

OPTIMA HEALTH GROUP: VP Provider Manual Supplement

This Provider Manual Supplement is available for Providers who participate with Optima Health Group: VP. Information contained in this Supplement details additional information and exceptions that are specific to Optima Health Group: VP. Unless otherwise indicated in this Supplement, information in the Optima Health Provider Manual and the Optima Health Medicaid Program Provider Manual applies as appropriate. Providers should refer to the Optima Health Provider Manual and Optima Health Medicaid Program Provider Manual for policies and procedures not addressed in this Supplement. Contact Optima Health Network Education for additional questions regarding Optima Health Group: VP.

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Contact Us

| | Physical Address | Mailing Address | Phone |
|----------------------------|--|-------------------------------------|----------------|
| Innsbrook | 10800 Nuckols Road Glen Allen, VA 23060 | P.O. Box 5307 Richmond, VA 23220 | (804) 819-5151 |
| Roanoke | 5060 Valley View Blvd. NW Roanoke, VA 24012 | P.O. Box 1751 Roanoke, VA 24012 | 1-800-727-7536 |
| Southwest (Bristol) | 275 Village Circle Bristol, VA 24201 | P.O. Box 16092 Bristol, VA 24201 | 1-800-727-7536 |

| | |
|---|---|
| General Phone Number | Ph: 1-800-727-7536 |
| Customer Service | Ph: 1-800-727-7536 |
| Medical Admission Authorization (other than Behavioral Health) | Ph: 1- 888-251-3063 Fax: 1- 877-739-1365 |
| Outpatient Service Authorization (Excluding LTSS and BH) | Ph: 1-888-251-3063 Fax: 1-877-739-1371 |
| Behavioral Health Crisis Line | Ph: 1-844-513-4950 |
| Behavioral Health Authorizations Inpatient, ARTS, Crisis Services Fax | Ph: 1-855-214-3822 Fax: (804) 799-5105 |
| Behavioral Health Outpatient Fax | Fax: (804) 343-0304 |
| Long Term Support Services Fax or Contact Care Coordination | Ph: 800-727-7536 Fax: (877) 794-7954 |
| Medicaid Program New Waiver Requests | Fax: 1-833-977-4190 or 1-804-793-0579 |
| Medicaid Program Authorization Requests (Personal Care, Respite, ADHC, PDN, PERS, Environmental Modifications) | Ph: 800-727-7536 Fax: 1- 877-794-7954 |
| Medicaid Program Nursing Facilities/Hospice Admissions/Discharges | Ph: 800-727-7536 Fax: 1-800-846-4254 or 1-804-799-5108 |
| Appeals and Grievances | Ph: 1-855-813-0349 Fax: 1- 877-307-1649 |
| Nurse Advice Line (24/7) | 1- 800-256-1982 |

| | |
|--|---|
| Pharmacy Help Desk | 1- 877-779-2890 |
| Pharmacy Prior Authorizations Fax Line | 1-833-770-7569 |
| Provider Services | 1- 800-727-7536 |
| Provider Directory | VirginiaPremier.com |
| Provider Representatives and Relations Need to reach your Provider Services Representative? | Regional contacts available at the following link: www.virginiapremier.com/providers/medicaid/provider-resources/ Email: contactmyrep@virginiapremier.com |
| Member Inquiries | 1-800-727-7536 TTY: 711 |
| Member Services (8am - 8pm) | 1- 800-727-7536 |
| Eligibility | 1- 800-727-7536 |
| Dental | 1- 888-912-3456 |
| ARTS | 1- 800-727-7536 |
| DMAS AVRS Line (Automatic Voice Response System) | 1- 800-884-9730 |
| Transportation | 1- 855-880-3480 |
| Claims Inquiries | 1- 800-727-7536 |

Interpreter Services

Providers are required to assist members with obtaining interpreter services if their speech cannot be understood (for example, if the language they are speaking is not understood by the provider or if they have a speech disturbance).

SECTION I: ELIGIBILITY AND PCP ASSIGNMENT

Eligibility Verification

Each new member enrolled in Optima Health Group: VP will receive an individual member identification card. It is important to remember that a member's eligibility could change on a month-to-month basis. Consequently, you should verify your patient's eligibility each time they present the identification card for services. Physician offices can verify member eligibility through the monthly PCP enrollment and panel listing, online through Virginia Premier's Provider Portal VirginiaPremier.com or by calling Optima Health Group: VP directly.


Optima Health Group: VP has an IVR (interactive voice response) system that allows providers to check member eligibility by entering in the member data utilizing your phone's keypad.

Member Identification Card

Members should be asked to present their member ID card at each visit. Members that have both Medicaid and Medicare should present both their Optima Health Group: VP Medicaid and Medicare ID card when receiving services. Remember that possession of an ID card does not guarantee eligibility for benefits, coverage or payment. The back of the member identification card contains helpful reminders to our members along with instructions on how to reach us. The ID card includes valuable information as displayed in this manual.


ID Card Samples

Optima Health Group: VP FAMIS ID card



OPTIMA COMMUNITY CARE

Member Name: <XXXXX XXXXX>
Member Number: <XXXXXXXXXX> RxBIN: 003858
Group Number: VP RxPCN: MA
Medicaid/Rx ID: <XXXXXXXXXXXX> RxGRP: VPMMDCD
PCP Name: <XXXXXXXX XXXXXX>
PCP Number: <XXX-XXX-XXXX>
DOB: <MM/DD/YYYY>
Member Effective Date: <MM/DD/YY>

 **FAMIS**
Virginia's Medicaid Program


Detailed benefit information at optimahealth.com

Pre-Authorization may be required for: hospitalization, outpatient surgery, therapies, advanced imaging, DME, home health, skilled nursing, acute rehab, or prosthetics.
IN CASE OF AN EMERGENCY: Call 911 or go to the nearest emergency room.
Always call your Primary Care Physician for non-emergent care.

Member Services/ARTS: *(Hearing Impaired/Virginia Relay: 711)* 1-800-881-2166
Behavioral Health Crisis Line: 1-844-513-4950
24/7 Nurse Advice Line: 1-800-256-1982
Pharmacist Help Desk: *(Including Pre-Authorization)* 1-877-779-2890
Dental: 1-888-912-3456

| | |
|--|--|
| Send Claims to P.O. Box 5550 Richmond, VA 23220 | Optima Health P.O. Box 66189 Virginia Beach, VA 23466 |
|--|--|


Optima Health Group: VP Medicaid Program ID



OPTIMA COMMUNITY CARE

Member Name: <XXXXXX XXXXX>
Member Number: <XXXXXXXXXX>
Group Number: VP
Medicaid/Rx ID: <XXXXXXXXXXXXXXXX>
PCP Name: <XXXXXX XXXXXX>
PCP Number: <XXX-XXX-XXXX>
DOB: <MM/DD/YYYY>
Member Effective Date: <MM/DD/YY>

RxBIN: 003858
RxPCN: MA
RxGRP: VPMMDCD


Virginia's Medicaid Program

Detailed benefit information at optimahealth.com

Pre-Authorization may be required for: hospitalization, outpatient surgery, therapies, advanced imaging, DME, home health, skilled nursing, acute rehab, or prosthetics.
IN CASE OF AN EMERGENCY: Call 911 or go to the nearest emergency room.
Always call your Primary Care Physician for non-emergent care.

Member Services/ARTS: *(Hearing Impaired/Virginia Relay: 711)* 1-800-881-2166
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Pharmacist Help Desk: *(Including Pre-Authorization)* 1-877-779-2890
Dental: 1-888-912-3456

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|--|--|
| Send Claims to P.O. Box 5550 Richmond, VA 23220 | Optima Health P.O. Box 66189 Virginia Beach, VA 23466 |
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PCP Assignment

New members are asked to select a PCP at the time of enrollment. Members may select any Optima Health Group: VP participating PCP whose panel is open to accepting new members. If the member does not select a PCP, Optima Health Group: VP will select one on their behalf. We will consider all available information related to any prior relationship the patient may have had with a PCP, special clinical needs, language requirements, as well as geographic proximity to the provider. Optima Health Group: VP will notify the member of their PCP assignment and will issue a Member Identification Card with the PCP's name, address and phone number. The PCP will be responsible for getting the Optima Health Group: VP member panel from our Web Portal at VirginiaPremier.com.

Members may request a change to their PCP assignment at any time. PCPs will still receive reimbursement for services rendered to eligible Optima Health Group: VP members whether the PCP's name is printed on the member's card or not.

Member Panels

Optima Health Group: VP now offers a Web Portal for ease of the PCPs to access a Member List of all patients paneled to that provider. Please visit VirginiaPremier.com. This listing provides important information and should be reviewed at least monthly by your office staff. Please continue to check eligibility through the portal as this listing does not necessarily reflect eligibility. Please refer to these resources before providing services or referring members to specialists.

At Member’s Request

Members have the right to change their PCP with or without cause. Members must contact Optima Health Group: VP’s Member Services Department to initiate the change. Member Services staff will identify and document the reason for a PCP change. We will monitor changes to identify possible trends to be addressed through our Quality Program.

At the PCP’s Request

PCPs have the right to request that a member be transferred to another participating PCP. Requests for member transfers may be initiated by telephone but must also be submitted in writing to Optima Health Group: VP’s Provider Service’s Department and should include the reason(s) for the request. All decisions regarding such transfers shall be made and become effective as soon as administratively feasible, but, in any event, decisions shall be made within 60 days from the date of the request. In the event that a PCP wishes to dismiss a patient from their panel, the provider is still responsible for providing that member with Primary Care Services, participating in the ICT, and facilitating the ICP until the transfer to another PCP has taken place. In addition, the current PCP is required to share with the new PCP or other provider any and all medical records related to the member’s care.

Mail or fax your request to:

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|---|
| <p>Central Virginia / Western Optima Health Group: VP – Member Services P.O. Box 5307 Richmond, VA 23220 Fax: 1-804-819-5188</p> |
| <p>Roanoke / Bristol Optima Health Group: VP – Member Services P.O. Box 5307 Richmond, VA 23220 Fax: 1-276-619-0967</p> |
| <p>Tidewater / Rural Tidewater Optima Health Group: VP – Member Services P.O. Box 5307 Richmond, VA 23220 Fax: 1-757-459-2230</p> |

SECTION II: MEDICAL MANAGEMENT

Authorizations

Primary Care Physicians (PCPs) in the Optima Health Group: VP network include board certified or board eligible practitioners in the fields of internal medicine, general practice, family practice, and pediatrics. Each Optima Health Group: VP member chooses a PCP or if not chosen, they are assigned a PCP, who assumes responsibility for the management of our member’s health care needs. An obstetrician may assume care for members during pregnancy, but generally will refer back to the PCP for health care issues unrelated to the pregnancy. If a PCP determines that a member requires the services of a specialist or other treatment that they are unable to provide, then the PCP must make a recommendation for the appropriate specialist for the services, however Optima Health Group: VP does not require a referral from the PCP in order for the member to obtain specialist services. The PCP shall request and ensure receipt of copies of medical records of the services provided by the specialist. The PCP will evaluate the outcome of the specialist services and coordinate further care for the member. If a member requires specialist services and a participating specialist is not available, the PCP shall obtain authorization from Optima Health Group: VP to refer to a non- participating specialist. Any approval by Optima Health Group: VP for a course of treatment or referral services does not release the PCP from his/her obligation to verify member eligibility at the time covered services are rendered.

Members may be referred to an out of network specialist with prior authorization from Optima Health Group: VP in the following circumstances:

- Optima Health Group: VP’s contracted providers are unable to provide the specialty service required for the member’s medical care.
- Optima Health Group: VP does not have a provider in the network with appropriate training or experience.
Services are prior authorized by another HMO or Medicaid program prior to enrollment with Optima Health Group: VP.
- When Optima Health Group: VP cannot provide the needed specialist within the distance of 30 miles in urban areas and 60 miles in rural.

| Central Virginia / Fredericksburg / Western | |
|--|--|
| Address | Optima Health Group: VP Referral and Authorizations P.O. Box 5307 Richmond, VA 23220 |
| Phone | 1-888-251-3063 |
| Fax | 1-800-827-7192 Admissions Only: 1-877-739-1365 Specialty: 1- 804-799-5118 |

| Roanoke / Southwest Virginia | |
|-------------------------------------|---|
| Address | Optima Health Group: VP Referral and Authorizations 5060 Valley View Blvd. NW Roanoke, Virginia 24012 |
| Phone | 1-888-251-3063 |
| Fax | 1-800-827-7192 Admissions Only: 1-877-739-1365 Specialty: 1-804-799-5118 |

Out-of-Plan Authorizations

Referrals to non-participating specialists are permitted in certain circumstances if the required specialty service is not available through the Optima Health Group: VP network and the service is pre-authorized by the Plan.

- All out-of-plan referrals must receive advance approval by the UM Department representative, or the Medical Director as indicated with the exception of emergent services and family planning. Authorization must be obtained before a claim is submitted by the non-participating specialist or the claim will be denied.
- The PCP or rendering provider should call the UM department to request approval for out-of-plan services.
- The Medical Director will review the request if the request does not meet continuity of care guidelines or if the service can be provided in network.
- If approved, the PCP or the Medical Director will recommend the appropriate out-of-plan specialist to be utilized. The PCP will obtain an authorization number from the UM Department.
- The specialist must complete the evaluation, document the findings, and send a report back to the PCP. If the referral is not approved by Optima Health Group: VP, the Rendering provider will be notified and provided with alternative recommendations. The PCP has the right to appeal the denial and may discuss medical indications with the Medical Director.

The following circumstances may warrant the use of an out-of-network provider:

- Optima Health Group: VP has pre-authorized an out-of-network provider
- Emergency and family planning services
- When the needed medical services are not available in Optima Health Group: VP's network or the in-network physician does not, because of religious or moral objections, provide the service the member needs
- When Optima Health Group: VP does not have an in-network provider within 30 miles in urban areas and 60 miles in rural areas
- During the members continuity of care period

Prior Authorization

The PCP is responsible for providing and/or managing all health care services for the Optima Health Group: VP member. However, some services also require pre-authorization from us. The prior authorization process allows Optima Health Group: VP to:

- Verify the member’s eligibility
- Determine whether or not the service is a covered benefit
- Make sure that the chosen provider is in the Optima Health Group: VP network
- Evaluate the medical necessity criteria for the service
- Enter the member into Optima Health Group: VP’s Case or Disease Management program if appropriate

To pre-authorize services, contact Optima Health Group: VP’s UM Department at the number listed for the service area. Failure to pre-authorize services will result in denial of payment and the provider may be held responsible for the services.

Please see Mental Health Services for clarification of authorization requirements.

Procedures Requiring Prior Authorization

The full listing of services can be found at VirginiaPremier.com. Go to For Providers, Medicaid, Utilization Management, and then PAL Search Tool, or to this link:

www.authorization.virginiapremier.com/

If a provider has any questions pertaining to prior authorization, please contact the Utilization Management Department or check our PAL list on our website prior to performing the procedure.

Non-Participating Providers

Out-of-network providers are required to obtain authorization prior to providing services (excluding emergency services).

Out-of-network providers are prohibited from causing the cost to the member to be greater than it would be if the services were furnished within the network. If an out-of-network providers delivers services to a member, Optima Health Group: VP will coordinate with the provider to ensure the cost to the member is appropriate.

Authorization Decision Time Frames

Standard Authorization Decisions

For standard authorization decisions, Optima Health Group: VP shall provide the decision notice as expeditiously as the member’s health condition requires and within state-established timeframes described in the table below, with a possible extension of up to 14 additional calendar days, if:

- The member or the provider requests extension; or
- Optima Health Group: VP justifies to the state agency upon request that the need for the additional information is in the member’s interest.

Expedited Authorization Decisions

For cases in which a provider indicates, or Optima Health Group: VP determines, that following the standard timeframe could seriously jeopardize the member’s life, health or ability to attain, maintain, or regain maximum function, Optima Health Group: VP will make an expedited authorization decision. Optima Health Group: VP will provide notice as expeditiously as the member’s health condition requires, but no later than 72 hours after receipt of the request for service.

Optima Health Group: VP may extend the 72-hour turnaround time frame by up to 14 calendar days if the member requests an extension or Optima Health Group: VP justifies (to the State agency upon request) a need for additional information and how the extension is in the member's interest.

| Service Authorization Decision Timeframes for the Medicaid Program (See above description for extensions.) | Turnaround Times |
|---|---|
| Physical Health | |
| Inpatient (Standard or Expedited) and Concurrent Inpatient | 1 calendar day if all clinical information is available, or up to 3 calendar days if additional clinical information is required (or as expeditiously as the member's condition requires) |
| Outpatient / EPSDT Outpatient (Standard) | 14 calendar days if all clinical information is available |
| Outpatient (Expedited) | No later than 72 hours from receipt of request (or as expeditiously as the member's condition requires) |
| Long Term Services and Supports to include - CCC Plus Waiver (including waiver services through EPSDT), Nursing Facility, Respite, Personal Care, Long Stay Hospital, etc. (Standard) | 14 calendar days |
| Long Term Services and Supports to include CCC Plus Waiver (including waiver services through EPSDT), Nursing Facility, Respite, Personal Care, Long Stay Hospital, etc. (Expedited) | No later than 72 hours from receipt of request (or as expeditiously as the member's condition requires) |
| Behavioral Health | |
| Standard UM Review | 14 days if all clinical information is available (or as expeditiously as the member's condition requires) |
| Inpatient (Standard or Expedited) and Concurrent Inpatient | 72 hours |

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| Expedited Urgent reviews for other urgent services | 72 hours |
|--|----------|

Utilization Management Staff Availability

UM personnel are available to assist you in expediting care for your Optima Health Group: VP patient. UM Offices are open from 8:00 am to 6:00 pm daily. If you call after hours or on a weekend, a confidential voice response system will receive your call. Please leave detailed information and a Optima Health Group: VP representative will respond to your call on the next business day.

Hospital Admissions: Elective Admissions

All inpatient elective hospital admissions, some admissions (excluding OB), and outpatient ambulatory surgical procedures must be pre-authorized using the following guidelines (also referred to as “pre-admission certification”).

- The admitting physician or his/her designee will notify Optima Health Group: VP’s UM nurse of the planned admission. If this is an emergency admission, Optima Health Group: VP must be notified within 24 hours of admission, or the next business day.
- The UM nurse will verify eligibility, then obtain baseline information:
 - Demographic profile
 - Requested admission date
 - Requested procedure date, if applicable and/or different from admission date
 - Hospital or outpatient facility
 - Admitting physician
 - Diagnosis
 - Procedure, if applicable
 - Expected length of stay (LOS)

The UM Nurse will review the request based upon clinical information obtained.

1. If authorized, an authorization number will be given to the physician. All hospital stay extensions beyond the originally authorized length of stay will require additional review.
2. If the reported information is not consistent with Optima Health Group: VP policy, the Medical Director will review the request for further consideration. If the admission is imminent, the Medical Director will make a determination within the allotted timeframe of the authorization.
3. Notification to the requesting provider will be made no later than one business day before the scheduled admission. Hospitals not receiving prior authorization must contact Optima Health Group: VP to verify status of authorization.

Admission / Concurrent Review

All inpatient hospital stays require an authorization. At the time of the review for emergency admission, Optima Health Group: VP will determine if the admission was medically necessary. Pending availability of clinical data, determinations will be made within 24 hours of Optima Health Group: VP’s notification with subsequent notification to providers within 24 hours of making the decision. When applicable, the admission will be documented in the member’s ICP.

Concurrent or continued stay reviews are performed on all non-DRG hospitalized patients and DRG admissions that exceed expected length of stay (LOS). Medical Records review will determine if the assigned LOS remains appropriate or if it should be modified given significant changes in the patient's condition. Continued stay decisions will be communicated by telephone to the appropriate contact in the facility's UM Department and to the attending physician's office. Letters are generated for approvals and adverse determinations which include instructions on submitting an appeal. The facility, attending physician and member are notified in writing of the decision by the expiration date of the authorization.

Inpatient Denials

If an attending physician continues to hospitalize a member who does not meet Optima Health Group: VP's medical necessity criteria, all claims for the hospital and physician may be denied from that day forward.

Note: The member cannot be billed for covered services that Optima Health Group: VP has denied. If the patient/family member insists upon continued hospitalization (even though both the attending physician and Optima Health Group: VP agree that the stay is no longer medically necessary) or if the services are non-covered benefits, the member will be financially responsible for those services if notified prior to receiving services and gives consent. The Optima Health Group: VP UM nurse will notify the member or the member's family of the determination of denial. The hospital must notify the member of their financial responsibility.

Medical Necessity Appeals

The Medical Necessity Appeals process is a mechanism through which a member, member's representative, attending physician / provider or facility can request a review of a decision by Optima Health Group: VP. Appeals will be considered if received within 60 days of the decision.

Note: A decision made by Optima Health Group: VP may be due to the failure to demonstrate medical necessity for admissions, continued length of stays, services, procedures, and diagnostic tests. Medical necessity is based on Optima Health Group: VP approved medical policy, Interqual[©] criteria, and state and national clinical guidelines. A provider and/or member may request a copy of the criteria that was used to make a non-certification decision.

Medical Necessity Criteria

Optima Health Group: VP uses McKesson Interqual[©] criteria, nationally recognized clinical practice guidelines / standards and approved Optima Health Group: VP peer-review guidelines for determinations of medical necessity for medical and behavioral health inpatient services. The following factors are considered when applying criteria to a given individual:

- Age
- Co-morbidities
- Complications
- Progress of treatment
- Psychosocial situation
- Home environment, if applicable
- Benefit coverage

Upon request, individual criteria used in a medical necessity determination will be provided to a member, practitioner and/or facility.

For all of the DMAS defined behavioral health services, medical necessity is based on the DMAS guidelines and policies outlined in the DMAS Mental Health Manuals. The ASAM criteria is utilized in determining medical necessity criteria for services under the DMAS Addiction and Recovery Treatment

Services (ARTS).

Expedited Medical Necessity Appeal

Expedited appeals may be requested when a non-certification decision is made by Optima Health Group: VP

prior to, or during the course of treatment. If the member or physician / provider believes that Optima Health Group: VP's decision is not acceptable, a request to appeal should be faxed to Optima Health Group: VP's Medical Management Department. Once the appeal is received, Optima Health Group: VP will select a physician of the same or related specialty to review the case. This physician will be responsible for returning a decision within 72 hours of receiving the information required for the expedited appeal. A member may appeal to Optima Health Group: VP and/or DMAS. A member / provider must exhaust the plan level appeal process before appealing to DMAS.

Standard Medical Necessity Appeal

Standard appeals are generally made after the services have been rendered. Copies of medical or hospital records may be required before the process can begin. All documentation should be faxed or mailed to Optima Health Group: VP's Medical Management Department. Once the related information is received, the appeal will be reviewed by a physician of the same or related specialty, and a decision rendered in 30 days. A member may appeal to Optima Health Group: VP and/or DMAS.

Optima Health Group: VP will provide in writing, clinical rationale for the non-certification decision to the member, physician / provider, or the facility. A member/provider must exhaust the plan level appeal process before appealing to DMAS.

All medical information and appeals for reconsideration of prior authorization/notification or appeals of medical necessity should be sent to:

Optima Health
Group: VP
Appeals
P.O. Box 5006
Glen Allen, Virginia 23058

Providers must exhaust appeals with Optima Health Group: VP before appealing to DMAS.

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

Gynecology and Obstetrical Services

All eligible Optima Health Group: VP members have direct access to in-network OB/GYNs for annual and routine visits and all necessary follow-up care without a referral. If the Optima Health Group: VP member requires continuous follow-up care, the OB/GYN can provide such care without authorization or a referral but should consult with the member's PCP either before or after the care is provided. Consultations may be made by telephone.

When an eligible Optima Health Group: VP Medicaid program member with an Interdisciplinary

Care Team (ICT) has selected their OB/GYN, the OB/GYN must become part of the ICT.

Some outpatient surgical procedures or hospitalizations require pre-authorization from Optima Health Group: VP. Services can be coordinated through Optima Health Group: VP's Medical Management Department for obstetric patients that require additional specialist visits.

OB/GYN services include:

- Prenatal, labor and delivery, and post-partum care
- Specialty gynecological care
- Family planning services in or out of network
- Annual routine pelvic exams under the Women's Wellness Program
- Counseling for HIV testing
- Maternal and newborn home health assessment (home health visits within 48 hours)
- Abortions are covered in some limited cases

When a pregnant member's estimated date of delivery (EDD) is determined, the obstetrician must:

- Complete the OB Registration Form which can be accessed at VirginiaPremier.com.
 - This form is used to identify pregnant members early and to assist with care coordination. Optima Health Group: VP seeks to partner with the provider to ensure consistent prenatal care by the member.
- Return the request form to the Medical Management Department by faxing to the number found on the form.
- OB ultrasounds and non-stress test **do not** require prior authorization.

OB/GYN's are responsible for coordinating services with participating hospitals and specialists for OB related care. The participating OB/GYN is responsible for notifying Optima Health Group: VP's Case Management Department for assistance with prenatal care and enrollment in the maternal health program.

Providers should promote member receipt of postpartum services as medically necessary throughout the postpartum period and within 60 calendar days of delivery.

Outpatient Studies

Optima Health Group: VP partners with NIA (National Imaging Associates) to manage the outpatient imaging management services precertification process using nationally revered clinical guidelines for imaging / radiology services.

Prior authorization is required for the following outpatient radiology procedures through NIA:

- CT/CTA/CCTA
- MRI/MRA
- PET Scan
- Nuclear Cardiology

The ordering physician is responsible for obtaining authorization prior to rendering the above listed services. To obtain authorization, the provider should go to the NIA website www.RadMD.com, or through the NIA dedicated toll-free phone number, 1-800-642- 7578.

- Providers rendering the services listed above should verify that the necessary

authorization has been obtained by visiting www.RadMD.com, or by calling NIA at 1-800-642-7578. Failure to do so may result in nonpayment of your claim. A complete listing of CPT codes requiring preauthorization through NIA is available at www.RadMD.com.

- Note: Emergency room, observation and inpatient imaging procedures do not require authorization.
- Any requests to perform services out of plan must receive prior authorization through Optima Health Group: VP's Medical Management Department or will result in nonpayment of the claim.

Mental Health Authorizations

Mental health providers that are part of the Medicaid program should submit a request for authorization with clinical information to receive an initial and concurrent authorization for services outlined in the DMAS Mental Health Services Manual, Addiction Recovery and Treatment Services (ARTS) Manual, and Inpatient Psychiatric admissions. Unless providing an urgent or emergent mental health service, out of network providers should obtain prior authorization before initiating mental health services, such as traditional outpatient services and electroconvulsive therapy. Authorization must be obtained before seeing patients or payment of services may be denied. Request for authorization can be submitted via fax, Inpatient/ARTS Fax: (804) 799-5105, Outpatient fax: (804) 343-0304 or Virginia Premier's web portal.

Registration of Services

Registration may be required for some services that do not require authorization. Registration is a key element to the success of a care coordination model. Registering a service with Optima Health Group: VP as the service is being provided ensures that the care coordinator has a complete picture of all the services an individual is receiving. Registration also may assist with identifying gaps in services that may help an individual progress in their recovery.

Registration is a means of notifying Optima Health Group: VP that an individual will be receiving behavioral health services, avoiding duplication of services and ensuring informed care coordination. Providers rendering services that require registration rather than authorization should register the start of any new service within two business days of the service start date.

LTSS Authorizations

Some LTSS services shall require prior authorization and approval of services is based on the DMAS screening tools and LOC assessment and score if applicable. Authorizations for Medicaid Program waivers are required. The authorization process allows Optima Health Group: VP to:

- verify the member's eligibility
- ensure there is valid Medicaid program screening that authorizes LTSS, and this screening is attached in the member's chart
- determine whether or not the service is a covered benefit
- contact the member to review their chosen model of care delivery and agency preference if they have selected to have agency directed care or ADHC
- make sure that the chosen provider is in the Optima Health Group: VP network or facilitate the provider to join the network
- evaluate the medical necessity criteria for the service
- refer the member to Optima Health Group: VP's Chronic Care Management and/or

Health Education program, if appropriate coordinate care and additional services as needed

- update the member's ICP

EI Authorizations

Participating providers are not required to obtain authorization for EI services. Non-participating providers will be required to obtain authorization before treating a Optima Health Group: VP member.

SECTION III: TELEHEALTH

Reimbursable Telehealth Services

Services delivered via telehealth will be eligible for reimbursement when all of the following conditions are met:

- The provider at the distant site deems that the service being provided is clinically appropriate to be delivered via telehealth;
- The service delivered via telehealth meets the procedural definition and components of the CPT or HCPCS code, as defined by the American Medical Association (AMA);
- The service provided via telehealth meets all state and federal laws regarding confidentiality of health care information and a patient's right to his or her medical information;
- Services delivered via telehealth meet all applicable state laws, regulations and licensure requirements on the practice of telehealth; and
- DMAS deems the service eligible via telehealth through Medicaid program published fee schedule.

In order to be reimbursed for services using telehealth that are provided to MCO-enrolled individuals, Providers must follow their respective contract with the MCO.

Reimbursement and Billing for Telehealth Services Telemedicine

Distant site providers must include the modifier GT on claims for services delivered via telemedicine.

Place of Service (POS), the two-digit code placed on claims used to indicate the setting, should reflect the location in which a telehealth service would have normally been provided, had interactions occurred in person. For example, if the member would have come to a private office to receive the service outside of a telehealth modality, a POS 11 would be applied. Providers should not use POS 02 on telehealth claims, even though this POS is referred to as "telehealth" for other payers. POS codes can be found at www.cms.gov.

Store-and-Forward

Distant site providers must include the modifier GQ.

Place of Service (POS), the two-digit code placed on claims used to indicate the setting, should reflect the location where the distant site provider is located at the time that the service is rendered.

All Telehealth Modalities

The only procedure code an originating site provider may bill is Q3014.

Originating site providers, such as hospitals and nursing homes, submitting UB-04/CMS- 1450 claim forms, must include the appropriate telemedicine revenue code of 0780 ("Telemedicine- General") or 0789 ("Telemedicine-Other"). The use of these codes is currently not applicable for services administered by Magellan.

Telehealth services may be included in a Federally Qualified Health Center (FQHC), Rural Health Clinic (RHC), or Indian Health Center (IHC) scope of practice, as approved by HRSA and the Commonwealth. If

approved, these facilities may serve as the Provider site and bill under the encounter rate. When an FQHC or RHC serves as the originating site, the originating site fee is paid separately from the center or clinic all-inclusive rate.

Provider Requirements

All coverage requirements for a particular covered service described in the DMAS Provider Manuals apply regardless of whether the service is delivered via telehealth or in-person.

Providers must maintain a practice at a physical location in the Commonwealth or be able to make appropriate referral of patients to a provider located in the Commonwealth in order to ensure an in-person examination of the patient when required by the standard of care. Licensed healthcare providers who provide health care services exclusively through telemedicine are not required to maintain a physical presence in the Commonwealth. More information can be found on dmas.virginia.gov/.

Providers must meet state licensure, registration or certification requirements per their regulatory board with the Virginia Department of Health Professions to provide services to Virginia residents via telemedicine. Providers shall contact DMAS Provider Enrollment (1- 888-829-5373) or the Medicaid MCOs for more information.

Documentation Requirements

Providers delivering services via telehealth must maintain appropriate documentation to substantiate the corresponding technical and professional components of billed CPT or HCPCS codes. Documentation for benefits or services delivered via telehealth should be the same as for a comparable in-person service. The distant site provider can bill for covered benefits or services delivered via telehealth using the appropriate CPT or HCPCS codes with the corresponding modifier and is responsible for maintaining appropriate supporting documentation. This documentation should be maintained in the patient's medical record.

When billing for an originating site, the originating site and distant site providers must maintain documentation at the originating provider site, and the distant provider site respectively to substantiate the services provided by each. When the originating site is the member's residence or other location that cannot bill for an originating site fee, this requirement only applies to documentation at the distant site.

Utilization reviews of enrolled providers are conducted by DMAS, the designated contractor or Optima Health Group: VP. These reviews may be on-site and unannounced or in the form of desk reviews. During each review, a sample of the provider's Medicaid billing will be selected for review. An expanded review shall be conducted if an excessive number of exceptions or problems are identified. Providers should be aware that findings during a utilization review that support failure to appropriately bill for telemedicine services as defined in this policy manual, including use of the GT/GQ modifier, appropriate POS or accurate procedure codes are subject to retractions.

SECTION IV: CLAIMS AND COORDINATION OF BENEFITS

Claim Filing Guidelines

Providers participating with Optima Health Group: VP are required by their participation agreement to submit claims in the required format for all services rendered. If a claim is submitted with incomplete information for required fields, it will be rejected and returned to the submitter as unprocessed.

Claims for services provided to Optima Health Group: VP members must be submitted on HIPAA- standard health care claim formats. Institutional claims submitted electronically must use the ASC X12 837 Institutional Claim guidelines. Institutional claims submitted on paper must use the CMS-1450 (UB04) form. Professional claims submitted electronically must use the ASC X12 837 Professional Claim guidelines. Professional claims submitted on paper must use the CMS-1500 form.

When submitting claims, refer to the most recent version of the following professional resources for coding accuracy, including:

- American Medical Association Physicians' Current Procedural Terminology (AMA/CPT Book)
- International Classification of Diseases, Revised Edition
- Clinical Modification (ICD-10-CM)
- HCPCS Level II Medicare Codes Manuals

All claims submitted must be computer generated or typed to ensure accurate processing. All required fields and appropriate CPT and diagnosis codes must be accurate on the claim form in order to be considered a clean claim. Optima Health Group: VP cannot accept copied versions of claim forms; all claims must be submitted on original red and white claim forms.

Please Note: Handwritten claims are subject to rejection and return to the provider.

Optima Health Group: VP requires that all claims be submitted within the timeframes established in the provider contract. Please refer to your Optima Health Group: VP contract for your specific timely filing period.

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

By following these claim submission guidelines and corporate claim submission policy, Optima Health Group: VP will be able to improve overall claims data and submission accuracy while enhancing claims adjudication turn-around times.

Paper Claim Submissions

Paper claims should be submitted to the following addresses:

| |
|---|
| <p>Optima Health Group: VP Claims P.O. Box 5550 Richmond, VA 23220</p> |
|---|

**Optima Health Group: VP Claims
Reconsiderations
P.O. Box 5286
Richmond, VA 23220**

Coordination of Benefits (COB)

CMS developed a model national contract, called the Coordination of Benefits Agreement (COBA), which standardizes the way that eligibility and Medicare claims payment information within a claims crossover context is exchanged.

For members with another primary carrier, all Explanations of Benefits (EOBs) from the primary carrier will be required with claims submission for Optima Health Group: VP to process secondary claims.

This section provides guidance for coordination of benefits for Medicaid Managed Care members who also have Medicare Parts A and B or other Third-Party Liability (TPL) coverage.

Medicaid is considered the payer of last resort. For members that have other health insurance coverage, Optima Health Group: VP will coordinate benefits with the primary insurance payer.

Please follow the guidelines below to assist in billing services for members who have dual coverage.

| Services Being Billed | Primary Insurance | Billing Instructions |
|---|---|---|
| | Virginia Premier D-SNP Another D-SNP Payer Medicare FFS | Bill directly to Optima Health Group: VP |
| Medicaid Program Waiver Only (Medicare Non- Covered Services) | Other TPL Coverage | |
| All other Services | Virginia Premier D-SNP Another D-SNP Payer / Other TP Coverage | Submit one claim directly to Optima Health Group: VP who will process both the Medicare and Medicaid portion of the claim. Bill directly to the primary insurance. Upon receiving the final determination (Remit/EOB) from the primary payer, submit a secondary claim to Optima Health Group: VP. |

| | | |
|--|--------------|--|
| | Medicare FFS | Bill directly to CMS. Under the Coordination of Benefit Agreement (COBA), CMS will submit the crossover claim directly to Optima Health Group: VP. |
|--|--------------|--|

While we will accept paper secondary claims, we encourage providers to submit Coordination of Benefits (COB) claims electronically. Please ensure to follow the guidelines noted below when submitting secondary claims.

- For paper submissions:
 - Include a copy of the primary EOB
- For EDI submissions:
 - Create or forward claims in full HIPAA standard format (837) and include electronic payment information received from the primary payer's HIPAA standard electronic remittance advice (ERA)

Recoupment / Recovery Policy

The Deficit Reduction Act of 2005 (which established the Medicaid Program Integrity Plan), mandates Medicaid Managed Care Organizations (MCOs) to take measures to identify, recover, and prevent inappropriate Medicaid payments. Optima Health Group: VP will recoup/recover payments that are identified by our auditing and monitoring programs.

Denied Claims / Reconsiderations

Reconsideration for denied claims must be sent to Optima Health Group: VP within 365 days of the original date of denial or the last appeal decision date. The Claim adjustment / reconsideration form can be accessed at VirginiaPremier.com.

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

Optima Health Group: VP
 Attention: Claim Reconsideration Department
 P.O. Box 5286
 Richmond, VA 23220

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

Optima Health Group: VP
 Attention: Medical Management Department
 P.O. Box 5244
 Richmond, VA 23220

Inpatient Rounding

Optima Health Group: VP recognizes the need for PCPs to provide coverage for Inpatient Hospital Rounding. When providing inpatient coverage for another physician, please indicate the "referring physician" (e.g., the original PCP) in box 17 of the CMS 1500 claim form, "Name of Referring Physician or Other Source," when submitting the claim for payment. This data is tracked and reported quarterly to Optima Health Group: VP 's

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

Obstetric Services Reimbursement Schedule

One of Optima Health Group: VP ‘s ongoing initiatives is to increase the wellness of our membership through preventive medicine. One such initiative is Optima Health Group: VP’s reimbursement design for obstetrical services. Optima Health Group: VP allows providers to either bill OB care globally or to unbundle those services as care is rendered to the member.

Your Optima Health Group: VP contract will stipulate which methodology you should follow, but providers can only select one method. In allowing the unbundling of OB services, which include antepartum and postpartum visits, the provider is not limited on the number of times that he/she can see the patient, thus increasing the wellness of the mother and her unborn child and increasing reimbursement to the physician for healthy outcomes.

OB Unbundled Method

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

CPT codes to be utilized with unbundled method:

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

Global OB Method

Providers who bill Optima Health Group: VP for OB services globally should follow the AMA guidelines. The global (bundled) delivery method includes: all antepartum visits, delivery (to include all services associated with the admission and discharge), and postpartum visits. If a provider provides prenatal services but does not perform the delivery, visits should be billed to Optima Health Group: VP as follows: CPT 99201 – 99215 for three or less visits for each visit, CPT 59425 if member had four to six visits (unit should be one) and CPT 59426 if member had seven or more visits (unit should be one).

Preventive E&M Services

Providers should bill preventive Evaluation and Management (E&M) services using the CPT code range of 99381 - 99397 to reflect preventive medicine. Preventive medicine services should be billed using the appropriate “V” diagnosis code from the ICD-10 diagnosis listing. Also, all services billed for preventive medicine must include any appropriate modifiers.

Injectables

When submitting claims for injections:

- Provide the name, dosage, and strength of the injectable drug.
- Optima Health Group: VP requires that prescription drug products using a drug-related Healthcare Common Procedure Coding System (HCPCS) J-code, to include the National Drug Code (NDC) of the drug dispensed on all electronic (837P) and paper claims (CMS-1500) submissions. The quantity of each NDC submitted and the unit of measurement qualifier (F2, ML, GR or UN) will also be required.
- Providers participating in the 340B drug discount program must submit a UD modifier on each revenue line with the HCPCS/CPT code and NDC for revenue codes 0250 through 0259 and 0636 through 0639. All providers, including those not participating in the 340B discount program, must continue to submit NDC codes for revenue codes 0250 through 0259 and 0636 through 0639 and applicable HCPCS/CPT codes for each drug submitted.

Unlisted Procedure Codes

All procedure codes ending in “99” must have additional documentation attached to the claim to sufficiently explain the services provided. This documentation may be an office note, operative note, invoice or other documentation. This information is used in determining the medical appropriateness of the service or supply as well as the level of reimbursement for these services. Lack of supporting documentation may result in a lower level of reimbursement or a denial.

Modifiers

Modifiers are important in determining the level of reimbursement for services rendered in different settings. Include modifiers when appropriate to avoid unnecessary delay or reduction in payment. Optima Health Group: VP follows the use of modifiers as outlined in the CPT (Current Procedural Terminology). Optima Health Group: VP accepts all AMA approved modifiers.

- Optima Health Group: VP requires that bilateral procedures billed on one claim line with the modifier - 50 and 1 unit should be indicated for us to properly reimburse a bilateral procedure.

Hearing Aid Services

NationsBenefits, LLC will administer hearing aid services for all eligible Medicaid program members ages 22 and older. The benefit includes a \$2,000 annual allowance that includes a complete routine hearing exam and evaluation, hearing aid fittings, a three (3) year supply of batteries, up to sixty (60) batteries per hearing aid per year, and a three (3) year manufacturer's warranty on all hearing instruments. In addition, members will be able to access NationsBenefits, LLC's network of hearing aid providers.

Note: Effective October 1, 2022, Optima Health Group: VP will administer hearing aid services for pediatric members 21 years of age and younger. Providers can bill Optima Health Group: VP directly for this age range.

Members can access their benefits information by visiting Nationshearing.com/virginiapremiermedicaid or by calling NationsBenefits, LLC at 844-376-8637. Member Experience Advisors are available 24

hours per day, 7 days per week, 365 days per year. Language support services available free of charge.

Collection of Charges from Third Parties

Optima Health Group: VP providers should verify the member’s eligibility for each visit. Individuals enrolled in comprehensive health insurance, group health plans, and/or insurance provided to military dependents, are excluded from eligibility with Optima Health Group: VP as set forth in the DMAS contract. If the recipient is enrolled in and receives services through Optima Health Group: VP and is subsequently discovered to have another source of health insurance, Optima Health Group: VP shall retract payments made for such services and deny them as coordination of benefits until primary carrier payment information is received.

Until the recipient is removed from Optima Health Group: VP ‘s enrollment, Optima Health Group: VP will be responsible for providing Medicaid covered services as set forth in our contract with DMAS. Payment amounts will be determined by a review of the primary carriers EOB and Optima Health Group: VP’s allowable rate.

Durable Medical Equipment Individual Consideration Request Submission

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

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

Without both the wholesale and retail invoices, the claims will be denied. Please refer to DMAS Appendix B (Medicaid) for item listed as IC or UCC. Items will be reimbursed in accordance with the Optima Health Group: VP fee schedule.

Member Hold Harmless Policy

Providers may not charge members nor Optima Health Group: VP for any service:

- that is not a Medically Necessary Covered Service or non-covered service
- for which there may be other Covered Services or non-covered services that are available to meet the member’s needs
- where the previous two items are not explained in writing, the member will not be liable to pay the provider for the provision of any such services

Electronic Filing Clearinghouses

Medicaid program electronic claims can be filed by utilizing one of the following Clearinghouses:

| Clearinghouse | Contact Information | Optima Health Group: VP Payer ID |
|---------------|--|----------------------------------|
| Availity | 1-800-282-4548 www.availity.com/about-us/contact-us | All Claim Types: VAPRM |

| | | |
|-------------------|--|----------------------------------|
| Relay Health | 1-800-527-8133 www.relayhealth.com/contact-us | All Claim Types: VAPRM |
| Change Healthcare | 1-866-371-9066 www.changehealthcare.com/support/customer-resources/enrollment-services | All Claim Types: VAPRM |

Providers who wish to submit claims electronically must complete all necessary documents related to the process. Please allow at least 30 business days to complete this process. Providers are encouraged to contact their claims clearinghouses to confirm they are set up to submit claims electronically. Submitting claims electronically without full clearance will cause claims processing delays.

Optima Health Group: VP

Attention: EDI Enrollment Team Fax:
804-819-5174

Providers participating with Optima Health Group: VP who require the ability to create and submit claims through our direct data entry portal will need to do the following prior to submitting their first claim:

- Go to <https://www.virginiapremier.com/providers/medicaid/provider-portals/> and go to the “New Users” section
- Sign up for a new account through HealthTrio Connect
- You will receive a response within 3-5 business days with your username and temporary password
- Submit claims submission via the portal
- Primary insurance payer please follow the Denied Claims/Reconsiderations guidelines below to assist in billing services for members who have dual coverage

SECTION V: MEMBER RIGHTS AND RESPONSIBILITIES

Member Rights

Members of Optima Health Group: VP are entitled to all the benefits outlined in their Member Handbook Evidence of Coverage. With Optima Health Group: VP's support, each member must learn the plan guidelines, follow proper procedures and seek services from our network of participating providers. Members can exercise these rights without having their treatment adversely affected. Optima Health Group: VP members have the right to:

- A copy of the Privacy Notice annually or when requested.
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, as specified in federal regulations on the use of restraints and seclusion.
- Be furnished health care services in accordance with 42 CFR §§ 438.206 through 438.210.
- Be treated with respect and with due consideration for his or her dignity and privacy.
- Call Member Services to file a complaint/grievance about Optima Health Group: VP, or to file an appeal if they are not happy with the answer to their inquiry (question), complaint/grievance, or care given.
- Choose their personal Optima Health Group: VP doctor/Primary Care Physician (PCP). Members can find the Provider Directory online at VirginiaPremier.com or contact Member Services for assistance.
- Change their personal Optima Health Group: VP doctor and choose another one from Optima Health Group: VP's Provider Directory. The Provider Directory can be found online; members can call Member Services for assistance.
- Free exercise of rights and the exercise of those rights that do not adversely affect the way Optima Health Group: VP and its providers treat their members.
- Have health care services 24 hours a day, 365 days a year, including urgent, emergency, and post-stabilization services.
- Have their doctor tell them about all treatment options and alternatives, presented in a manner that can be easily understood, regardless of the cost or benefit coverage. They can also receive a second opinion Optima Health Group: VP's network of providers.
- Have timely access to their medical records in accordance with applicable state and federal laws. They may be required to sign for release of those records.
- Make suggestions regarding Optima Health Group: VP's Member Rights and Responsibilities statement, which is found in the Member Handbook.
- Make their own doctor/PCP appointments to be seen in a private office at their convenience.
- Not be balanced billed by any provider for covered services other than the Patient Pay established by DSS towards LTSS services.
- Not be discriminated against due to medical conditions, including physical and mental illness, claims experience, receipt of health care and medical history.
- Not to be treated against their will.

- Participate with their doctor in making decisions about their health care, give their consent for all care, and make decisions to accept or refuse medical care to the extent permitted by law and be made aware of the medical consequences of such action.
- Be provided language assistance services including but not limited to interpreter and translation services, and effective communication assistance in alternative formats such as auxiliary aids, free of charge to members and/or the member's representative.
- Receive information on available treatment options and alternatives presented in a manner appropriate to their condition and ability to understand.
- Receive information in accordance with 42 CFR § 438.10.
- Receive information about Optima Health Group: VP, its services, costs, providers, network pharmacies, drugs, and Members' Rights and Responsibilities.
- Rights to reasonable accommodations.
- Request and receive a copy of his or her medical records and request that they be amended or corrected, as specified in 45 CFR §§ 164.524 and 164.526.
- Timely access to their PCP and referrals to specialists when medically necessary, or as needed, and timely access to all covered services, both clinical and non-clinical.
- Know the names and qualifications of the physicians and health care professionals involved in their medical treatment.
- Privacy and to have their medical records and personal health information kept private unless they sign a permission form.
- See their doctor/PCP, receive covered services and get their prescriptions filled within a reasonable period of time. They should not be afraid to ask their doctor/PCP questions.
- Use Advance Directives (such as a Living Will or a Power of Attorney) and be provided information about advance directives and any changes made in state law as soon as possible, but no later than 90 days after the effective date of change.
- Treatment with quality care, respect and dignity regardless of their race, physical or mental ability, ethnicity, gender, sexual orientation, creed, age, religion or their national origin, cultural or educational background, economic or health status, English proficiency, reading skills, or source of payment for their care.

Supplemental Member Rights

Optima Health Group: VP members also have the right to:

- Confidentiality when coordinating care including medical records, their information and appointment records for the treatment of sexually transmitted diseases.
- File any type of complaint/grievance, including those related to advance directives, with Optima Health Group: VP. Medicaid program members may call toll free at 1-800-727- 7536, the Department of Medical Assistance Services, the Bureau of Insurance and the Department of Health.
- Get emergency care and family planning services in or out-of-network without prior authorization. Family planning services, preventive services, and basic prenatal care do not need preauthorization, but the member should get care from an in-network doctor/provider
- Give female members direct access (no referral needed) to a woman's health doctor/provider in the network for covered routine and preventive care services. This is in addition to the Member's assigned primary care doctor/provider if that person is not a women's health doctor/provider.

- Have his/her health care needs and information discussed and given to the doctors /providers they want and they are advised to sign a release form with their current provider in order to have the information released.
- Have the doctor write in his or her medical record whether or not the member has completed an advance directive.
- Not have the doctor/provider condition the delivery of care or discriminate against them based on whether he/she has completed an advance directive form.
- To be held harmless (not responsible for the bill or extra costs), if out-of-network services are given to them for emergency care or care that has been preauthorized other than the Patient Pay established by DSS for LTSS services.
- To contact Optima Health Group: VP staff that has been trained on advance directives and asks questions, if needed.
- To have any service that has been stopped reactivated if a member's location is known.
- To obtain care from a doctor/provider acting within the lawful scope of practice.
- Optima Health Group: VP will not prohibit or otherwise restrict a doctor or provider from advising or advocating on behalf of the member as a patient as related to their health condition, medical care, or treatment choices, including any other treatment that may be self-administered.
- To obtain information in different formats (i.e., large print, braille, etc.), if needed, and in an easy form that takes into consideration the special needs of those who may have problems seeing or reading.
- To see a doctor in the Optima Health Group: VP network of his/her choice based on language and/or race and one who is sensitive to their cultural needs, including those who cannot speak English well and those with different cultural and racial backgrounds.
- To see an in-network doctor in a timely manner based on the access standards listed in this document under the section called: Access to Health Care Standards.
- To see in-network doctors/providers with the same office hours as those for other patients who may not have Medicaid, like private commercial insurance members, and/or other types of Medicaid members (fee for service), if the doctor/provider sees only Medicaid members.

Member Responsibilities

- Act in a way that supports the care given to other patients and helps the smooth running of their doctor's office, hospitals, and other offices.
- Carry their and/or their child's Optima Health Group: VP Member ID Card with them at all times.
- Choose their and/or their child's Optima Health Group: VP PCP from the list of our doctors from the provider directory. Work with their PCP to help establish a proper patient-physician relationship.
- Follow plans and instructions for care given by their physician.
- Get their health care from a participating PCP, hospital, or other health care provider.
- Give their PCP and other providers honest and complete information they need about their health to care for them.
- Inform their PCP of visits to other doctors so that he can be kept informed about the care that they are receiving.

- Inform Optima Health Group: VP if they have other health insurance coverage
- Keep their doctor's appointments or call to cancel them at least 24 hours ahead of time.
- Learn the difference between emergency and urgent care. Know: What is considered an emergency, what to do if an emergency happens, and how to keep one from happening.
- Let Optima Health Group: VP know if they have any problems, concerns, or suggestions on how we can work better for them.
- Take into advisement the recommendations of the care managers and other health care professionals at Optima Health Group: VP.
- Tell the doctor that they are a member of Optima Health Group: VP at the time that they speak with their doctor's office.
- Understand their health problems and discuss and/or agree upon a treatment plan with their physician.

SECTION VI: APPEALS AND COMPLIANTS/GRIEVANCES

Appeals

The appeals process is a mechanism through which a member or physician/provider can request a review of an adverse benefit determination. An adverse benefit determination is the denial of a service authorization request, the reduction, suspension, or termination of a previously authorized service and/or denial in whole or in part of a payment for a covered service.

Expedited Appeal

Expedited appeals may be requested by phone or in writing. Optima Health Group: VP may not require that oral requests for an appeal be followed with a written appeal. This applies to requests concerning admissions; continued stay or other health care services that:

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

A provider, member, member's authorized representative, or member's attorney may request an expedited appeal by notifying Optima Health Group: VP via telephone or by faxing the clinical documentation to support the request, along with the attached form to the numbers listed below. (There is no phone number listed). Once the appeal is received, Optima Health Group: VP will select a physician of the same or related specialty to review the case. This physician will be responsible for returning a decision within seventy-two (72) hours of receiving the information required for the expedited appeal but is not the same physician who rendered the initial denial. A member or physician/provider must exhaust all Optima Health Group: VP r appeals before appealing to DMAS.

Standard Appeal

A provider, member, member's authorized representative, or member's attorney may request a standard appeal telephonically or in writing within 60 calendar days of the date of the adverse action letter. All oral requests must be followed by a written appeal request. This type of appeal applies to requests for non-urgent pre-service or post-services. The practitioner/provider may submit written comments, documents, records, and other information relevant to the appeal.

Appeals that involve clinical issues will be reviewed by a practitioner that was not involved in the initial denial that is of the same or similar specialty of the treating practitioner. An appointed Optima Health Group: VP staff member that was not involved in the initial adverse decision will review non-clinical appeals such as benefit determinations. The member or practitioner/provider will be notified of the appeal decision in writing within 30 calendar days of the appeal request.

Once the related information is received, the appeal will be reviewed by a physician of the same or related specialty, and a decision rendered in t 30 calendar days but is not the physician who rendered the initial denial. A member or physician / provider must exhaust all Optima Health Group: VP appeal before appealing to DMAS. Optima Health Group: VP will provide in writing, clinical rationale for the adverse benefit determination to the member or physician/provider.

For Optima Health Group: VP appeals, all request and clinical information should be sent to:

Optima Health Group: VP
Appeals and Grievances Department
P.O. Box 6253
Glen Allen, VA 23058
Phone: 844-434-2916 (TTY: 711)
Fax: 866-472-3920

DMAS Appeal (State Fair Hearing)

The practitioner or provider may appeal to DMAS upon exhaustion of the Optima Health Group: VP appeals process by notifying DMAS in writing within 120 calendar days of notification of Optima Health Group: VP 's appeal decision.

For DMAS appeals, all request and clinical information should be sent to:

Department of Medical Assistance Services – Appeals Division
600 E Broad Street
Richmond, VA 23219
Phone: 804-371-8488 (TTY: 800-828-1120)
Fax: 804-452-5454
Email: appeals@dmas.virginia.gov
Online: www.dmas.virginia.gov/#/appealsresources

FAMIS Appeal

Providers can appeal to KEPRO for an External Review after exhausting the Optima Health Group: VP appeals process, for members participating in the FAMIS program. Providers must ask KEPRO for an External Review in writing; requests by phone will not be accepted. The request must be sent within 30 calendar days from the date of the last notice saying the appeal was denied. KEPRO an external, independent review organization will review the appeal request. Please send these requests for review to:

FAMIS External Review c/o KEPRO 2810
N. Parham Road Suite 305
Henrico, VA 23294
Fax: 877-652-9329
Phone: 888-827-2884
Email: VAproviderissues@kepro.com

For more information or to create an external review appeal, visit dmas.kepro.com.

During an appeal, each member has the right to:

- Know that he/she may have to pay for the cost of the benefits if the state hearing decision is the same as Optima Health Group: VP's decision, to deny the benefits. If the final decision of the appeal is to deny the benefits, Optima Health Group: VP may bill the member for the cost of all services or benefits that were pending during the appeal process.

- Have benefits continue pending the outcome of the appeal and/or state fair hearing.
- The member can request continued benefits by writing a letter stating, “please continue benefits during my appeal” and forwarding it to Optima Health Group: VP, or by calling 1-855-813-0349.
- Ask for an extension, orally or in writing, up to 14 calendar days, while the appeal is going on, if the extension is best for the member.
- To be contacted by Optima Health Group: VP, in writing, of the appeal extension reason like “the appeal needs to be extended for additional information” and how the delay is best for the member.
- Look at all documents before and during the appeal, by writing to Optima Health Group: VP with the request; the member can call calling 1-855-813-0349 for help.
- To include, as parties to the appeal, the legal representative of a deceased member’s estate.

Complaint/Grievance

The complaint/grievance process is a mechanism through which a provider, member and/or a member’s representative may request a review of a matter that has caused dissatisfaction with Optima Health Group: VP. A complaint/grievance is an expression of dissatisfaction about any matter other than an action (i.e., denial, suspension, or termination of services) taken by Optima Health Group: VP. Possible subjects for complaints/grievances include, but are not limited to, the quality of care or services provided and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the member’s rights. Members can request a grievance by telephone or in writing.

Optima Health Group: VP will resolve and respond to all complaints/grievances within 30 calendar days from the date of initial receipt of the complaint/grievance. Only written complaint/grievance requests will be responded to in writing unless the member requests a written response to a verbal complaint/grievance. When the complaint/grievance is of a health care nature, individuals at Optima Health Group: VP with appropriate clinical expertise in treating the member’s condition or disease will make decisions on complaints/grievances.

Whenever a member, member’s representative, or provider is not satisfied with the resolution of a complaint/grievance, the member, member’s representative, or provider has the right to appeal the outcome of the complaint/grievance. Optima Health Group: VP will answer any questions regarding the complaints/grievances and appeals process during normal business hours, Monday through Friday 8:00 am to 8:00 pm by contacting:

Optima Health Group: VP
 Appeals and Grievances Department
 P.O. Box 6253
 Glen Allen, VA 23058
 Phone: 844-434-2916 (TTY: 711)
 Fax: 866-472-3920

SECTION VII: MEDICAL RECORDS

Requests for Medical Records

Optima Health Group: VP requires participating physicians make medical records available to members and their authorized representatives within 10 working days of receiving a request.

Retention and Transfer of Records

Participating physicians are required to maintain all records pertaining to Optima Health Group: VP members for 10 years or longer if required under applicable state law.

Optima Health Group: VP requires that participating physicians make medical records available to members and their authorized representatives within 10 working days of receiving a request.

PCPs are responsible for obtaining copies of medical records from both participating and non-participating providers to whom they make referrals, in order to ensure continuity of care and integrated medical records.

Practitioners who do not meet Optima Health Group: VP's medical record standards performance threshold will be expected to document and implement a corrective action plan within a specified time frame. At least every six months after the initial review, each deficiency will be monitored for progress and/or until the performance standards are met. If deficiencies are not resolved within a six-month time frame, they will be presented to the Senior Medical Director and/or the Credentialing Committee to begin a review and sanctioning process with the practitioner.