VPHP Web Site at:

www.vapremier.com or the Virginia Board of Health Professions Web Site at: <http://www.vahealthprovider.com/>

Provider Sanctions

VPHP 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. VPHP 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 VPHP members:

Service	VPHP Standard
Appointment for health assessment, EPSDT screens, general physical exams, first examinations (preventive care)	Scheduled within 30 days of request.
Initial health screens for new members under EPSDT regulations (preventive care)	Scheduled within 30 days of request and completed within 3 months of enrollment date.
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 enrollee'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	Scheduled within 14 calendar days.
Maternity Care – Second Trimester	Scheduled within 7 calendar days.
Maternity Care – Third Trimester	Scheduled within 3 business days.
High Risk Appointments	Scheduled within 3 business days.
Urgent appointments	Provided within 24 hours of enrollee'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
VPHP 24 Hours Medical Help Line	Practitioners shall advise members to contact VPHP 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 VPHP 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 (800) 727-7536 (Central Virginia/Fredericksburg/Western), (757) 461-0064 or (800) 828-7989 (Tidewater) and (540) 344-8838 or (888) 338-4579 (Southwest). A VPHP Outreach Worker will contact the member and work with them directly to facilitate compliance. **Note: VPHP members cannot be billed for a missed appointment in accordance to Medicaid regulations.**

Medical Record Keeping Policies

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

- At a minimum, participating physicians are expected to have office policies and procedures for medical record documentation and maintenance, which follow NCQA standards and ensure that medical records are:
 - Accurate and legible
 - Safeguarded against loss, destruction or unauthorized use
 - Maintained in an organized fashion for all members receiving care and services, and accessible for review and audit by DMAS or contracted External Quality Review Organizations
 - Readily available for VPHP’s Medical Management staff with adequate clinical data to support utilization management activities
 - Comprehensive with adequate information to allow record transfer procedures to provide continuity of care when members are treated by more than one provider

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

The VPHP 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 VPHP members for seven (7) years or longer if required under applicable state law.

VPHP 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 VPHP'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 VPHP employees
- Credentialing Department ongoing monitoring process
- Other Quality related initiative

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

VPHP Quality Staff will assess the following during an Office Site Visit:

- Facility Accessibility, Appearance and Adequacy
- Safety
- Adequacy of Medical Supplies and Practices
- Medical Record Keeping Practices
- Availability of Appointments

Practitioners who do not meet VPHP'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.

Program Integrity

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

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

If you have questions or concerns related to:

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

Call the Program Integrity Department:
(800) 727-7536

You can also 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.

Program Integrity and Compliance Plan

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

Standards of Professional Conduct

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

- Treat members with respect and dignity
- Deal openly and honestly with fellow employees, members, providers,

representatives, agents, governmental entities, and others

- Adhere to federal and state laws, regulations and Virginia Premier policies in procedures in all business and personal dealings whether at work or outside of work
- Exercise discretion in the processing of claims regardless of provider, practitioner, and vendor source
- Notify and return overpayments to the health plan immediately upon receipt of such payments
- Notify the Program Integrity Officer of any instances of non-compliance and cooperate with all investigational efforts by Virginia Premier and other state and federal agencies
- Use supplies and services in an efficient manner to reduce cost to the health plan
- Do not misuse Virginia Premier resources nor influence in such a way as to discredit the reputation of Virginia Premier
- Maintain high standards of business and ethical conduct in accordance with regulatory and accredited agencies to include standards of business to address fraud, waste, and abuse
- Practice good faith in transactions occurring during the course of business
- Conduct business dealings in a manner that the organization shall be the beneficiary of such dealings
- Preserve patient confidentiality, unless there is written permission to divulge information, except as required by law
- Refuse any illegal offers, solicitations, payment or other enumeration to induce referrals of the members we serve for an item of service reimbursable by a third party
- Disclose financial interest/affiliations with outside entities to Virginia Premier as required by the Conflict of Interest Statement
- Hold all contracted parties to the same Standards of Professional Conduct as part of their dealings with Virginia Premier
- Notify the Program Integrity Officer of any instances of non-Compliance and cooperate with all 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 a 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 Beneficiary
- Medical Record
- Biometric identifier

Uses and Disclosures of PHI

Covered entities are not required to obtain a member's approval to use or disclose protected health information for **T**reatment, **P**ayment and healthcare **O**perations (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.

Authorization is required for any use or disclosure other than TPO.

Authorization is required for psychotherapy notes.

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) amend 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; and
- Expand the Business Associates Agreement requirements.

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 health care 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. Virginia Premier Health Plan, Inc. (VPHP) 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.

VPHP has established several mechanisms to detect and combat fraud and abuse. Our Program Integrity and Compliance Plan 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 health care programs. Additionally, Virginia Premier is prohibited from contracting with any provider who has been terminated from a state Medicaid program, FAMIS, or Medicare for fraud, waste or abuse.

Likewise, under federal and state laws and regulations providers who receive reimbursement from Virginia Premier are prohibited from employing, doing business with, or entering into a contract with excluded individuals or entities. Providers are required to use the U.S. Department of Health and Human Services, 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 health care programs. The screening should be done prior to hire or contract signing and monthly thereafter.

In the event a provider, a provider's employees as stipulated above, or contractor is excluded, debarred, suspended or otherwise determined to be, or identified as, ineligible to participate in federal health care programs, or is listed on the OIG List of Excluded Individuals and Entities (LEIE), this agreement will, at the sole option of Virginia Premier, immediately terminate.

To ensure compliance, all providers shall implement a procedure for LEIE screening on no less than a monthly basis for all managing employees, physicians, nurse practitioners,

nurses, and contractors. Upon reasonable request, providers shall provide written verification of such screenings.

Affirmative Statements and Incentives

VPHP 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.

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 health care.
Appeal	A request from a member, attending physician, provider or facility to reconsider a decision made by VPHP 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.
Capitation	Pre-arranged payments made on a regular basis for specified physician services based on a defined patient population. PCPs agree to accept the capitated payment as payment in full for all capitated services, regardless of the number or type of services actually provided.
Centers for Medicare & Medicaid Services (CMS)	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 health care 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 HMO'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. Medicaid HMOs do not have co-payments.
Cost Sharing	Co-payments paid by the enrollee in order to receive medical services.

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).
EPSDT	Early Periodic Screening, Diagnosis, and Treatment – Those services defined by Federal law (in Section 1905® of the Social Security Act, 42 USC §1396 d ®), to include screening and diagnostic services to determine physical or mental defects in recipients under age twenty-one (21), and health care, treatment, and all other measures to correct or ameliorate any defects and chronic conditions discovered.
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.
Enrollee	A person eligible for Medicaid who is enrolled with VPHP to receive health care 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.
FAMIS	The Family Access to Medical Insurance Security Plan (FAMIS) is a program to Provide assistance with comprehensive health benefits coverage for children through the age of 18 who do not have any health insurance. The plan is paid for by the state and federal government and is designed to cover children of working Virginia families who make too much to qualify for medical assistance under Medicaid, and who do not have access to other health insurance. The Virginia Department of Medical Assistance Services administers FAMIS and eligibility determination and enrollment is handled by the Central Processing Unit.
FAMIS Plus	Children who meet “medically indigent” criteria under Medicaid program rules, and who are assigned a program designation (PD) code of 90; 91 (under 6 years of age); 92 and 94. FAMIS Plus children receive the full Medicaid benefit package and have no cost sharing responsibilities.
Fee for Service	The traditional health care payment system in which physicians and other providers receive a payment for each unit of service they provide. This

	payment is contrasted with capitation, which pays per person, not per service.
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	An oral or written communication made by or on behalf of a member expressing dissatisfaction with the resolution of a complaint. Grievances are overseen by the VPHP Continuous Quality Improvement Committee (CQIC) and are related to the availability, delivery or quality of health care services including the utilization review decisions that are adverse to the member or the payment or reimbursement of health care service claims.
HMO	Health Maintenance Organization (HMO). A medical care organization to deliver and finance health care services to its members for a fixed prepaid premium. A primary care physician must provide or authorize all services provided to members. Members must use in-network physicians.
Managed Care	Use of a planned and coordinated approach to providing healthcare with the goal of quality care at a lower cost. Usually emphasizes preventive care and often associated with an HMO.
Medallion	One of three managed care programs administered by DMAS. Medallion is a primary care provider (PCP) based program. The PCP acts as a gatekeeper for all of the recipient's medical services, promoting preventive care.
Medallion 3.0	One of the three managed care programs administered by DMAS. Medallion II is DMAS's mandatory HMO enrollment program. Recipients are required to select or be assigned to a Medicaid/ FAMIS Plus HMO that has contracted with DMAS. The HMO then administers the recipient's health care benefits.
Medicaid	Medicaid is a Federal-State medical assistance program 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.
Member	An individual who is eligible for Medicaid/FAMIS Plus and who is currently enrolled with VPHP. All members are assigned a PCP to provide and/or coordinate all health care services.
NCQA	National Committee on Quality Assurance. A not-for-profit organization performing accreditation review of managed care plans.

Network Provider	The health care entity or health care professional that has a contract with VPHP or its subcontractor to render covered services to enrollees.
Non-par Provider	Non-participating Provider – a health care entity or health care provider who is not contracted with VPHP to provide services to enrollees. 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.
Urgent Care	A medical (physical, mental or dental) 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.
VPHP	Virginia Premier Health Plan, Inc. – A Medicaid/FAMIS Plus HMO contracted with the Department of Medical Assistance Services to provide health care services for Medallion 3.0 recipients in the Central Virginia/Fredericksburg & Surrounding Counties, Tidewater/Rural Tidewater and Western/Southwestern areas of the state.
VFC	Vaccines for Children Program – Provides free vaccine to Medicaid-eligible children aged 18 years or younger, those without health insurance, Native Americans, and children whose health insurance doesn’t cover immunizations. The latter group must receive vaccines at federally qualified health centers.