

Provider Resource Tool

VPHP Mission and Corporate Overview

Mission Statement

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.

Corporate Overview

- Operational since 1995
- Subsidiary of the University Health Services
- Medicaid HMO over 135,000 members
- VPHP, Inc. was featured in the November 17, 2008 edition of US News and World Report Magazine as the "Top 25" Best Medicaid Health Plans in the Nation and as the "Top Ranked" Health Plan in Virginia
- VPHP, Inc. was awarded the "Recognizing Innovation in Multicultural Health Care Award" by the National Committee for Quality Assurance (NCQA) in 2008
- Third Largest Medicaid MCO statewide
- Operating in over 75 counties in Virginia

Benefit Summary, Enrollment and Eligibility Verification

Benefit Summary

- No co-payments for services (except for FAMIS members)
- Dental Services for Emergencies (routine & preventative services go through Smiles for Children Program)
- Vision
- Nurse Advice Line
- Primary Care Doctors (PCP)
- Well Child Care
- Hospital Service
- Emergency Care Services
- Health Education Classes
- Prescription Drugs
- Quarterly Member Advisory Committee Meetings (MAC)
- Member Newsletter
- Non-emergent Transportation (except FAMIS)

Enrollment Process

- Each month PCP's receive a panel report that list all members assigned to the PCP.
- New VPHP members are asked to select a PCP at the time of enrollment, if the member fails to select a PCP VPHP will select one for them based on geographic proximity and the age of the member.
- Members may request a PCP change at any time by calling member services. Once a change has been made the member will receive a new card with reflecting the PCP change within 7 - 10 business days.
- Enrollment data is supplied to VPHP from DMAS at the end of each month. Members are assigned to VPHP either by selecting the HMO during the enrollment process or assigned by DMAS if they fail to select a HMO.
- Participating PCP's will be paid for eligible services even if their name does not appear as the PCP on the member's ID card.

Eligibility Verification

VPH Member Services: (800) 727-7536.

Hours of Operations: 8:00 a.m. to 5:00 p.m., Monday - Friday

- **Assists members and providers with:**
 - Benefit Questions
 - PCP Selection and Provider Participation
 - Eligibility Verification
 - Transportation Scheduling
 - Member Orientation and Education
 - Claims inquiries
 - Member address changes and ID card Request
 - Verification of authorizations and referrals

Should you be interested in verifying eligibility online, please register for NaviNet. For more information on NaviNet go to the Virginia Premier website at: WWW.VAPREMIER.COM

Eligibility Verification

(INTERACTIVE VOICE RESPONSE SYSTEM)

Providers **can verify member's eligibility 24/7 days** a week by using Virginia Premier's Interactive Voice Response System (IVR).

Providers will need to use the following steps to verify eligibility.

- Call us at (800) 727-7536
- Press Option 1 for Member Services
- Press Option 1 to check member's eligibility → First prompt by the IVR System
- Press Option 2 if you are a provider
- Provider is prompted to enter Provider ID → Enter your 10 digit NPI number
- **(Provider ID is played back for verification)**
- Press Option 1 if correct
- Provider is prompted to enter Member Medicaid ID Number
- Member ID number is played back for verification)
- Press Option 1 if correct
- Provider is prompted to enter date in appropriate format → Example: 10/01/2009
- **(Member eligibility information is given out)**
- Press Option 1 to look up another member
- If you would like to speak with a Member Services Representative in person Press Option 0

Claims

Claims: Filing and Guidelines

- **Timely Filing:** Participating providers are required to submit their claims to VPHP within the timeframe established in their provider contract (180 days is the standard timeframe for most providers). Claims not submitted in accordance with the timely filing guidelines will be denied.
- **Claim Appeals:** Appeals for denied claims must be submitted to VPHP within 60 days of the original date of the denial. Should a claims processing error be attributable to Virginia Premier, providers have up to 365 days after receipt of payment to appeal.
- **Claim Forms:** Provider, ancillary and OP services should be submitted to VPHP on the CMS-1500. Hospital and facility claims should be submitted to VPHP on the UB04 form.
- For services that required an authorization that number should be submitted to VPHP in Box 23 if the CMS-1500 form.
- Providers should always refer to the most current versions of the CPT and ICD9 coding manuals when billing services.

Claims: Paper Claims

- **PCP Claims :**
PO Box 5207
Richmond, VA 23220-0207
- **Specialty Claims:**
PO Box 5208
Richmond, VA 23220-0208
- **Hospital Claims:**
PO Box 5120
Richmond, VA 23220-0120

Claims: EDI Vendors

VPHP strongly encourages providers to consider filing claims electronically. Advantages to submitting electronic claims: timely submission to payers, reduces claims administrative costs, and increases payment turnaround.

Allscripts : (800) 654-0889 <http://www.allscripts.com>

Benchmark: (800) 779-0902 <http://www.benchmark-systems.com>

Claims Logic: (866) 252-4656 <http://www.claimlogic.com>

Gateway EDI: (800) 969-3666 <http://www.gatewayedi.com>

McKesson /Relay Health: (800) 981-8601 <http://www.mckesson.com>

MedAssets: (866) 323-6332 <http://www.medassets.com>

Noteworthy Medical Systems: (877) 891-8777

<http://www.noteworthyms.com/>

SSI Group: (800) 881-2739 <http://www.thessigroup.com/>

WebMD-Emdeon: (877) 363-3666 <http://www.emdeon.com/>

Zirmed: (877) 494-7633 <http://www.zirmed.com>

Claims: Customer Service

Providers needs assistance with contact the Claims Customer Service Department at: (800) 727-7536 Option 4.

They can assist providers with:

- Verifying claim status
- Claim edits
- Researching claims issues
- Explanation of EOB's

Claims: Appeals Process

- Providers may appeal a claim outcome by completing a Claim Adjustment/Appeal Request Form which can be found online at <http://www.vapremier.com> under the tab for Claims. Appeals for denied claims must be sent or faxed to VPHP within **60 days** of the original denial date on the EOB.
- Claim denials not submitted to VPHP within the allowed 60 day timeframe must be directed to your local Provider Service Rep who will request a review of the claim for payment.
- Claims denied for non-medical reasons (duplicate claim, CPT/ICD9 denial) should be appealed to:

Virginia Premier Health Plan, Inc.
Attn: Claim Appeals Department
PO Box 5286
Richmond, VA 23220

- Claims denied for medical reasons should be appealed with clinical documentation to:

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

Medical Management

Medical Management: ER 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 will assess the member's medical condition and instruct the member on obtaining appropriate medical care.
- If a PCP directs a member to the ER then the office should notify VPHP the next business day so the claim can be paid without retrospective review.
- Emergency Room services that do not meet the Prudent Layperson standard will be reimbursed for a medical screening or "triage fee" only.

Medical Management: Referrals

- VPHP does not require referrals to participating (in-network) specialist for its members.
- Virginia Premier is committed to ensuring coordination and communication between the member's PCP and specialist; therefore, we ask that PCP's communicate to the specialist that the member is being recommended by the PCP to see the specialist.
- A written report from the specialist to the PCP informing them of the evaluation and care rendered should be sent after the member's visit.
- Members are required to visit participating providers for care and services. Referrals to non-participating specialists are permitted only if the required specialist is not available through the Virginia Premier network and the service is pre-authorized by VPHP. Please contact your local VPHP office and speak with Medical Management to request an out-of-network referral.

Medical Management: Authorizations

- VPHP requires providers to obtain pre-authorizations from the health plan for certain services, procedures and all hospital admissions. ***Failure to obtain pre-authorization from VPHP for services will result in a denial of the services and the provider will be held responsible for the services.***
- In order to pre-authorize services call your local VPHP office and select the option for Medical Management. Providers also have the option to fax a IP/OP Auth Form to VPHP which can be found online at:
<http://www.vapremier.com/index.php?page=referral-authorization-guidelines>.

Procedures Requiring Prior Authorization

(Pre-authorization is required for services including, but not limited to, the following);

- All inpatient hospitalizations (& extensions beyond the original LOS).
- All 23 hour observation admissions (excluding OB observations).
- Chemotherapy
- Chiropractic (This a FAMIS Benefit Only)
- Cosmetic Surgery (e.g. Keloid & Scar Revisions, Varicose Veins, Mammoplasty, Reduction & Augmentation)
- Enteral Nutrition & TPN*
- Health Education & Training Services
- Home Health Services
- Hyperbaric Therapy
- Infusion Services
- Mental Health Outpatient Counseling and Alcohol and Drug Abuse Treatment (beyond initial assessment & two(2) follow-up visits per member, per year)
- Non Emergent Medical Transportation

Procedures Requiring Prior Authorization

(Pre-authorization is required for services including, but not limited to, the following);

- Organ Transplant Evaluation & Surgery
- Outpatient surgical procedures done in a hospital/ambulatory setting
- Durable Medical Equipment (include Orthotics & Prosthetics when applicable*)
- Out of Network Referrals
- Pain Management (e.g. joint injections, spinal cord stimulator)
- Psychological/Neuropsychological Testing
- Rehab Therapy (e.g. PT/OT/SP)
- Radiological (non-routine imaging for example: CT, CTA, MRI, MRA, Nuclear Scan, PET Scans)
- Radiation Therapy
- Renal Dialysis
- Specialty Drugs

***Age Requirements**

Note: If a provider has any questions pertaining to prior authorization, please contact VPHP before performing the procedure.

Medical Management: Admissions & 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 48 hours with notification to providers within 48 hours of making the decision.
- Concurrent or continued stay reviews are performed on non-DRG hospitalized patients. Medical record review will determine if the assigned length of stay remains appropriate or if it should be modified given significant changes to the patient's condition.

Medical Management: Appeals Medical Necessity

- The Medical Necessity Appeals process is a mechanism through which a 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.
- There are 2 types of Medical Necessity Appeals:
 - Expedited Appeal: may be requested when a denial is made by VPHP prior to, or during the course of treatment. If the member or provider feels that VPHP's decision is not acceptable, a request to appeal should be faxed to VPHP's Medical Management Dept. (804) 819-5186. 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.
 - Standard Appeal: Standard appeals are generally made after services have been rendered. All documentation and/or medical records should be faxed to (804) 819-5186 or mailed to:

Virginia Premier Health Plan, Inc.
Medical Management/ Quality Appeals
PO Box 5244
Richmond, VA 23220-0244

Medical Management: Case Management Programs

- 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 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
- To refer a patient for VPHP's Case Management Services, call Medical Management at (800) 727-7536 in the Central Virginia Area, (800) 828-7989 in the Tidewater Area, and (888) 338-4579 in the Roanoke Area.

Medical Management: Disease Management Programs

- VPHP is pleased to welcome members to its Disease Management programs. These programs will help members better understand their condition and keep them updated on new information.
- Our programs are based on nationally accepted guidelines and support the physician-patient relationship at no cost to the member.

Available programs:

- [Asthma](#)
- [Childhood Nutrition](#)
- [COPD](#)
- [Diabetes](#)
- [HHB \(High Risk Pregnancy\)](#)
- [Heart Disease](#)

Medical Management: Medical Outreach/Healthy Heartbeats

- VPHP recognizes the importance and role of health education in the prevention of illness, which is why we utilize a team of Medical Outreach Representatives to reach out to our members who may have specific health and /or social service needs.
- While visiting, the member the Outreach Representative will assess the home environment, solicit from the member specific health needs and a health care assessment will be completed with the member. Based on the assessment the outreach team will refer the member to the appropriate resources if needed.
- All pregnant members are enrolled in VPHP's Health Heartbeats program which included regular home visits. This program offers personalized pre-natal care from conception to delivery to insure the best pregnancy and delivery experience for our members. OB Providers are encouraged to complete and fax the VPHP OB Registration form after a members first pre-natal visit. This enables us to quickly enroll members into our Healthy Heartbeats program and target those at risk who may need additional interventions.

Ancillary Benefits

Ancillary Benefits: DME

- All DME requests should be coordinated through the Case Manager at VPHP.
- Submit Certificate of Medical Necessity (CMN) to the Case Manager including request for Orthotics/Prosthetics.
- VPHP will honor Medicaid CMN or a Physician order as long as it is signed and dated by the PCP or referring physician.
- The CMN or Physician order must be completed in its entirety and signed and dated by the PCP or referring Practitioner. The PCP or referring Practitioner should mail or fax the referral form to the Medical Management Department at (800) 827-7192.
- VPHP will cover all medically necessary equipment and supplies for rental or purchase when ordered by a participating provider. We will follow the Medicaid guidelines for equipment and supplies based on medical necessity. Please consult the DMAS guidelines for equipment being requested for Medicaid members.
- Should you have any questions, please contact the Medical Management Department at (888) 338-4579.

Ancillary Benefits: Rehabilitative Services

- PT and OT therapies are available to VPHP members. These services require pre-authorization and medical necessity must be demonstrated. Providers must submit treatment plans in order for VPHP to authorize services.
- Inpatient Rehab Services may be provided through a rehabilitative hospital or other specialized facility.
- Speech and audiology services are covered benefits for members under twenty-one (21) years of age. All services require pre-authorization from VPHP. School based speech therapy is not a covered benefit through VPHP and is reimbursed by the Department of Medical Assistance Services (DMAS).

Ancillary Benefits: Vision

**Routine eye exams and eyeglasses are
covered through Vision Service Plan
(VSP) at:**

(800) 852-7600

Ancillary Benefits: Dental

Dental Services are provided by Department of Medical Assistance Services “Smiles for Children” Program at:

(888) 912-3456

Behavioral Health

Behavioral/Mental Health

Behavioral/Mental Health benefits are available to all eligible Virginia Premier Medallion II and FAMIS Members through VPHP's network of behavioral/mental health providers

Participating Providers

- Participating providers are required to complete an Initial Outpatient Treatment Report (IOTR) following initial review for authorization.
- The IOTR can be found at the following:
http://www.vapremier.com/uploads/pdf/9761_IOTRForm.pdf
- A subsequent Outpatient Treatment Report (OTR) will need to be completed and submitted for reauthorization of additional services.
- The OTR can be found at the following:
<http://www.vapremier.com/uploads/pdf/OutpatientTreatmentReport.pdf>

Psychological Testing

- Psychological Testing must be pre-authorized for outpatient services.
- A treatment plan must be submitted to VPHP's Behavioral Health Unit at the time of request.
- 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 and submit for authorization prior to test being performed.
- The Psychological Testing Form can be found at the following:
<http://www.vapremier.com/uploads/pdf/RequestforPsychologicalTesting.pdf>

Outpatient Substance Abuse Benefits

- A review of substance abuse will be conducted after the initial 3 visits and after each block of authorized outpatient visits that have been utilized.
- An Outpatient Treatment Report (OTR) must be completed following the initial review. This report is carefully reviewed by the UR Nurse. The following information is requested:
 - Diagnosis including precipitating event and patient history treatment goal(s)
 - Treatment modality appropriate to diagnosis
 - Medication and prescribed therapy including dosage levels, frequency and expected duration of treatment(s)

Outpatient Substance Abuse Benefits

- Physician Advisor
 - VPHP makes its authorization decision based on the above provided information. If the treatment plan does not appear to be appropriate for the diagnosis or the current condition of the patient, the UR nurse will refer the case to a Physician Advisor.
 - The Physician Advisor will contact the member's provider to discuss the case.

Inpatient Mental Health Services

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

Inpatient Mental Health Services

- At the end of an 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
 - Medication and prescribed therapy including dosage levels, frequency and expected duration of treatment(s)
- Following the review of the treatment plan, the Mental Health UR nurse will assign an appropriate length of stay.
- Inpatient mental health admissions are limited to twenty-one (21) days in a sixty (60) day period for the same or similar diagnosis for members twenty-one years and over.

Inpatient Mental Health Services

- The Mental Health 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

Inpatient Substance Abuse Services

- VPHP does not cover inpatient, residential or day treatment substance abuse services. 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 ninety (90) days per enrollee. (maximum lifetime benefit)
- FAMIS members are limited to thirty (30) days per calendar year including partial day treatment services for inpatient health.

Free-standing Psychiatric Facility Admissions

- Admission to a “free-standing” psychiatric facility is permitted under the following circumstances:
 - The member is under twenty-one (21) years of age or over sixty-four (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 twenty-one (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 disenrollment of the child from the FAMIS program.

Pharmacy Benefits

Pharmacy Contact Information

- **Prescription Plan**
 - Express Scripts (800) 824-0898
- **Specialty Pharmacy**
 - Axiom Healthcare Pharmacy (800) 546-2172

Preferred Drug Listing (PDL)

- The Virginia Premier Preferred Drug List is a combination of open and closed therapeutic classes. Drugs or medications not on our Preferred Drug List can be reviewed through the Prior Authorization process. The pre-authorization form can be found at www.vapremier.com.
- Virginia Premier pharmacy benefits are administered by Express Scripts (ESI). Prior Authorization requests should be faxed to Express Scripts and can be found at www.vapremier.com and are located under the Medical Management tab.
- The Preferred Drug Listing are located on Virginia Premier's website in a PDF and a searchable format under the under the Medical Management tab.
- If you have a question or problem related to a member's prescription you may contact Express Scripts' Pharmacy Help Desk at (800) 824-0898.

Pharmacy Benefit

- VPHP covers the following OTC drugs and supplies when they are prescribed in writing by a participating provider (not a FAMIS benefit). Examples of those covered OTC items are below:
 - Generic oral analgesics for pain relief
 - Generic antacids
 - Generic antidiarrheals
 - Generic antifungals (topical and vaginal)
 - Generic cough and cold products
 - Generic antihistamines
 - Generic topical corticosteroids
 - Generic anti-ulcer
 - Generic laxatives
 - Generic prenatal vitamins

Pharmacy- Specialty Services

- Axiom Health Care Pharmacy is the specialty pharmacy benefit manager for specialty drugs. Axiom's medication therapy management program services medications to a wide range of patient populations including the following:
 - **Growth Hormone**
 - **Hepatitis**
 - **Multiple Sclerosis**
 - **Rheumatoid Arthritis**
 - **Hemophilia**
 - **Osteoarthritis**
 - **HIV/Aids**
 - **IVIG**
 - **Psoriasis**
 - **Cancer**

Network Development

Provider Services Team

Provider Services can be contacted at the following offices:

- Central Virginia/Fredericksburg: (800) 727-7536
- Tidewater: (800) 828-7989
- Roanoke & Surrounding: (888) 338-4579
- Harrisonburg: (800) 595-1630

Hours of Operations: 8:00 a.m. to 5:00 p.m., Monday - Friday

Handles:

- Provider Recruitment
- Assist with contract negotiations (as needed)
- Provider Claims Issues
- Provider In-services
- Quarterly Provider Advisory Committee Meetings
- Provider Site Visits

Contracting Team

Contracting can be reached by calling the (800) 727-7536.

Hours of Operations: 8:00 a.m. to 5:00 p.m., Monday - Friday

Handles:

- Provider Recruitment
- Negotiate Contracts
- Provider Claims Issues (as needed)
- Assist with PAC Meetings/In-services as needed
- Provider Changes
- Quarterly Provider Newsletters
- Provider Manual
- Semi-Annual Provider Directories
- Network Assessments
- Website Updates

Compliance

Claims Fraud and Abuse

Definitions:

- False Claim - any claim for payment to which the submitter is not entitled to reimbursement
- False Claims Act - prohibits knowingly submitting or causing another person to submit false claims
- Abuse - the receipt of services which are inappropriate, are not medically necessary or were obtained for personal benefit
- Fraud - when someone knowingly and willingly lies in order to receive money or benefits for him/herself/or someone else

Examples of a False Claim

- Claim for service not rendered
- Falsifying records - altering signatures, dates of service, and treatment plans
- Participating in kickback schemes
- Billing for services not medically necessary
- Unbundling services that should be billed as one

Examples of Fraud & Abuse

Committed by Providers:

- Billing for services not provided
- Billing for “free” services
- Misrepresenting services or dates of service
- Improper Coding
- Accepting or offering a kickback or bribery in exchange for medical services or referrals

Committed by Members:

- Loaning ID card to ineligible person
- “Doctor Shopping” and excessive trips to the ER for narcotics
- Falsifying information on Medical Assistance application in order to receive benefits

Whistleblower Protections

- False Claims Act provides protection for providers' employees who wish to report suspected wrong doing
- Employers are prohibited from retaliating against an employee for suspected misconduct. Employers cannot subject individuals to the following for reporting suspected fraud:
 - Termination
 - Demotion
 - Promotions withheld
- Suspected fraud should be reported to:
Corporate Compliance Officer or Human Resources, or Virginia Premier Health Plan, Inc.

Reporting Responsibilities

As a means to encourage individuals to come forward and report misconduct, individuals are permitted to bring qui tam actions based on information discovered in the course of their employment only if that employee has made a good faith effort to exhaust internal reporting procedures by reporting through the official channels established.

Reporting Fraud & Abuse

To report suspected wrongdoing directly to Virginia Premier, please contact the corporate Compliance Office, Gloria Reynolds at (800) 727-7536. You may also report your concerns confidentially to the Compliance Help Line at (800) 620-1428 or on the web at <http://www.compliance-helpline.com>.