Utilization Management Program Description

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2009 Utilization Management Program Description

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VIRGINIA PREMIER HEALTH PLAN, INC.

2009 Utilization Management (UM) Program Description

I. SCOPE

The Program is designed to ensure that medical services rendered to members are medically necessary and/or appropriate, as well as in conformance with the benefits of the Plan. The program encompasses services rendered in ambulatory, inpatient and transitional settings. The following principals govern the program:

A. Virginia Premier Health Plan's (VPHP) Medical Directors, Utilization Management Committee, and Vice President of Medical Management are responsible for administering the Utilization Management Program.

B. The Program's policies and procedures are developed by the Medical Management Department and approved by Utilization Management Committee and New Technology Committee (UMC). Ratification by the Continuous Quality Improvement Committee (CQIC) and VPHP's Board of Directors shall occur after review and approval of the recommendations and policies of the UMC.

C. The Medical Management Department is responsible for determining medical necessity of services in accordance with program policies and procedures. If services are determined by the Medical Management Department to be either not medically necessary or not covered under the VPHP benefit's contract, payment for services will be denied. The member is to be held harmless for payment in cases of lack of prior authorization or medical necessity determinations for covered benefits. Members and providers may exercise their appeal rights for request that are denied by VPHP. The Medical Management Department is also responsible for identifying trends of over and under utilization of services by monitoring referral patterns, encounter data, pharmacy data, medical record site reviews and authorization requests.

D. The Medical Management Department is responsible for determining medical necessity of services; however, VPHP does not prohibit or restrict a health care practitioner to act within their lawful scope of practice, from advising or advocating on behalf of a member that is their patient regarding the following:
   a. Health status
   b. Medical care or treatment options
   c. Any alternative treatments that may be self administered

E. Covered benefits include physician, outpatient, pharmacy and inpatient services for behavioral health and medical diagnosis. ***(Attachment A)***

F. Determinations of lack of medical necessity may be made prospectively, concurrently, or retrospectively based on notification to VPHP.

G. VPHP's Physician Advisors, who are board certified physicians in their specialty, assist the Utilization Management staff and Medical Directors in the determination of medical necessity in accordance with program policies and procedures when a second opinion is warranted or upon appeal of a denial decision.

H. VPHP's UMC and Pharmacy & Therapeutics committees in collaboration with the Medical Directors review the health plan's prescription drug and covered over the counter medication utilization trends for appropriateness and cost effectiveness with feedback to providers and the VPHP's pharmacy benefits manager for improvements.

I. Participating providers are responsible for complying with program policies and procedures prior to rendering services.

J. When reimbursement is reduced or denied, the member cannot be held financially responsible for denied service costs unless the member has agreed to bear such costs prior to receiving **non-covered** services by signing in advance a waiver permitting billing for service.

K. Determinations of lack of compliance with the program by participating providers are reviewed by the Utilization Management staff and directed to the Medical Director. VPHP's Medical Director gives individual feedback to providers if providers are not in compliance with the program's policies and procedures.

L. Determinations of lack of medical necessity or lack of compliance with the program may be appealed according to established VPHP UM program policies and procedures.

M. Findings of repeated occurrences of lack of medical necessity or lack of compliance with the program will be referred to VPHP's UMC and subsequently to the CQIC.

N. Dissemination and storage of patient information shall comply with Federal, State, HIPAA and any other applicable statutes and regulations pertaining to confidentiality.

O. The program accommodates the contractual requirements of the Department of Medical Assistance Services (DMAS), the Balanced Budget Act (BBA) and

Centers for Medicare and Medicaid Services (CMS) regulations and accreditation standards for the National Committee for Quality Assurance (NCQA).

II. OBJECTIVE

This section outlines VPHP's Utilization Management Program. The objective of the program is to ensure that medical services rendered to members enrolled in VPHP are medically necessary and/or appropriate, as well as in conformance with the benefits of the Plan. The program functions on consistently applied systematic evaluation of appropriateness criteria and by considering circumstances unique to the member.

III. GOALS

A. The goals of the Utilization Management Program are to ensure:

1. Services rendered are medically necessary and provided in the most appropriate setting.

2. Services are rendered at the appropriate level of care.

3. Available resources are utilized in an efficient manner in the delivery of services.

4. Services are rendered in accordance with the benefits of VPHP.

B. In support of these goals, the program incorporates the following objectives:

1. To implement prospective, concurrent, and retrospective review procedures.

2. To provide guidance, feedback, and education to participating providers in the efficient delivery and utilization of resources.

3. To convey identified relevant information to the UMC and the CQIC committee for examination.

C. The Medical Management Department shall evaluate and update the Utilization Management program on an annual basis with review and feedback from the UMC.

1. The Medical Management Department may submit recommendations for program improvements to the UMC.

2. All recommended changes to the UM program will be presented to the Continuous Quality Improvement Committee (CQIC) and ultimately to VPHP's Board of Directors for approval. ***(Attachment B)***

3. The following items will be reviewed by the committee semi-annually and included in the utilization management program evaluation:

   - Admits/1000 enrollees
   - Days/1000 enrollees
   - Average length of stay
   - Inter-rater reliability results of nurses and physician reviewers
   - Timeliness of prior authorization decisions
   - Appeals Decisions
   - Over and Under Utilization
   - Case Management and Disease Management Outcomes
   - Provider and Member Satisfaction with the UM process
   - Accomplishments and Opportunities for Improvement

IV. ORGANIZATION

A. Program Participants:

The following individuals and organizations play key roles in VPHP's Utilization Management program:

1. VPHP's Board of Directors
2. Continuous Quality Improvement Committee (CQIC)
3. Utilization Management Committee (UMC)
4. Medical Directors and Vice President of Medical Management
5. Case Management, Utilization Review Nurses and Support Staff
6. Physician Advisors (Consultants)
7. Participating Providers/Contracted Facilities

B. Responsibilities and Limits of Authority *(Attachment B)*

The responsibilities and limits of authority of each of the individuals and organizations which play key roles in the UM Program are delineated in the following subsections:

1. VPHP's Principals

   The Principals of VPHP are the Board of Directors, CQIC, and Utilization Management Committee. Responsibilities of the Board of Directors include:

   a) Ratifying program policies and procedures including sanctions for non-compliance with the program after review by the CQIC.

   b) Oversight of the CQIC.

2. Continuous Quality Improvement Committee (CQIC)

   a) The CQIC is composed of the senior management team of VPHP. The committee meets at least four (4) times a year. The CQIC is responsible for reviewing the decisions of the Medical Management Department and UMC.

3. Medical Directors and Utilization Management Committee (UMC)

   The Utilization Management Committee is composed of board certified participating providers within VPHP's network. The provider specialties currently represented on the committee include: Internal Medicine, Family Practice, Pediatrics, OB/GYN, Endocrinology/Metabolism, Gastroenterology, General Surgery, and Psychiatry. This committee meets on a quarterly basis.

   The Medical Directors, Utilization Management Committee and designated administrative staff are responsible for administering the Utilization Management program. The responsibilities of the Medical Directors and Utilization Management Committee include:

   a) Providing medical direction and support to the Medical Management staff.

   b) Making denial decisions, or modifications in, requests for medical services from providers based upon medical necessity and treatment protocols.

   c) Reviewing and rendering decisions on appeals resulting from denials of or modifications in, requests for medical services from providers based upon medical necessity or treatment protocols. This occurs only if the Medical Director was not involved in the initial determination of denial.

d) Providing individual feedback to providers on over and under utilization of services based on the HEDIS® data from VPHP's authorization system, claims system, prescription benefits' plan, and vendor encounters.

4. Medical Management Department

The Medical Management Department hours of operation for utilization management and care coordination are Monday – Friday, 8:00 am to 5:00 pm. The Senior Medical Director, Medical Director and/or Associate Medical Directors are available Monday – Friday, 8:00 am to 5:00 pm to speak with practitioners regarding a pending medical necessity denial prior to the denial. They can be reached toll-free at (800) 727-7536. All communications that require a response will be responded to within one (1) business day of receipt. Providers are able to send information to the department by confidential fax and voice mail after hours.

The Medical Management Department consists of an interdisciplinary team, of Utilization Review Nurses (LPN), Case Managers (RN and LCSW- behavioral health only), Health Educators, Medical Outreach Workers, Referral Coordinators, Quality Management Coordinator (RN), Credentialing Specialist, Accreditation Manager, Manager, Grievance/Appeals Coordinator, Vice President of Quality and Accreditation, Vice President of Medical Management, Associate/Assistant Medical Directors, Medical Director and the Senior Medical Director (Virginia licensed MDs). ***(Attachment C)***

All decisions to deny a request based on medical necessity are performed by a medical or behavioral health physician. All initial decisions to deny Early Periodic Screening Diagnosis and Treatment (EPSDT) services require a secondary physician review.

The Associate and Assistant Medical Directors, Senior Medical Director or Physician Advisors may not make a determination of medical necessity on an appeal if she/he has previously been involved in the initial determination of the appealed case unless additional information provided leads the medical director to reverse and approve his/her initial decision. In addition, the physician reviewing and making determinations on an appeal shall not be a subordinate of the person making the initial non-certification decision.

Responsibilities of the Vice President of Medical Management in collaboration with the Senior Medical Director and Utilization Management Committee include the following:

a) Developing, recommending, and refining program policies and procedures, including criteria used to determine medical necessity, and establishment of thresholds for acceptable utilization levels based on the enrollee's benefit plan.

b) Establishing policies and reviewing concerns regarding medical necessity in prospective, concurrent, and retrospective review, and appeals.

c) Identifying areas of improvement and reporting to the Quality Improvement Committee (QIC) and Credentialing Committee for recommendations to participating providers for changes in practice patterns to conform to practice standards.

d) Determining provider compliance with program policies and procedures, and recommending review for program non-compliance to the UMC and CQIC.

e) Identifying possible quality issues and referring them to the Senior Medical Director, Director of Quality Improvement and QIC.

f) Reporting to the Principals regarding program effectiveness.

5. Medical Management Staff

The Medical Management licensed staff are responsible for administering the UM program with oversight from the Senior Medical Director, Associate Medical Directors, Utilization Management Committee (UMC) and Vice President of Medical Management. Case managers and utilization review nurses review clinical request according to Interqual™ criteria. Medical case managers are registered nurses licensed in the Commonwealth of Virginia. Behavioral Health case managers are registered nurses and/or licensed clinical social workers licensed in the Commonwealth of Virginia. In addition, utilization review functions are performed by Virginia registered and licensed practical nurses. The medical management staff report to a manager that is a Virginia licensed registered nurse. The managers of Medical Management report to the Vice President of Medical Management, a Virginia licensed registered nurse. The Senior Medical Director provides oversight for all clinical decisions. ***(Attachment C)***

Responsibilities of the staff include but are not limited to:

a) Serving as support staff to the UMC, including participating in UMC meetings as necessary.

b) Conducting reviews of utilization data and provider practice patterns to identify outliers for the Medical Directors' review.

c) Presenting reports and analyses of utilization and case management data to the Vice President of Medical Management, Medical Directors, and UMC.

d) Assisting in the development of UM policies and procedures.

e) Ensuring compliance with VPHP's reporting requirements involving utilization data.

f) Making utilization decisions that are not influenced by conflicts of interests.

6. Physician Advisors

Physician Advisors are board certified physicians and dentist that assist the Medical Management staff and Medical Directors in the determination of medical necessity in prospective, concurrent and retrospective review, and appeals on an as-needed basis. Member Doctor/Physician Advisors do not determine provider compliance with program policies and procedures or determination of payment of benefits.

V. UTILIZATION MANAGEMENT CRITERIA

The program functions on consistently applied systematic evaluation of appropriateness criteria. The criteria are selected based on nationally recognized standards of practice for medical and behavioral health services and is applied on an individual needs basis. Criteria used for utilization review decisions are from Interqual™ criteria and approved VPHP guidelines. Nurse Reviewers are oriented to the application of the criteria with annual assessment of the application. Each office has written instructions in the application of Interqual™ criteria. The UMC and Quality Improvement Committee (QIC) review the Interqual™ criteria and VPHP guidelines/policies annually for changes and updates.

When UM criteria or guidelines are not appropriate for the case in review, the reviewer will submit all information to the Medical Director for individual consideration and discussions with providers in the same or similar specialty for standards of care and practice. The following factors are included in individual consideration decisions:

- Age of the member
- Comorbidities
- Complications

- Progress of treatment
- Psychosocial situation
- Home environment, if applicable
- Network composition, i.e. availability of skilled nursing facilities, home care
- Benefit coverage
- Capabilities and services of the network or out of network facilities
- Community resources for discharge planning and follow up care

The consistent application of the criteria is evaluated at least twice a year for all nurse and physician reviewers. Opportunities for improvement are identified with individual feedback given to the reviewer. Each nurse and physician reviewer must reach a comprehensive score of eighty (80) percent on the inter-rater reliability assessment in order to continue making medical necessity decisions.

Criteria used in decision-making are available to practitioners, facility personnel, providers and members upon request to VPHP.

VI. BEHAVIORAL HEALTH PROGRAM

The program outlines VPHP's efforts to monitor and improve behavioral health care. The behavioral health practitioner on the UMC is a board certified psychiatrist who acts as a consultant for the development and implementation of the Utilization Management Program through annual review of policies, criteria and behavioral health utilization. This practitioner also serves as a physician reviewer for medical necessity determinations. In addition, VPHP has two Assistant Medical Directors that are also board certified psychiatrists and are available Monday through Friday, 8:00am to 5:00pm for medical necessity determinations.

Goals of The Program

1. To coordinate and provide high-quality managed behavioral healthcare services
2. To sustain a formal Quality Improvement Committee (QIC) comprised of practitioners representing all VPHP geographical regions, numerous specialties, to include a behavioral health practitioner
3. To meet requirements of the National Committee for Quality Assurance (NCQA), the Healthcare Effectiveness Data and Information Set (HEDIS)
4. To determine the impact of behavioral health treatment on physical health status
5. Ensure patient satisfaction with care provided and aspects of the delivery system

Scope of the Program

To provide quality of direct patient care in behavioral health while seeking care from network and out of network practitioners in outpatient and inpatient settings for adults, adolescents and children.

Coordination of Care

Utilization review and case management is performed within VPHP by Virginia licensed clinical social workers (LCSW) and registered nurses (RN) that have behavioral health clinical expertise. Licensed practical nurses (LPN) with behavioral health clinical expertise also perform utilization review functions for the health plan. The Plan offers twenty-four (24) hour clinical coverage for behavioral health services through open access to inpatient, outpatient and emergency services. Members have open access to participating behavioral health practitioners, up to a maximum of three outpatient initial visits. Four or more outpatient visits require preauthorization.

VPHP's behavioral health utilization nurses assist in the coordination of care between PCP's and behavioral health providers by notifying the PCP of any BH admissions. This notification includes information about the member's follow up visit with the behavioral health provider post discharge.

Member Information

VPHP provides care management and quality assurance to ensure that members have access to the highest quality behavioral healthcare possible. The Plan maintains a network of practitioners and providers who work closely with VPHP to provide the most effective and efficient treatment available, based on current research and driven by a commitment to address the unique needs of VPHP members.

Members and providers can find behavioral health providers listed in the provider directory or by contacting VPHP's directly at the numbers listed below.

Richmond VA #:	1-800-727-7536
Tidewater VA#:	1-800-828-7989
Roanoke, VA #:	1-888-338-4579

VPHP's behavioral health case managers will help members select a practitioner, if needed.

Behavioral Health Referrals

Members may self refer for the initial three (3) behavioral health visits of the benefit year. VPHP does not have a triage system for referrals. Behavioral Health providers may request additional visits by completing an outpatient treatment report and sending it to VPHP prior to rending services. Authorization requests will not be reviewed retrospectively except in cases of emergency services. Behavioral health review and response timeframes are the same as medical review and are outlined below.

VII. UTILIZATION MANAGEMENT REVIEW PROCESSES

This subsection describes the utilization management review processes, including prospective, concurrent and retrospective review.

A. Prospective Review Process (Preservice- Urgent and Nonurgent)

The prospective review process ensures that no service is rendered to a member prior to determining both the medical necessity of the service as well as the coverage limits of the member's benefit plan.

1. Objectives

The objectives of the prospective review process include the following:

a) Determining medical necessity, benefit compliance and appropriateness of services in accordance with VPHP's medical policies and practice guidelines.

b) Ensuring the use of VPHP's participating physicians/contracted facilities, when feasible.

c) Ensuring that services rendered by an out of network practitioner are not provided without a referral from the primary care physician (PCP) when required by VPHP.

2. Procedures

a) Prior Authorizations
   (1) Decision Timeframes
   Utilization decisions will be made as soon as possible for cases involving urgent care but no later than 72 hours of the receipt of request. Non-urgent cases will have a determination within fourteen (14) calendar days of the receipt of the request. Oral notification of the decision will be given to the requesting provider and member *(only if denied)* on the same day that the decision is made.

Electronic or written notification of a determination of denial with appeal rights will be given no later than three (3) calendar days after the oral notification to the member, provider and facility.

(2) Coordination and Transition of Preauthorized Services for New Enrollees

VPHP's medical management licensed staff will call the new enrollee's former plan to verify prior authorization of all requested services. If services were authorized with an out of network provider, the UM nurse/Case Manager will assist the enrollee with obtaining an appointment to a comparable in network provider whenever possible. If there is no comparable in-network provider or changing the provider will disrupt the member's care, VPHP will authorize care to the out of network provider.

(3) Inpatient Services

VPHP requires pre-authorization of all admissions (elective and urgent). Failure to pre-authorize admissions may result in payment denial. VPHP must receive notification of an emergency admission within 24 hours of the admission date. VPHP will orally communicate an approval decision to the facility within 24 hours of the admission. A decision may be rendered within 48 hours of the urgent request only if the information received was incomplete. The member or member's representative will be notified and given at least 48 hours to provide the information. If the request is denied, VPHP will orally communicate the denial to the facility, member and provider within 24 hours of the request followed by a letter with appeal rights to the member, facility and provider within three (3) calendar days of the oral notification. During the pre-authorization process, the UM nurse/Case Manager will request information regarding the diagnosis, history and physical, laboratory results, and the current treatment plan to determine medical necessity.

(4) Outpatient Services

a. All outpatient procedures (i.e. surgery, DME, home health, non-routine radiological tests) require pre-authorization from VPHP. Decisions on non-emergent or non-urgent procedures will be rendered

within fourteen (14) calendar days of the request with decisions for urgent request communicated in 24 hours. A decision may be rendered within forty-five (45) calendar days of the non-urgent request only if the information received was incomplete. The member or member's representative will be notified and given at least 45 days to provide the information. During the pre-authorization process, the UM nurse/Case Manager (CM) will request information regarding the diagnosis, history and physical, laboratory results, and the current treatment plan to determine medical necessity.

(5) Emergency Room Visits

a. Enrollee's may seek emergency care as needed at participating or non-participating facilities.
b. All urgent/non-emergent visits must be authorized through the PCP, VPHP's UM/CM staff or the Nurse Advice Line (available 24 hours/day/7 days a week).

(6) Pharmacy Prior Authorizations

a. Physicians must submit **(Attachment E)** to Perform Rx for prior authorization of prescriptions on the formulary that require authorization or exceptions to drug limitations or step therapy.
b. Specialty drug injections for provider office administration or member self injection. **(Attachment F)** require a prior authorization from VPHP/Perform **(Attachment G).**
c. VPHP will respond within 48 hours of receipt of authorization requests.

(7) Post Stabilization Services

d. Post-stabilization services are defined as covered services related to an emergency medical condition that is provided after a member is stabilized in order to maintain the stabilized condition or to improve or resolve the member's condition. These services are covered under the following conditions:

- Pre-approved by a VPHP provider or by VPHP;
- Not pre-approved by a VPHP provider or VPHP, but administered to maintain the member's stabilized

condition within 1 hour of a request to VPHP for pre-approval of further post-stabilization care services;

- Not pre-approved by a VPHP provider or VPHP, but administered to maintain, improve, or resolve the member's stabilized condition if:
  - o VPHP does not respond to a request for pre-approval within 1 hour;
  - o VPHP cannot be contacted; or
  - o VPHP and the treating physician cannot reach an agreement concerning the member's care and a VPHP physician is not available for consultation. In this situation, VPHP will give the treating physician the opportunity to consult with a VPHP physician, and the treating physician may continue with care of the patient until a VPHP physician is reached.

Exceptions to the above will occur when one of the following criteria is met.

- A VPHP physician with privileges at the treating hospital assumes responsibility for the member's care;
- A VPHP physician assumes responsibility for the member's care through transfer;
- VPHP and the treating physician reach an agreement concerning the member's care; or,
- The member is discharged.

(7) Non-Participating Providers

a. Use of non-participating specialty providers for non-emergent services may be used under the following circumstances in accordance with the member's benefit plan with pre-authorization from VPHP:

i. VPHP's contracted providers are unable to provide the specialty service required for the member's medical care.

ii. VPHP does not have a provider in the network with appropriate training or experience.

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

(8) Referrals for specialty visits are not required; however, it is the expectation of VPHP that the PCP will recommend specialty care for the member.

(a) Member Self-Referral *(PCP recommendation not required)*

i Members may self refer for family planning services (in or out of network), OB/GYN care, preventive services and annual mammograms (age 40 and over).

ii Members may self refer for the initial three (3) behavioral health visits of the benefit year.

iii Members may not self refer for tertiary care except in emergent cases based on the prudent layperson standard.

(b) Recurring Services

i Recurring services such as, Physical Therapy, Occupational Therapy, Speech Therapy require annual authorizations from VPHP for evaluation. Additional services may be requested by submitting clinical documentation to the Case Manager/UR nurse for extended visits before services are rendered.

B. Concurrent Review Process

The concurrent review process ensures that the ongoing care provided to a patient is reviewed on a periodic basis to ensure the continued need for acute care and that the care is in conformance with the patient's plan benefits.

1. Objectives

The objectives of the concurrent review process include the following:

a) To ensure the length of treatment is medically necessary and appropriate based on medical record documentation.

b) To ensure urgent and emergent treatment for medical necessity is in accordance with program criteria.

c) To identify services provided by non-contracted providers to determine medical necessity and appropriateness of services and recommendation to the contracting department for addition to the VPHP's provider network.

d) To ensure follow-up services and/or continuing care needs are met and are in compliance with plan policies regarding covered benefits.

2. Procedures

VPHP's UM/CM staff will orally notify the provider, member and facility of approval or denial status within twenty-four (24) hours of reviewing the admission. Communication of a non-certification decision will be given on the day prior to the start of a non-certified day (unless specific certified days were agreed upon with the physician and/or member.) Members, facilities and practitioners assume continued approval in the absence of notification. If days are denied, non-certification letters will be sent to the physician, member and the hospital's Utilization Management (UM)/Quality Improvement (QI) departments within three (3) calendar days of the oral notification to deny services.

The Medical Management Department will be responsible for the following activities in the concurrent review process:

a) Obtaining medical updates for purposes of reviewing patients for continued care and providing updates to the Medical Directors.

b) Coordinating with the hospital utilization review and discharge planning staff to arrange for follow-up, and ensure that written referrals are obtained in accordance with the UM Program Description.

C. **Retrospective Review Process**

The retrospective review process is employed in cases where clinical information could not be obtained during the enrollee's hospitalization or emergency department visit. Clinical information will not be reviewed for retrospective denials for urgent preservice requests after UM hours. Retrospective review will not be done for outpatient cases or elective admissions that did not receive prior authorization. The facilities and practitioners assume continued approval in the absence of notification. If the post service review is denied, non-certification letters will be sent to the physician, member and the hospital's Utilization Management

(UM)/Quality Improvement (QI) departments within 30 calendar days of the request.

1. Objectives

   a) To determine medical necessity, compliance with VPHP benefits and appropriateness of services rendered by providers.

   b) To identify and address UM program compliance issues.

   c) To identify possible quality issues, and refer them to the quality improvement staff or the QIC.

   d) To report changes and outliers in participating provider practice patterns to the Medical Director and UMC.

   e) To provide a mechanism for education of providers/members, feedback to providers, and corrective action.

2. Procedures

The Medical Management department will be responsible for the following activities in the retrospective review process and making determinations based solely on the medical information available to the practitioner/provider at the time the medical care is provided.

   a) Reviewing pended claims against established guidelines in order to determine medical necessity, benefit compliance and appropriateness of services provided.
   b) Reviewing medical records of emergency room visits for medical necessity based on the prudent layperson standard.

D. **Provider/Patient Appeals Process**

A member, provider or facility rendering services has at least 30 calendar days after the receipt of a notice of non-certification to initiate the appeals process by telephone or written notification. Telephone notifications to initiate the standard appeals process must be followed by written confirmation from the member or provider.

1. Expedited Appeal

   a) When an enrollee or their provider requests an expedited appeal, VPHP will make such appeal proceedings available with notification of a decision within seventy-two (72) hours of the

initiation of the appeal process. This request can be made in writing or called to VPHP. The UM/CM nurse reviewer and physician involved in the original denial shall not review the information in the case of an appeal.

b) Expedited review may be requested when VPHP, the member or the member's provider determines that the standard appeals timeframe could seriously jeopardize the member's life or health, or ability to attain, maintain, or regain maximum function.

c) Decisions for expedited appeals will not exceed three (3) calendar days from the initial receipt of the appeal. If the appeal exceeds the stated timeframe, the appeal is approved.

d) Members or their authorized representatives may request that benefits continue until a decision is reached.

e) VPHP may extend the three (3) days by up to an additional fourteen (14) calendar days if the member requests the extension or if VPHP provides evidence satisfactory to DMAS that a delay in rendering the decision is in the enrollee's interest. The review will be completed for final determination as expeditiously as the member's health condition allows and shall not exceed the date on which the extension expires. VPHP's Senior Medical Director will make all requests for extensions of appeals for clinical reasons to DMAS.

f) VPHP will notify the provider or member, as the case may be, with a prompt verbal notice of any decisions that are not resolved completely in favor of the member, and shall follow with a written notice of action that contains further appeal rights within two (2) calendar days of the verbal notification.

g) In instances where the enrollee's request for an expedited appeal is denied, the appeal will be transferred to the timeframe for standard resolution of appeals.

2. Standard Appeal

   a) When an enrollee or their provider request an appeal, VPHP will make such appeal decisions in writing within 30 calendar days of the initiation of the appeal process. If the appeal exceeds the stated timeframe, the appeal is approved. The UM/CM nurse reviewer and physician involved in the original denial shall not review the information in the case of an appeal.

   b) VPHP may extend the thirty (30) days up to an additional fourteen (14) calendar days if the member requests the extension or if VPHP provides evidence satisfactory to DMAS that a delay in rendering the decision is in the member's interest. The member will be notified of the approved extension in writing. VPHP's Senior

Medical Director will make all requests for extensions of appeals for clinical reasons to DMAS.

c) For standard service authorization decisions that extend the review timeframe in excess of the standard fourteen (14) days, VPHP will mail the written notice no later than the 14th day to the enrollee.
d) VPHP will provide the member with written notice of the reason for delay on any appeal decision not rendered within thirty (30) days.
e) An appeal decision that is pending because additional information is needed will be issued within forty-five (45) days from the initial date of receipt of the appeal. VPHP's original decision will be upheld on appeals pended because of the need for if such information is not received within the forty-five (45) days.

E. Sentinel Event Reporting

1. Sentinel events are identified by the UM Nurse Reviewers or Case Managers and sent to the Quality Management Coordinator on the Quality of Care Indicator Report. If the sentinel event is reportable to DMAS, the nurse identifying the case completes the DMAS Sentinel Event Reporting Form and forwards it to the Quality Management Coordinator for monthly submissions to DMAS or Family Access to Medical Insurance Security (FAMIS).

SENTINEL EVENTS/QUALITY OF CARE

SENTINEL EVENTS

1. Deaths (emergency room, inpatient or outpatient)- reportable to DMAS and FAMIS
2. Trauma or injury suffered while in a health care facility/provider office/HMO site to include:
3. Surgery on wrong body part
4. Surgery on wrong patient
5. Loss of function not related to illness or condition
6. Rape in 24 hour care facility
7. Suicide in 24 hour care facility
8. Infant abduction or discharge to wrong family
9. Hemolytic transfusion reaction related to wrong blood type or incompatible blood products

QUALITY OF CARE EVENTS

1. Treatment in the emergency room within 7 days of discharge for the same diagnosis
2. Readmission to the hospital within 7 days of discharge
3. Unplanned return to the operating room during one inpatient stay

4. Post surgical infections
5. Unplanned admission to the hospital after outpatient test or procedure
6. Prematurity (< 37 weeks and/or <2500 grams)
7. Asthma Readmissions
8. Ketoacidosis Admissions (exclude if new onset of Diabetes)
9. ER treatment or IP admission for Hypertensive crisis/Malignant Hypertension
10. Any other occurrence that would impede care or access to care resulting in a significant adverse effect

2. The Sentinel Event is also reported to VPHP's QI coordinator who will review all documentation and obtain medical records for follow up if there is a potential quality of care issue. Records are forwarded to the DMAS Peer Review Organization when requested for external quality monitoring for any reportable occurrence.

3. Occurrences that are unusual or may indicate a concern in quality of care or service in either an inpatient or outpatient setting are screened, investigated, analyzed, trended and monitored by the Quality Management Department. The VPHP Medical Director acting as a first level peer reviewer, reviews all referrals for quality of care/service issues. These data are presented to the QMC/MMC in aggregate and included in the affected provider's credentialing file for consideration at the time of recredentialing.

   All unresolved cases at the first level peer review will be submitted for second level peer review by the QIC/ for determination of severity level and appropriate corrective action.

   Final determinations regarding any serious disciplinary actions will require approval by both the CQIC and the VPHP Board of Directors. VPHP will adhere to the reporting requirements of the Virginia State Medical Board and the National Practitioners Data Bank.

VIII. Case Management Services

A. Case Management facilitates the coordination of services through the health care continuum. The case management process develops a care plan, which enhances or maintains the patient's quality of care and could reduce the expected expenses for the patient's treatment. Early identification of patients compromised by an acute injury or episode of illness is key to successful implementation of case management services. The PCP is a key component of the care management team with the case manager facilitating the coordination of all other services.

1. Potential cases for case management are identified primarily through the UM program, claims history, prescription utilization, internal and external referrals and authorizations from health care providers.
2. All postpartum patients who are discharged from the hospital prior to postpartum day three (vaginal deliveries) and postpartum day five (Cesarean deliveries) must be offered a home health visit.
3. The Case Manager works with the member's physician, family, and caretakers to determine the availability of resources to meet the plan of care.

B. Case Management identifiers include but are not limited to the following:
   1. Healthy Heartbeats – Maternal/Child Program
   2. Transplants
   3. HIV
   4. All NICU admissions
   5. Three or more co-morbid conditions
   6. BiPolar Disorder and Schizophrenia
   7. Children with Special Health Care Needs (CSHCN)
   8. Three or more ED visits in a quarter or two or more hospitalizations in a year

IX. Disease Management

Disease management is a system of coordinated healthcare interventions and communications for populations with conditions in which patient self-care efforts are significant. VPHP has a disease management program for Asthma, Diabetes, Heart Disease, Childhood Weight Management and Nutrition, Chronic Obstructive Pulmonary Disease and High Risk Maternity. Disease management:

- Supports the physician or practitioner/patient relationship and plan of care,
- Emphasizes prevention of exacerbations and complications utilizing evidence-based practice guidelines and patient empowerment strategies, and
- Evaluates clinical, humanistic, and economic outcomes on an ongoing basis with the goal of improving overall health

The disease management coordinator (DMC) manager will utilize the following process when enrolling high risk members in disease management programs.

1. The DMC uses established reports to identify members for the disease management programs. Members will also be referred to the programs by external and internal resources.
2. The DMC will complete an assessment and determine short and long term interventions/goals. The assessment includes physical, emotional, economic, environmental, behavioral, and self-management skills.
3. Once the assessment is completed, the DMC will select the standardized treatment plan, review with the member and individualize as needed.

4. Based on the plan of care, the DMC will contact the member and on each contact complete an assessment and make changes to the interventions based on members needs.
5. The DMC will coordinate all care for the member while they are in the disease management program.
6. All low to moderate risk members receive a letter informing them about the program and educational materials.

X. Medical Outreach

Medical Outreach assists case management with the implementation of the medical or behavioral health care plan. Outreach staff is responsible for visiting high-risk populations in their homes to assess environmental issues and resource needs. In addition, they are responsible for educating members on preventative care, follow up of members with multiple physician no show visits and providing benefit information. The Case Managers, Managers of Medical Management and the Vice President of Medical Management provide direct oversight of this staff.

APPROVED BY:

________________________________	____________________
Utilization Management Committee	Date
________________________________	____________________
Senior Medical Director	Date
________________________________	____________________
Continuous Quality Improvement Committee	Date
________________________________	____________________
Board of Directors, Virginia Premier Health Plan, Inc.	Date

ATTACHMENT II - SUMMARY OF COVERED MEDALLION II and MEDICAID/FAMIS PLUS SERVICES

This attachment is not intended to be a comprehensive list of benefits. All benefit limits should be verified through the appropriate DMAS Provider Manual.

Mental Health Services Are Listed At the End of this Summary Table				
Service	**State Plan Reference or Other Relevant Reference**	**Medicaid/FAMIS Plus Covered (see notes section)**	**Medallion II Covered**	**Notes**
Abortions, induced	12 VAC 30-50-100 and 12 VAC 30-50-40	No except in those cases where there would be substantial danger to health or life of mother	No	**The Contractor is not required to cover services for abortion**. Requests for abortions where the life of the mother is endangered shall be forwarded to the Department for review to ensure compliance with Federal Medicaid rules. The Department will be responsible for payment of abortion services meeting Federal Medicaid requirements under the fee-for-service program.
Case Management Services for Recipients of Auxiliary Grants	12 VAC 30-50-470	Yes	No	**The Contractor is not required to cover this service.** This service will continue to be covered through the DMAS fee-for-service system.
Case Management Services for the Elderly	12 VAC 30-50-460	Yes	No	**The Contractor is not required to cover this service**. This service will continue to be covered through the DMAS fee-for-service system.
Chiropractic Services	12 VAC 30-50-140	No	No	This service is not a Medicaid/FAMIS Plus covered service. **The Contractor is not required to cover this service.**
Christian Science Nurses and Christian Science Sanatoria	12 VAC 30-50-300	No	No	This service is not a Medicaid/FAMIS Plus covered service. **The Contractor is not required to cover this service.**
Clinic Services	12 VAC 30-50-180	Yes	Yes	The Contractor is required to cover all clinic services which are defined as preventative, diagnostic, therapeutic, rehabilitative, or palliative services, including renal dialysis clinic visits.
Colorectal Cancer Screening	12 VAC 30-50-220	Yes	Yes	The Contractor shall cover colorectal cancer screening in accordance with the most recently published recommendations established by the American Cancer Society, for the ages, family histories and frequencies referenced in such recommendations.
Court Ordered Services	Code of Virginia Section 37.1-67.4	Yes	Yes	The Contractor is required to cover all medically necessary court ordered Medallion II services.

Mental Health Services Are Listed At the End of this Summary Table				
Service	**State Plan Reference or Other Relevant Reference**	**Medicaid/FAMIS Plus Covered (see notes section)**	**Medallion II Covered**	**Notes**
Dental Services	12 VAC 30-50-190	No except for certain circumstances.	No except for certain circumstances.	The Contractor is required to cover CPT codes billed by an MD as a result of an accident. The Contractor is required to cover CPT and other "non-CDT" procedure codes billed for medically necessary procedures of the mouth for adults and children. The Contractor is required to cover medically necessary anesthesia and hospitalization services for certain individuals when determined such services are required to provide dental care.
Early and Periodic Screening, Diagnosis and Treatment (EPSDT)	12 VAC 30-50-130	Yes	Yes	The Contractor is required to cover EPSDT screenings **(including lead screenings)** and diagnostic services as well as any and all services identified as necessary to correct or ameliorate any identified defects or chronic conditions. (Some services may require prior authorization) The Contractor shall screen and assess all children. The Contractor is required to cover immunizations. The Contractor is required to educate providers regarding reimbursement of immunizations and to work with the Department to achieve its goal related to increased immunization rates.

Mental Health Services Are Listed At the End of this Summary Table				
Service	**State Plan Reference or Other Relevant Reference**	**Medicaid/FAMIS Plus Covered (see notes section)**	**Medallion II Covered**	**Notes**
Early Intervention	Virginia Code § 2.2-5300 12VAC30-130-10 and 12VAC30-50-200	Yes	Yes	***The Contractor shall cover all medically necessary, Medicaid/FAMIS Plus covered services for children from birth to age three, who are determined eligible for Part C services of the Individuals with Disabilities Act by the Department of Mental Health Mental Retardation and Substance Abuse Services or applicable Early Intervention Interagency Council. The Contractor shall cover medically necessary services, including rehabilitative therapies within the amount duration and scope as defined in 12VAC30-130-10 and 12VAC30-50-200. All services shall be specific and provide effective treatment for the patent's condition in accordance with accepted standards of medical practice; this includes the requirement that the amount, frequency, and duration of the services shall be reasonable. The Contractor or its designated subcontractor may require prior authorization of services for the purposes of determining medical necessity of therapies and services.***
Emergency Services	12 VAC 30-50-110 12 VAC 30-50- 12 VAC 30-50-300 12 VAC 30-120-395	Yes	Yes	***The Contractor is required to cover all emergency services without prior authorization. The Contractor is also required to cover the services needed to ascertain whether an emergency exists.*** The Contractor may not restrict an enrollee's choice of provider for emergency services.
Post Stabilization Care following Emergency Services	42 C.F.R. 422.100(b)(1)(iv)	Yes	Yes	The Contractor must cover post-stabilization services subsequent to an emergency that a treating physician views as medically necessary AFTER an emergency medical condition has been stabilized.
Experimental and Investigational Procedures	12 VAC 30-50-140	No	No	This service is not a Medicaid/FAMIS Plus covered service.

Mental Health Services Are Listed At the End of this Summary Table				
Service	**State Plan Reference or Other Relevant Reference**	**Medicaid/FAMIS Plus Covered (see notes section)**	**Medallion II Covered**	**Notes**
Family Planning Services	12 VAC 30-50-130	Yes	Yes	The Contractor is required to cover all family planning services and supplies for individuals of child-bearing age which delay or prevent pregnancy, including drugs, supplies and devices. The Contractor may not restrict an enrollee's choice of provider or method for family planning services or supplies, and the Contractor is required to cover all family planning services and supplies provided to its enrollees by network providers and by out-of-network providers.
HIV Testing and Treatment Counseling	Code of Virginia Section 54.1-2403.01	Yes	Yes	The Contractor is required to comply with the State requirements governing HIV testing and treatment counseling for pregnant women.
Home Health Services	12 VAC 30-50-160	Yes	Yes	The Contractor is required to cover home health services, including nursing services, rehabilitation therapies, and home health aide services. At least 32 home health aide visits shall be allowed. Skilled home health visits are limited based upon medical necessity. The MCO must continue to manage the following service related conditions, where medically necessary and regardless of whether the need is long-term or short-term. This includes those instances where the member cannot perform the services; where there is no responsible party willing and able to perform the services, and where and the service cannot be performed in the PCP office/outpatient clinic, etc. The MCO may cover these services under home health or may choose to manage the related conditions using another safe and effective treatment option. The MCO shall not refer for skilled nursing under the home and community based waivers for these conditions. · B-12 shots · Insulin injections · Central line and porta cath flushes · Blood draws, for example where the recipient is medically unstable or is morbidly obese and requires transportation via lab/MD office by ambulance · Changing of indwelling catheter

Mental Health Services Are Listed At the End of this Summary Table				
Service	**State Plan Reference or Other Relevant Reference**	**Medicaid/FAMIS Plus Covered (see notes section)**	**Medallion II Covered**	**Notes**
Hospice Services	12 VAC 30-50-270	Yes	No	**The Contractor is not required to cover this service.** This service will continue to be covered through the DMAS fee-for-service system.
Immunizations	12 VAC 30-50-130	Yes	Yes	The Contractor is required to cover immunizations. The Contractor is required to educate providers regarding reimbursement of immunizations and to work with the Department to achieve its goal related to increased immunization rates.
Inpatient Hospital Services	12 VAC 30-50-100 12 VAC 30-50-105 12 VAC 30-80-115 12 VAC 30-50-220 Chapter 709 of the 1998 Virginia Acts of Assembly § 32.1-325(A)	Yes	Yes	The Contractor is required to cover inpatient stays in general acute care and rehabilitation hospitals for all enrollees. The Contractor is required to comply with maternity length of stay requirements. Contractor is required to comply with radical or modified radical mastectomy, total or partial mastectomy length of stay requirements. The Contractor is required to cover an early discharge follow-up visit if the mother and newborn, or the newborn alone, are discharged earlier than 48 hours after the day of delivery.
Laboratory and X-ray Services	12 VAC 30-50-120	Yes	Yes	The Contractor is required to cover all laboratory and x-ray services directed and performed within the scope of the license of the practitioner.
Lead Investigations	12 VAC 30-50-227	Yes	No	**The Contractor is not required to cover this service**. This service will continue to be covered through the DMAS fee-for-service system.
Mammograms	12 VAC 30-50-220	Yes	Yes	Contractor is required to cover low-dose screening mammograms for determining presence of occult breast cancer
Medical Supplies and Equipment	12 VAC 30-50-160	Yes	Yes	The Contractor is required to cover all medical supplies and equipment at least to the extent they are covered by DMAS. The Contractor is responsible for payment of any specially manufactured DME equipment that was prior authorized by the Contractor.
Mental Health Services (See last page of this table)				

Mental Health Services Are Listed At the End of this Summary Table

Service	State Plan Reference or Other Relevant Reference	Medicaid/FAMIS Plus Covered (see notes section)	Medallion II Covered	Notes
Nurse-Midwife Services	12 VAC 30-50-260	Yes	Yes	The Contractor is required to cover nurse-midwife services as allowed under State licensure requirements and Federal law.
Organ Transplantation (Reference Table of Coverage shown in Article II.G.20.)	12 VAC 30-50-540 through 12 VAC 30-50-580, and 12 VAC 30-10-280 12 VAC 30-50-100G 12 VAC 30-50-105K	Yes	Yes	For the purposes of organ transplantation, all similarly situated individuals will be treated alike. Transplant services for kidneys, corneas, hearts, lungs, and livers (from living or cadaver donors) shall be covered for all eligible persons. High dose chemotherapy and bone marrow/stem cell transplantation shall be covered for all eligible persons with a diagnosis of lymphoma, breast cancer, leukemia, or myeloma when medically necessary. Transplant services for any other medically necessary transplantation procedures that are determined to not be experimental or investigational shall be limited to children (under 21 years of age). Standards for coverage of organ transplant services are in 12VAC30-50-540 through 12VAC30-50-580.
Outpatient Hospital Services	12 VAC 30-50-110 -	Yes	Yes	The Contractor is required to cover preventive, diagnostic, therapeutic, rehabilitative or palliative outpatient services rendered by hospitals, rural health clinics, or federally qualified health centers. The Contractor is required to cover limited oral surgery as defined under Medicare.
Pap Smears	12 VAC 30-50-220	Yes	Yes	Contractor is required to cover annual pap smears
Physical Therapy, Occupational Therapy, Speech Pathology and Audiology Services	12 VAC 30-50-200 12 VAC 30-50-225	Yes	Yes	The Contractor is required to cover physical therapy, occupational therapy, and speech pathology and Audiology services that are provided as an inpatient or outpatient hospital service or home health service. The Contractor's benefits shall include coverage for acute and non-acute conditions and shall be limited based upon medical necessity.
Physician Services	12 VAC 30-50-140 -	Yes	Yes	The Contractor is required to cover all symptomatic visits to physicians or physician extenders and routine physicals for children up to age twenty-one under EPSDT.
Podiatry	12 VAC 30-50-150 -	Yes	Yes	The Contractor is required to cover podiatry services including diagnostic, medical or surgical treatment of disease, injury, or defects of the human foot.

Mental Health Services Are Listed At the End of this Summary Table				
Service	**State Plan Reference or Other Relevant Reference**	**Medicaid/FAMIS Plus Covered (see notes section)**	**Medallion II Covered**	**Notes**
Pregnancy-Related Services	12 VAC 30-50- 12 VAC 30-50- 12 VAC 30-50-510 12 VAC 30-50-410	Yes	Yes	The Contractor is required to cover case management services for high risk pregnant women and children (up to age two). The Contractor is required to provide to qualified enrollees expanded prenatal care services, including patient education; nutritional assessment, counseling and follow-up; homemaker services; and blood glucose meters. The Contractor is required to cover pregnancy-related and post-partum services for sixty (60) days after pregnancy ends.
Prescription Drugs	12 VAC 30-50-210 -	Yes	Yes	The Contractor is required to cover prescription drugs, including those prescribed by a provider during a physician visit or other visit covered by a third party payer including Mental Health visits.
Private Duty Nursing	http://websrvr.dmas.virginia.gov/manuals/General/EPSDT_Nursing.pdf; 42CFR441.50 and 1905(a) of Social Security Act	Not covered for Adults. Coverage is available for children under age 21 under EPSDT.	Not covered for Adults. Coverage is available for children under age 21 under EPSDT.	The Contractor is required to cover medically necessary private duty nursing services for children under age 21 consistent with the Department's criteria described in the EPSDT Nursing Supplement, available on the DMAS website at: http://websrvr.dmas.virginia.gov/manuals/General/EPSDT_Nursing.pdf
Prostate Specific Antigen (PSA) and digital rectal exams	12 VAC 30-50-220	Yes	Yes	The Contractor is required to cover screening Prostate Specific Antigen (PSA) and the related digital rectal exams (DRG) for the screening of male enrollees for prostate cancer.
Prosthetics/Orthotics	12 VAC 30-50-210 12 VAC 30-60-120	Yes	Yes	The Contractor is required to cover prosthetics (arms and legs and their supportive attachments, breasts, eye prostheses) to the extent that they are covered under Medicaid. The Contractor is required to cover medically necessary orthotics for children under age 21 and for adults and children when recommended as part of an approved intensive rehabilitation program as described in 12VAC30-60-120.
Prostheses, Breast	12 VAC 30-50-210	Yes	Yes	The Contractor is required to cover breast prostheses following medically necessary removal of a breast for any medical reason.
Reconstructive Breast Surgery	12 VAC 30-50-140	Yes	Yes	Contractor is required to cover reconstructive breast surgery

Mental Health Services Are Listed At the End of this Summary Table				
Service	**State Plan Reference or Other Relevant Reference**	**Medicaid/FAMIS Plus Covered (see notes section)**	**Medallion II Covered**	**Notes**
Regular Assisted Living Services Provided to Residents of Assisted Living Facilities	12 VAC 30-120-450 12 VAC 30-120 12 VAC 30-120-470 12 VAC 30-120-480	No (auxiliary grant administered by DSS.)	No	**The Contractor is not required to cover this service.** When appropriate, the Department will reimburse the Assisted Living Facility as a carve-out payment. Reference the DMAS Assisted Living Facility Provider Manual for details.
School-health Services	12 VAC 30-50-229.1	Yes	No	The Contractor is not required to cover school health services. School health services that meet the Department's criteria will continue to be covered as a carve-out service through the Medicaid/FAMIS Plus fee-for-service system. School-health services are defined under the DMAS school-health services regulations and Medicaid school provider manual.. The Contractor is responsible for covering EPSDT screenings for the general Medicaid/FAMIS Plus student population. Reference Article I. Definitions section for more details. The contractor shall not deny medically necessary outpatient or home setting therapies based on the fact that the child is also receiving therapies in a school
Skilled Nursing Facility Care	12 VAC 30-50-130 -	Yes	No	**The Contractor is not required to cover skilled nursing facility care**. This service will be covered through the DMAS fee-for-service system. Institutionalized individuals will become excluded from Medallion II upon entry into the DMAS nursing facility authorization database. The Contractor may provide step down nursing care as an enhanced benefit to Medicaid enrollees.
Temporary Detention Orders (TDOs) & Emergency Custody Orders (ECOs)	42 CFR 441.150 and Code of Virginia 16.1-335 et seq.	Yes	Yes	The Contractor is required to provide, honor, and be responsible for all requests for payment of services rendered as a result of a TDO for Mental Health Services. The Contractor shall provide, honor and be responsible for payment of medically necessary screenings and assessments for persons who are under an emergency custody order.

Mental Health Services Are Listed At the End of this Summary Table				
Service	**State Plan Reference or Other Relevant Reference**	**Medicaid/FAMIS Plus Covered (see notes section)**	**Medallion II Covered**	**Notes**
Transportation	12 VAC 30-50-530 12 VAC 30-50-300	Yes	Yes	The Contractor is required to provide transportation to all Medicaid/FAMIS Plus covered services, including those Medicaid/FAMIS Plus services covered by a third party payer, and transportation to carved out services such as abortions and to services provided by subcontractors such as dental. The Contractor shall not be responsible for transportation for managed care recipients who subsequently become recipients in the federal waiver programs, as otherwise defined elsewhere in this chapter, for home and community-based Medicaid coverage (AIDS, IFDDS, MR, EDCD, Day Support, or Alzheimers, or as may be amended from time to time). These individuals shall receive acute and primary medical services via the MCO and shall receive waiver services and related transportation to waiver services via the fee-for-service program.
Vision Services	12 VAC 30-50-210	Yes	Yes	The Contractor is required to cover vision services including diagnostic examination and optometric treatment procedures and services by ophthalmologists, optometrists and opticians. The Contractor is also required to cover eyeglasses under age 21. The Contractor's benefit limit for routine refractions shall not be less than once every twenty-four (24) months.
Waiver Services (Home and Community Based)		Yes	No	The Contractor is not required to cover home and community based waiver services or transportation to related waiver services, however, individuals enrolled with a MCO that subsequently meet one or more of the criteria listed in Article II, D.1 during MCO enrollment shall be disenrolled as appropriate by DMAS, with the exception of those who subsequently become recipients in the federal waiver programs, as otherwise defined elsewhere in this chapter, for home and community-based Medicaid coverage (AIDS, IFDDS, MR, EDCD, Day Support, or Alzheimers, or as may be amended from time to time). These individuals shall receive acute and primary medical services via the MCO and shall receive waiver services and related transportation to waiver services via the fee-for-service program.

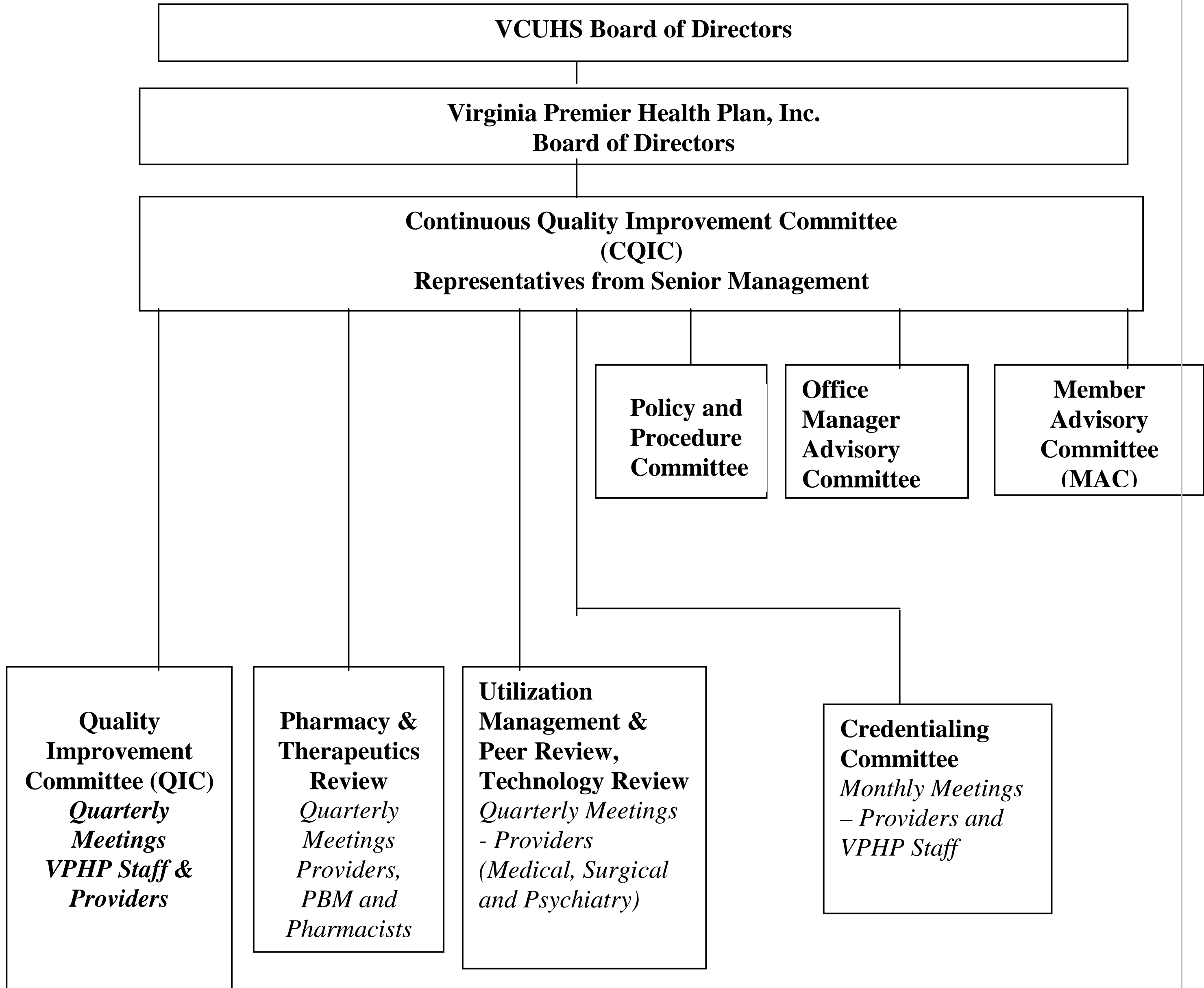
MENTAL HEALTH SERVICES				
Service	**State Plan Reference or Other Relevant Reference**	**Medicaid/FAMIS Plus Covered (see notes section)**	**Medallion II Covered**	**Notes**
Inpatient Mental Health Services				
Inpatient Mental Health Services Rendered in a Freestanding Psychiatric Hospital	12 VAC 30-50-230 12 VAC 30-50-250	Yes	Yes	The Contractor is required to cover medically necessary inpatient psychiatric hospital stays for covered individuals over age sixty-four (64) or under age twenty-one (21). The Contractor may authorize admission to a freestanding psychiatric hospital as an enhanced service to Medicaid enrollees.
Inpatient Mental Health Services Rendered in a Psychiatric Unit of a General Acute Care Hospital	12 VAC 30-50-100	Yes	Yes	Medically necessary inpatient psychiatric care rendered in a psychiatric unit of a general acute care hospital shall be covered for all enrollees, regardless of age, within the limits of coverage prescribed in 12 VAC 30-50-105.
Inpatient Mental Health Services Rendered in a State Psychiatric Hospital	12 VAC 30-50-230 12 VAC 30-50-250	Yes	No	**The Contractor is not required to cover this service**. This service will be covered through the DMAS fee-for-service system. Notify DMAS of all enrollee admissions to state mental hospitals.
Temporary Detention Orders (TDOs)	42 CFR 441.150 and Code of Virginia 16.1-335 et seq.	Yes	Yes	The Contractor is required to provide, honor, and be responsible for all requests for payment of services rendered as a result of a TDO for Mental Health Services.
TREATMENT FOSTER CARE AND RESIDENTAL TREATMENT SERVICES FOR CHILDREN				
Treatment Foster Care (TFC) for children under age 21 years.	12VAC30-60-170 12VAC30-50-480 12VAC30-130-900 to 950	Yes	No	****DMAS authorization into a TFC program will result in disenrollment of the recipient from Medallion II. The TFC provider must contact prior-authorization agent for authorization.**
Residential Treatment Facility Services (RTF) for children under age 21 years	12VAC30-130-850 to 890	Yes	No	****DMAS authorization into a RTF program will result in disenrollment of the recipient from Medallion II. The RTF provider must contact prior-authorization agent for authorization.**

OUTPATIENT MENTAL HEALTH SERVICES The Contractor is responsible to cover outpatient mental health services. The benefit maximum for adults **in the first year of treatment** shall not be less than 52 visits, and 26 visits per year following the first year of treatment. For children under age 21 the benefit maximum is based upon medical necessity.				
Psychiatric Diagnostic Exam	12VAC30-50-180 12VAC30-50-140	Yes	Yes	See the highlighted section above.
Individual Medical Psychotherapy	12VAC30-50-140, 12VAC30-50-150 and 12VAC30-50-180	Yes	Yes	See the highlighted section above.
Group Medical Psychotherapy	12VAC30-50-140, 12VAC30-50-150 and 12VAC30-50-180	Yes	Yes	See the highlighted section above.
Family Medical Psychotherapy	12VAC30-50-140, 12VAC30-50-150 and 12VAC30-50-180	Yes	Yes	See the highlighted section above.
Electroconvulsive Therapy	12VAC30-50-140, 12VAC30-50-150 and 12VAC30-50-180	Yes	Yes	See the highlighted section above.
Psychological/ Neuropsychological Testing	12VAC30-50-140, 12VAC30-50-150 and 12VAC30-50-180	Yes	Yes	See the highlighted section above.
Pharmacological Management	12VAC30-50-140, 12VAC30-50-150 and 12VAC30-50-180	Yes	Yes	See the highlighted section above.
COMMUNITY MENTAL HEALTH REHABILATATIVE SERVICES – STATE PLAN OPTION MENTAL HEALTH REHABILITATION SERVICES				
Community Mental Health Services	12VAC30-50-130 12VAC30-50-226 12VAC30-50-420 through 12VAC30-50-430	Yes	No	The MCO must provide information and referrals as appropriate to assist recipients in accessing these services. The MCO is required to cover transportation to and from SPO services and prescription drugs prescribed by the outpatient mental health provider.
Community Mental Retardation Services	12VAC30-50-440	Yes	No	The MCO must provide information and referrals as appropriate to assist recipients in accessing these services. The MCO is required to cover transportation to and from SPO services and prescription drugs prescribed by the outpatient mental health provider.

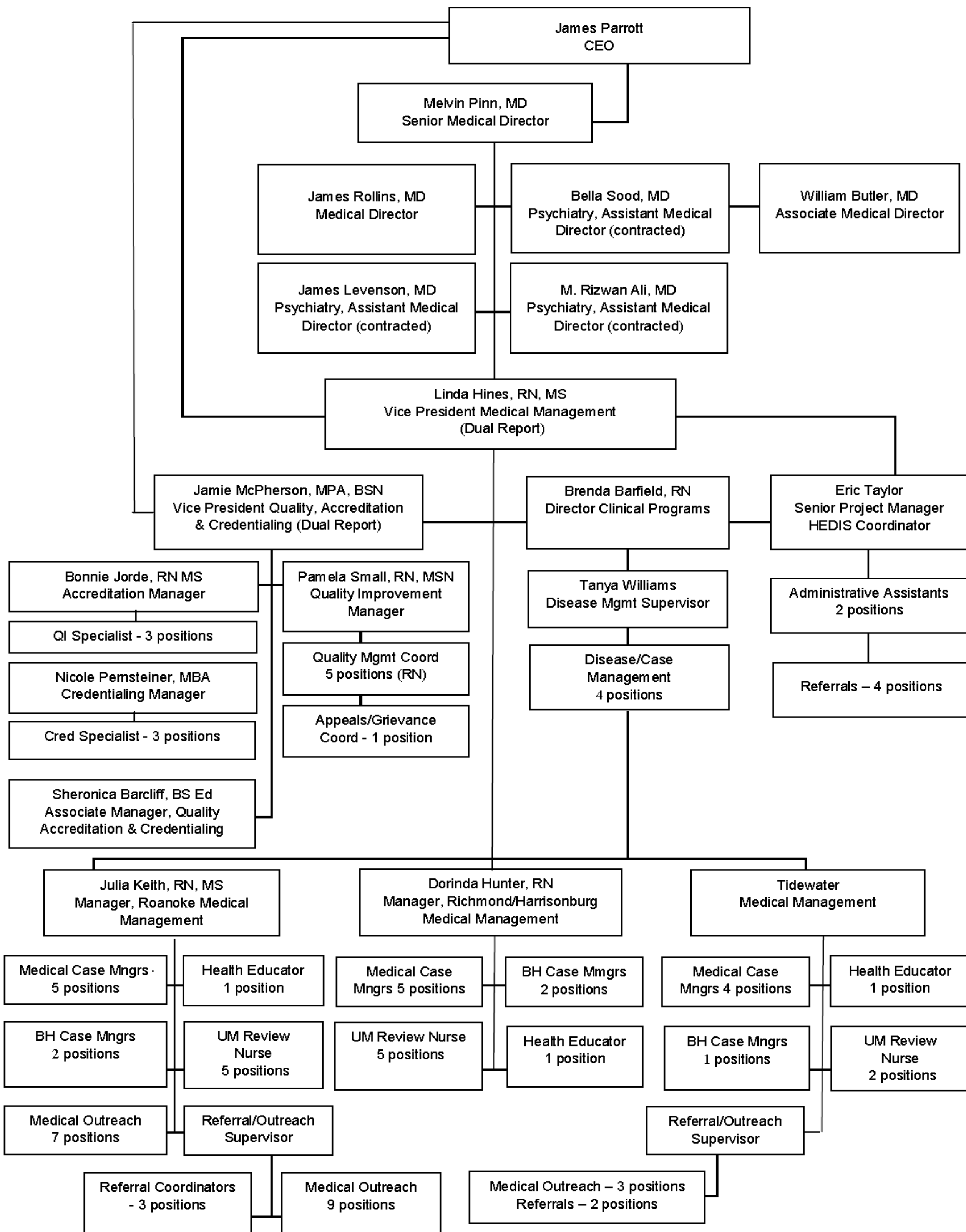
SUBSTANCE ABUSE TREATMENT SERVICES				
Out-patient substance abuse treatment		Yes	Yes	The Contractor is required to cover substance assessment and evaluation and outpatient services for substance abuse treatment for Medicaid/FAMIS Plus enrollees. The Department shall cover emergency services (crisis), intensive outpatient, day treatment and SA case management. Transportation and pharmacy services necessary for the treatment of substance abuse services including carved out services are the responsibility of the Contractor.
Residential Treatment for Pregnant Women	12VAC30-50-510	Yes	No	The MCO must provide information and referral as appropriate to assist recipients in accessing this services. The MCO is required to cover transportation to and from Community MH SPO services and prescription drugs prescribed by the mental health provider.
Day Treatment for Pregnant Women	12VAC30-50-510	Yes	No	See comment directly above.

ATTACHMENT B

Virginia Premier Health Plan, Inc.
Committee Structure



ATTACHMENT C



DURABLE MEDICAL EQUIPMENT (DME)
CERTIFICATE OF MEDICAL NECESSITY

This form is for prior authorization of durable medical equipment only. **ALL APPROVALS AUTHORIZED THROUGH THE USE OF THIS FORM ARE SUBJECT TO THE ENROLLEE'S BENEFITS AND ELIGIBILITY.**

Please fax to Case Management:
Central Virginia/Fredricksburg – (804) 819-5186 *or* toll free (866) 284-1057
Tidewater – (757) 466-1133
Roanoke – (540) 344-8007 *or* toll free (800) 827-7192

___________________________________ Patient's Date of Birth: _____/_____/_____
Patient's Name

Patient's ID# ________________________

____
Patient's Address

___________________________________ _______________________________
City, State, Zip Code Telephone Number

Type of Equipment/Supply/Appliance: ____

Please describe the patient's condition that warrants the requested equipment (include the ICD-9 code):

What other treatment modalities have been tried in the past?

____

What are your expected goals or outcomes for the patient?

____

How long will the patient need the equipment/supply/appliance?

Name/Phone Number of Preferred DME Vendor: __________________________ Phone #: ________________

This Certificate of Medical Necessity has been sent to preferred DME Provider? ***Yes*** ***No***

Name of Ordering Physician: _______________________________ Telephone Number: ________________

Physician's Address: ____

Physician's Signature: _________________________________ Date: ________________________________

MEMBER Name	Date
VA Premier Member ID:	Date of Birth:

Physician Name:

Address:

Specialty:	Medical License #:
Physician Phone:	Fax:

Medication Name and Strength Requested:

Directions:

Anticipated Length of Therapy:

o Days	o 3 months	o 6 months

Diagnosis:

Preferred medication tried/previous therapy:
(PLEASE include strength, frequency and duration)

Rationale for selecting this medication:
(PLEASE do not answer "DRUG OF CHOICE")

Physician's Signature

Please return this form to:
AmeriHealth Mercy
200 Stevens Drive
Philadelphia, PA 19113
PHONE: 800-294-4664
FAX: 877-693-8482

Note: Please ensure that your fax machine is programmed with the 10-digit fax number, as a confirmation of receipt of the request will be sent to the originating fax machine.

ATTACHMENT F

Listing of Specialty Drugs that Require Prior Authorization (Outpatient Physician Offices/Clinics)

Short Description	HCPCS	Short Description	HCPCS
Acetylcysteine injection	J0132	Ketorolac tromethamine inj	J1885
Injection adenosine 6 MG	J0150	Leuprolide acetate /3.75 MG	J1950
Adenosine injection	J0152	Levofloxacin injection	J1956
Adrenalin epinephrin inject	J0170	Lidocaine injection	J2001
Ampicillin 500 MG inj	J0290	Lorazepam injection	J2060
Succinycholine chloride inj	J0330	Inj midazolam hydrochloride	J2250
Azithromycin	J0456	Morphine sulfate injection	J2270
Atropine sulfate injection	J0460	Inj, moxifloxacin 100 mg	J2280
Baclofen 10 MG injection	J0475	Inj nalbuphine hydrochloride	J2300
Penicillin g benzathine inj	J0540	Natalizumab injection	J2323
Penicillin g benzathine inj	J0560	Ondansetron hcl injection	J2405
Penicillin g benzathine inj	J0570	Pamidronate disodium /30 MG	J2430
Bivalirudin	J0583	Palonosetron HCI	J2469
Botulinum toxin a per unit	J0585	Paricalcitol	J2501
Butorphanol tartrate 1 mg	J0595	Injection, pegfilgrastim 6mg	J2505
Inj calcitriol per 0.1 mcg	J0636	Pentobarbital sodium inj	J2515
Cefazolin sodium injection	J0690	Piperacillin/tazobactam	J2543
Ceftriaxone sodium injection	J0696	Pentamidine isethionte/300mg	J2545
Betamethasone acet&sod phosp	J0702	Promethazine hcl injection	J2550
Clonidine hydrochloride	J0735	Neostigmine methylslfte inj	J2710
Ciprofloxacin iv	J0744	Metoclopramide hcl injection	J2765
Prochlorperazine injection	J0780	Rho d immune globulin inj	J2790
Inj cosyntropin per 0.25 MG	J0835	Rhophylac injection	J2791
Cytomegalovirus imm IV /vial	J0850	Risperidone, long acting	J2794
Daptomycin injection	J0878	Ropivacaine HCl injection	J2795
Darbepoetin alfa, non-esrd	J0881	Sincalide injection	J2805
Darbepoetin alfa, esrd use	J0882	Na ferric gluconate complex	J2916
Epoetin alfa, non-esrd	J0885		J2916
Epoetin alfa, esrd on dialysis	J0886	Methylprednisolone injection	J2930
Methylprednisolone 40 MG inj	J1030	Alteplase recombinant	J2997
Dexamethasone sodium phos	J1100	Fentanyl citrate injeciton	J3010
Hydromorphone injection	J1170	Sumatriptan succinate / 6 MG	J3030
Diphenhydramine hcl injectio	J1200	Tenecteplase injection	J3100
Dipyridamole injection	J1245	Terbutaline sulfate inj	J3105
Inj dobutamine HCL/250 mg	J1250	Triamcinolone acetonide inj	J3301
Dolasetron mesylate	J1260	Vancomycin hcl injection	J3370
Injection, doxercalciferol	J1270	Thiamine hcl 100 mg	J3411

Short Description	HCPCS	Short Description	HCPCS
Injection, doxercalciferol	J1270	Inj magnesium sulfate	J3475
Eptifibatide injection	J1327	Inj potassium chloride	J3480
Filgrastim 300 mcg injection	J1440	Ziprasidone mesylate	J3486
Immune globulin, powder	J1566	Zoledronic acid	J3487
Gammagard Liquid injection	J1569	Reclast injection	J3488
Glucagon hydrochloride/1 MG	J1610	Normal saline solution infus	J7030
Granisetron HCl injection	J1626		
Ringers lactate infusion	J7050		
Factor viia	J7120		
Factor viii recombinant	J7189		
Factor IX recombinant	J7192	Fluorouracil injection	J9190
Prednisone oral	J7195	Gemcitabine HCl	J9201
Prednisolone oral per 5 mg	J7506	Irinotecan injection	J9206
Albuterol non-comp con1	J7510	Methotrexate sodium inj	J9250
Ipratropium bromide non-comp	J7611	Methotrexate sodium inj	J9260
Oral aprepitant	J7644	Oxaliplatin	J9263
Temozolomide	J8501	Paclitaxel protein bound	J9264
Doxorubic hcl 10 MG vl chemo	J8700	Paclitaxel injection	J9265
Bevacizumab injection	J9000	Pegaspargase/singl dose vial	J9266
Carboplatin injection	J9035	Pemetrexed injection	J9305
Cetuximab injection	J9045	Rituximab cancer treatment	J9310
Cisplatin 10 MG injection	J9055	Topotecan	J9350
Cytarabine hcl 100 MG inj	J9060	Vincristine sulfate 1 MG inj	J9370
Docetaxel	J9100	Vincristine sulfate 2 MG inj	J9375
Fluorouracil injection	J9170	Vinorelbine tartrate/10 mg	J9390

ATTACHMENT G

Physician Request Form for Patient Self-Administered Injectable and Specialty Drugs
Fax to PerformRx Pharmacy Services at ***877-693-8483***, or to speak to a representative call **800-294-4664.** *Form must be completed for processing.*

Patient's Name: ____________________ Plan ID#:____________________

Address: ____________________ Apt # or Suite #:____________________

City: ____________________ State: ____________ Zip Code: ____________________

Phone #: ____________ Height: ________ Weight: ________lbs = ________Kg Birth Date: ____________________

Physician's Name: ____________________ NPI #: ____________________

Address: ____________________ Apt # or Suite #: ____________________

City: ____________________ State: ____________ Zip Code: ____________________

Contact Person: ____________________ Phone #: ____________ Fax #: __________E Mail:____________

To be Administered from: ______________ to ______________ or on:______________

Drug Name: ______________________________ Item # (see below): ______________

Sig (How Administered): ______________________________

Diagnosis: ______________________________ ICD-9 Diagnosis Code: ____________________

Justification for Drug Use (Add Attachment if Necessary):______________________________

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Please Check if Patient is Filling at Their Local Pharmacy; or If You Desire PerformRx Pharmacy Services to Arrange Home Delivery, or Physician Delivery (for Patient Instruction)

☐ Deliver to Patient's Home ☐ Deliver to Physician's Office ☐ Patient Filling at Local Pharmacy (Name):____________________
Phone:____________________
Email:________________ Fax: _(_____)____________________
Physician Signature: ______________________________ Date: ____________________

Anticoagulants **Preferred NDCs GCNs**					**Pulmonary Drugs**
Heparin Sodium Does Not require prior Authorization					#23 Pulmozyme 1 mg/mL 2.5mL Neb-Ampul 30s 50242-0100-40 27200
#1 Heparin Sodium					#24 Tobi 300mg/5mL 5mL Neb-Ampul, 1s 63430-0065-01 61551
Dose:		Sig:			**Multiple Sclerosis Treatments**
#2 Fragmin	2,500U/0.2mL	syringe, 10s	62856-0250-10	63488	**Indicate Type of MS**
#3 Fragmin	5,000U/0.2mL	syringe, 10s	62856-0500-10	63431	❑ **Relapsing Remitting**
#4 Fragmin	7,500U/0.3mL	syringe, 10s	62856-0750-10	94116	❑ **Secondary Progressive with Relapses**
#5 Fragmin	10,000U/1mL	syringe, 10s	62856-0101-10	95075	❑ **Primary Progressive**
#6 Fragmin	2,500U/mL	vial, 3.8mL	62856-0251-01	95776	#25 Copaxone 20 mg/2mL, 2 mL vial, kit, 32s 00088-1150-03 16431
#7 Fragmin	10,000U/mL	vial, 9.5mL	62856-0102-01	63731	#26 Rebif 22mcg 0.5 syringe 44087-0022-03 15914
#8 Lovenox 00420	30mg/0.3mL	syringe, 10s	00075-0624-30		#27 Rebif 44mcg 0.5 syringe 44087-0044-03 15918
#9 Lovenox	40mg/0.4mL	syringe, 10s	00075-0620-40	70022	**#28 Rebif Titration Pack 44087-8822-01 24286**
#10 Lovenox	60mg/0.6mL	syringe, 10s	00075-0621-60	62771	Miscellaneous
#11 Lovenox	80mg/0.8mL	syringe, 10s	00075-0622-80	62772	**Cyanocobalamin DOES NOT require prior authorization**
#12 Lovenox	100mg/1mL	syringe, 10s	00075-0623-00	62773	#29 Cyanocobalamin 1000mcg/mL,10mL vial, 1s 00517-0032-25 94594
#13 Lovenox	120mg/0.8mL	syringe, 10s	00075-2912-01	42091	**#30 Other** (write in):

#14 Lovenox 42071	150mg/1mL	syringe, 10s	00075-2915-01	
#15 Lovenox 96334	100mg/1mL	vial, 3.0mL	00075-0626-03	
#16 Arixtra	2.5mg/0.5ml	syringe, 10s	00007-3230-02	15494
#17 Arixtra	5mg/0.4ml	syringe, 10s	00007-3232-02	23775
#18 Arixtra	7.5mg/0.6ml	syringe, 10s	00007-3234-11	23776
#17 Arixtra	10mg/0.8ml	syringe, 10s	00007-3236-11	23777
Hormones				
#16 Depo-Testosterone 100 mg/mL	10 mL	vial, 1s	00009-0347-02	10191
#17 Depo-Testosterone 200 mg/mL	10 mL	vial , 1s	00009-0417-02	10194
#18 Depo-Estradiol 5 mg/mL	5 mL	vial, 1s	00009-0271-01	10660

Rebif, Copaxone, Hormones, Pulmozyme: initial 30 days supply & 5 refills allowed. All other medications must be requested monthly.

PerformRx Pharmacy Services Use Only

REV 12-2003

Authorized By: ______________________________ Date: ______________________

Authorization #: ____________ Authorized Duration: __________ Member Eligibility on Date of Service: ______________________

Additional Notes:

Administered by **PerformRx** The Next Generation PBM