



# Commonwealth Coordinated Care



## Provider Training





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Services

# OVERVIEW OF COMMONWEALTH COORDINATED CARE



# Overview

- What is Commonwealth Coordinated Care?
- Options
- Eligibility
- Exemptions
- Benefits of enrolling
- Costs
- Does the Doctor change?
- Choosing a plan
- Enrollment
- What is VICAP?
- VICAP's role with CCC
- Coordinated Care Educator's role



# What is Commonwealth Coordinated Care?

- Blending of Medicare and Medicaid
- MMP's (Medicare-Medicaid Plans)
  - Anthem Healthkeepers
  - Humana
  - Virginia Premier
- CCC is an enhancement over regular Medicare/Medicaid

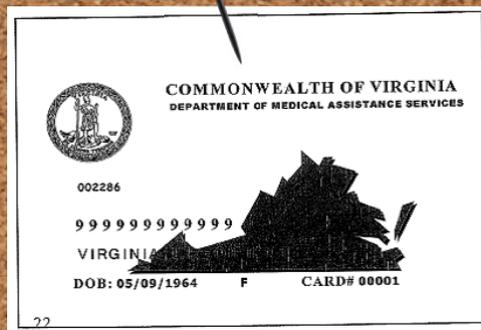


# Options

- Opt-in
- Opt-out of one plan and opt-in to another
- Opt-out of CCC completely
- Flexibility: No open enrollment



# Who is Eligible?

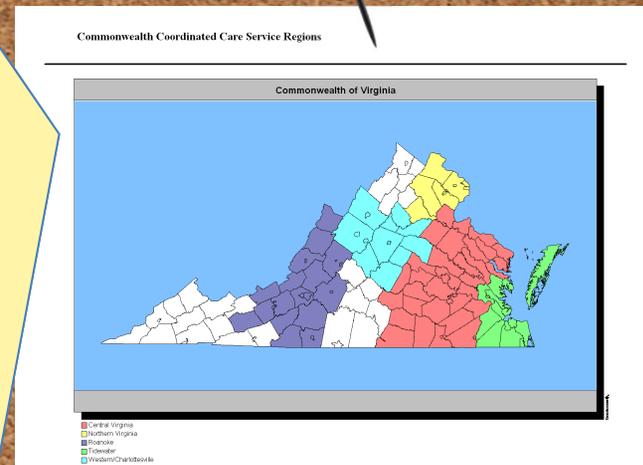


A, B & D

Full Benefit

EDCD &  
Nursing  
Home  
Residents

21 and  
Older





- Other Medicaid Long-Term Care Waivers
- Hospice
- Other Comprehensive Insurance

# Benefits for Signing Up

1

One system  
to  
coordinate  
care

2

One ID card  
for all care

3

24/7 local call  
center with  
access to  
beneficiary  
records

4

Unified  
appeals  
process

5

Person-  
centered  
care  
coordination

6

Expanded  
Benefits



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# Care Coordination

- Unique to CCC
- No extra cost
- Help with arranging appointments and services
- Care Manager gets to know member and helps to develop the care plan



# COSTS

- **No** deductibles, premiums or co-pays for doctor or specialist visits
- **Some** co-pays for prescriptions
- **No** co-pays or premiums for extra benefits
- **Continue** to pay long-term care patient pays



# Do I Have to Change Providers?

- Keep Providers that are In-Network
- Care continues with current providers for up-to 180 days
- Afterwards, will need to choose In-Network providers
- During transition providers bill the MMP, not Medicare & Medicaid



# Enroll in a Plan

# 1-855-889-5243



- Members may enroll by calling this number.
- NO PAPERWORK required for enrollment!
- Coverage begins 1<sup>st</sup> of month



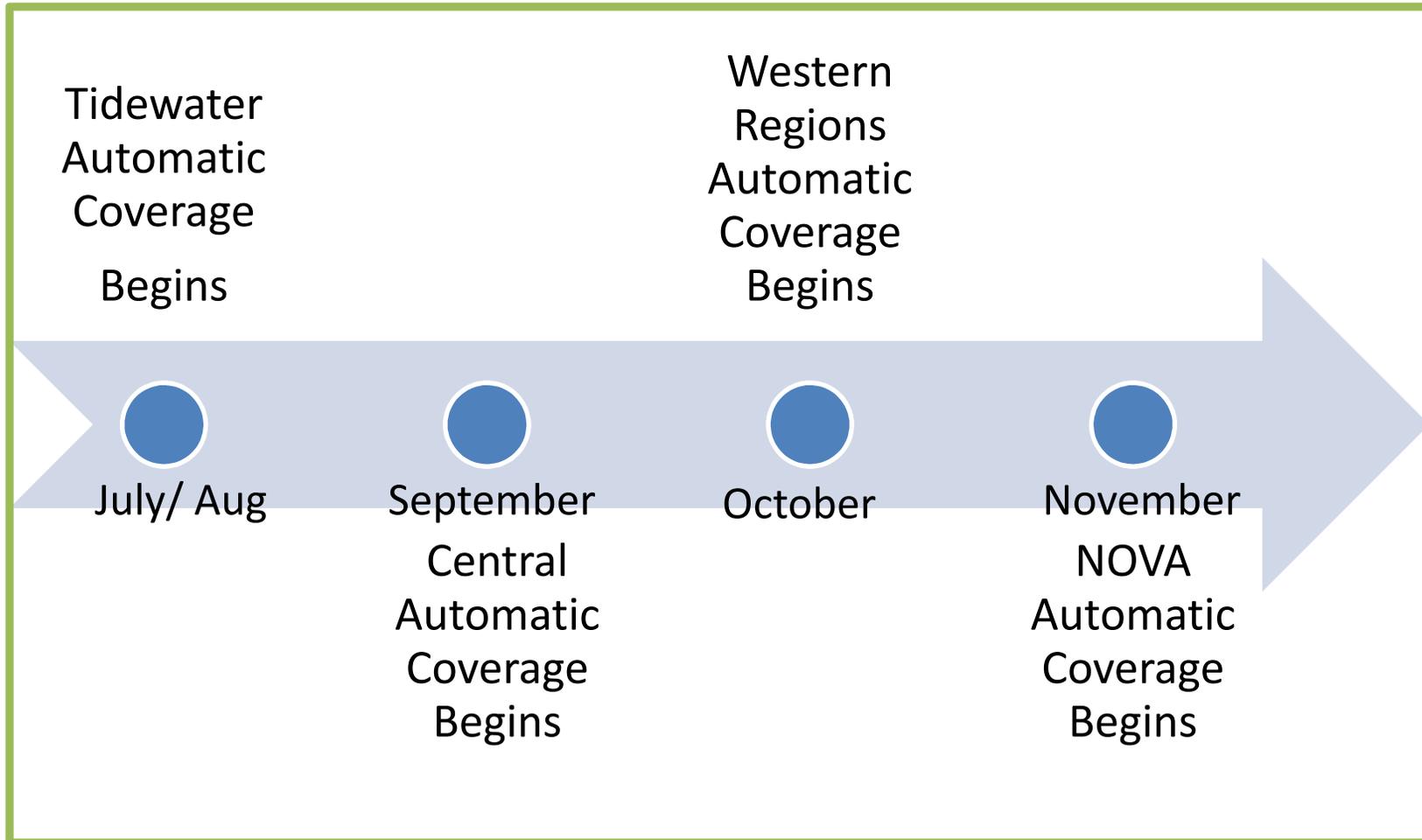
# Beneficiary Notification

Eligible individuals are identified by a joint process in DMAS and CMS information systems

## Eligible Individuals Receive 4 Letters

1. A letter introducing CCC
2. A 60 day letter informing the individual he/she will be signed up by a specific date unless he/she opts out
3. A 30 day letter informing the individual he/she will be signed up by a specific date unless he/she opts out
4. A welcome package from the health plan providing coverage for the individual

# CCC Timeline



# What is VICAP?

## *Virginia Insurance Counseling and Assistance Program*

- Information and Counseling on Medicare and other health insurance issues to seniors and adults with disabilities
- One of 54 State Health Insurance Programs (SHIPS)
- 100 % Federally funded
- Volunteer based



# VICAP Services to Beneficiaries

**Traditional  
Medicare  
(Medicare)  
A & B**

**Medicare  
Advantage  
Plans  
(Part C)**

**Medicare  
Prescription  
Drug Coverage  
(Part D)**

**Medigap or  
Medicare  
Supplemental  
Insurance**

**Long-Term Care  
Insurance**

**Coordination of  
Benefits**

**Appeals,  
Denials, etc.**



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# VICAP and Commonwealth Coordinated Care

Assist VICAP  
Coordinators  
&  
Counselors

Information, education, and guidance, to CCC-eligible individuals. Helping to increase the confidence of beneficiaries and their families in their Medicare and Medicaid supports

Collaborates  
with  
DMAS

Enhancing educational opportunities at venues serving Virginia's five service regions

Serves as  
Liaison

Serving as a liaison between the AAA's, VICAP Coordinators and DMAS



# CCC Consumers

Contact Anita Squire, VICAP CC Educator to

- Ask questions and receive educational materials
- To Schedule a CCC educational event
- For referrals to Maximus for enrollment or to a VICAP counselor for other Medicare options

**Department for Aging & Rehabilitative Services**

**Division of Aging**

[anita.squire@dars.virginia.gov](mailto:anita.squire@dars.virginia.gov)



# CCC Contact Information

Office of Coordinated Care  
Virginia Department of Medical Assistance  
Services

[CCC@dmas.virginia.gov](mailto:CCC@dmas.virginia.gov)



# Beneficiary Rights

- The Virginia Department for Aging and Rehabilitative Services **Long-Term Care Ombudsman** Program will **ensure** the beneficiaries of Commonwealth Coordinated Care (CCC) - as well as their caregivers and authorized representatives have **access to person-centered assistance in resolving problems** related to the CCC Demonstration.
- The State Long-Term Care Ombudsman Program serves individuals in **nursing facilities** and **assisted living facilities** as well as persons receiving **community-based services at home**. Coordinated Care Advocates serve individuals in the community.



# Ombudsmen & Coordinated Care Advocates provide the following:

- Assistance **understanding enrollee rights**, responsibilities and benefits;
- Help **investigate complaints and resolve beneficiary problems** with CCC health plan or services;
- Empower CCC enrollees to resolve problems with their health care, behavioral health care, prescription drugs, and long-term care services and supports;
- Assist beneficiaries to **gain access to covered benefits**, urgent needs for services and quality issues;
- Act as a **resource for beneficiaries**, family members & advocates;
- **Track** problems reported and provide recommendations for quality improvement.



# Issues CCC Advocates May Address

- Enrollment and Disenrollment
- Continuity of Care
- Accessibility and Information
- Timeliness of Plan Responses to beneficiary Inquiries
- Covered Services
- Appeals and Grievances



# CCC Advocate Program Contact Information:

Susan Johnson, CCC Advocate Manager  
Office of the State Long-Term Care Ombudsman  
Virginia Department for Aging and Rehabilitative  
Services

804-662-7162

Toll-free: 800-552-3402

[Susan.Johnson@dars.virginia.gov](mailto:Susan.Johnson@dars.virginia.gov)





## THE MEDICARE-MEDICAID PLANS



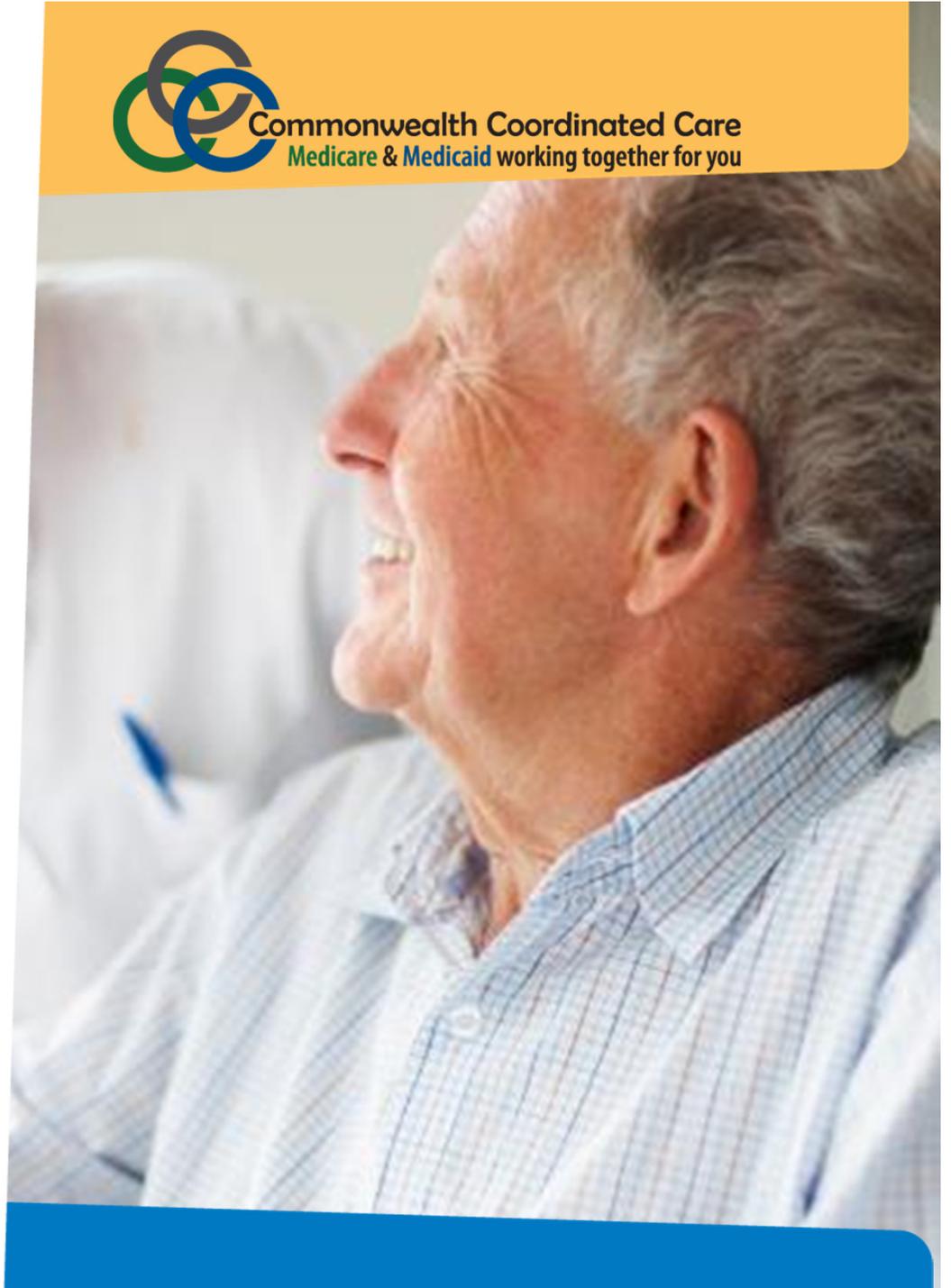


**Anthem** HealthKeepers  
Offered by HealthKeepers, Inc.

## Anthem HealthKeepers Medicaid-Medicare Plan (MMP)



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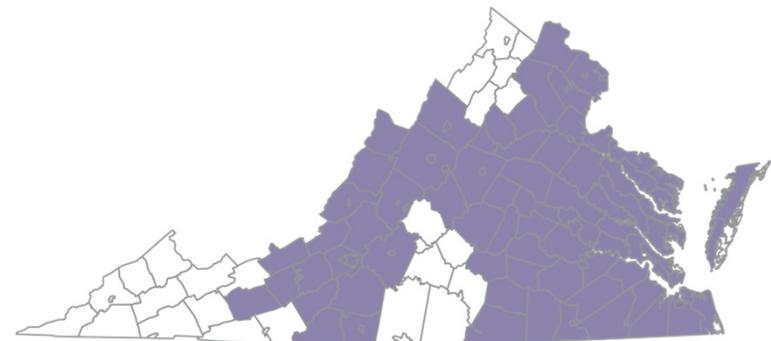
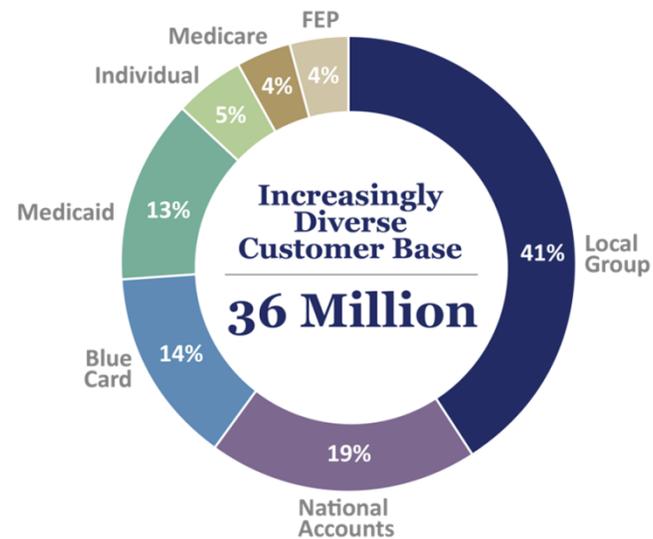
# About Anthem and HealthKeepers, Inc.

A leading provider of health care solutions for publicly funded programs.

We serve nearly 36 million people (1 in 9 Americans) in our family of health plans.

We're local: HealthKeepers, Inc. and its affiliates have been serving Virginia for over 75 years, including Medicaid Managed Care since 1995.

Our Mission: To improve the lives of the people we serve and the health of our communities.

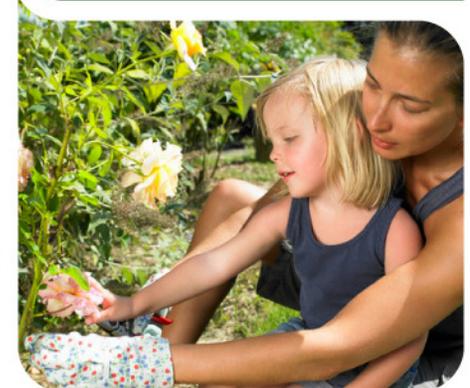




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# Humana Gold Plus Integrated, A Commonwealth Coordinated Care Plan Orientation Training



**Humana**®

**INDEPENDENT**  
*Living Systems*

660VA0114-A



## Who We Are: Humana

Humana and its various businesses serve more than 13 million members across the country. Humana delivers primary care and occupational health care services through a network of more than 300 wholly owned medical centers and clinics.

*Helping people achieve lifelong well-being*

- **Founded in 1961**
- **Long-term commitment to seniors and chronically ill**
- **5 million Medicare Advantage and Part D members**
- **550,000 dual-eligible Medicare-Medicaid members**
- **18 years Medicaid experience**

### Humana's Values

- Thrive Together
- Cultivate Uniqueness
- Pioneer Simplicity
- Inspire Health
- Rethink Routine

# Humana for Virginia

Our 9 years of experience in Virginia prepare us well to meet the specific needs of our Members.

## Our Virginia Footprint:

- 109k Medicare Advantage and 98K Medicare Prescription Drug Plan Members
- The only Dual Eligible Special Needs Plan (D-SNP) within the Commonwealth's demonstration (CCC) area
- Unique partnerships aimed at promoting quality, delivering the highest standards of care, and providing access to coverage in historically underserved with various Virginia provider groups and clinic arrangements (i.e., Jencare, EVCTP or Area Agencies on Aging in Tidewater Region)
- A highly-rated Medicare Advantage HMO plan across Virginia (achieving a CMS rating of 3.5 of 5 STARS)

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## Independent Living Systems

## Humana

- Founded in 2001
- Serves individuals who are elderly, frail, have chronic medical conditions or other special needs
- A management company for long-term-care providers who assists with rebalancing costs by using home and community based services as an alternative to facility based care
- Experienced in managed long-term care, population care management and home and community-based services

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## Beacon Health

## Humana

- Founded to meet the needs of local plans that serve the Medicaid population, Beacon has evolved with its customers.
- Beacon was founded in 1996 to develop an integrated behavioral health solution for a community-based health plan started by FQHCs.
- Beacon serves 9 million lives in 21 states, 60+ health plans and 13 state Medicaid programs.
- Beacon works with over 30 Medicaid plans serving all segments of the Medicaid population.
- Beacon counts many provider- and hospital-sponsored plans as clients.
- Beacon has been integrating care for dual-like populations for 15 years and is currently involved in duals demonstration projects in six states (MA, OH, CA, IL, RI, VA) managing more than 100,000 lives.

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# Humana Highlights

- Humana also offers
  - Assistive Technology
  - Vision, Dental and Hearing Benefits
  - \$35 per month of over the counter health and wellness items
  - Welldine provides ten prepared meals for you after a discharge from hospital
  - Pest control treatments (one every four months)
  - Transportation to and from medical appointments
  - The SilverSneakers Fitness Program
  - Quitnet to help you quit smoking
  - ...and many more!

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# VA Premier CompleteCare

a Commonwealth Coordinated Care Plan



# About Us

**VA Premier**  
**CompleteCare**  
a Commonwealth Coordinated Care Plan



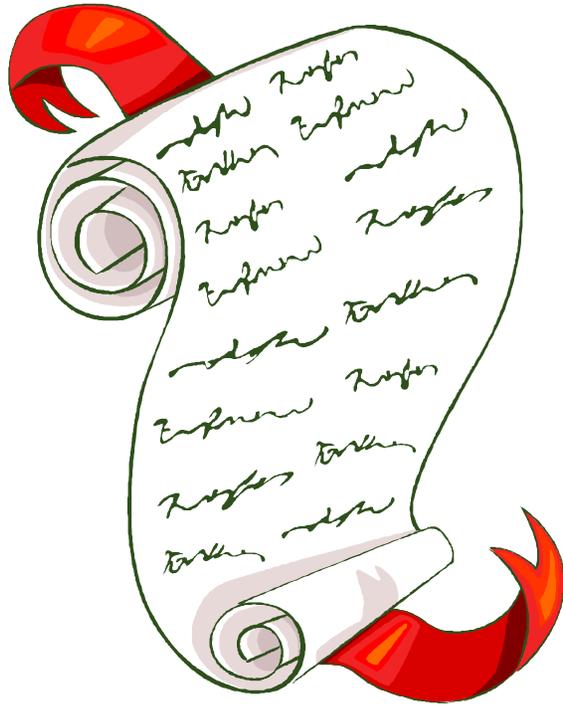
# What Sets Us Apart?



- We are the **#1 Medicaid Health Plan** in Virginia for six consecutive years, from **2008 - 2014**.\*
- Ranked **#38** in 2013 - 2014 by NCQA of Best Medicaid Health Plans in the United States.
- **Not-For-Profit** Health Plan
- The first and only **university-based** Managed Care Organization in Virginia

*\* NCQA's Medicaid Health Insurance Plan Rankings, 2013-2014*





**Information in this section will be the same across all health plans per their contracts with Medicare and Medicaid**

# **SERVICE DELIVERY OVERVIEW**



# Eligibility Check



- Find out if one of your dually eligible beneficiaries is in CCC during your regular monthly eligibility checks through ARS or MediCall. Both will inform you whether a beneficiary is enrolled in CCC and with which health plan
  - MediCall 1-800-884-9730 or 1-800-772-9996
  - ARS (Automated Response System): The Virginia Medicaid Web Portal can be accessed by going to: [www.virginiamedicaid.dmas.virginia.gov](http://www.virginiamedicaid.dmas.virginia.gov) (Providers must register through the Virginia Medicaid Web Portal in order to access this information. )



# Health Risk Assessment (HRA)

- Assessments completed within:
  - 90 days for Community Well
  - 60 days for EDCD and NF residents
- Assessments face-to-face for EDCD and NF



# Plan of Care (POC)

- The CCC POC does not take the place of the provider's POC (ex: Personal Care POC)
- CCC POC is intended to reflect services across the continuum of care for each beneficiary
- Beneficiaries participate in the care planning process



# Interdisciplinary Care Team (ICT)

- Who participates in the ICT?
  - Member and their trusted advocates
  - PCP
  - MMP Care Manager
  - Specialty practitioners
  - LTSS providers
  - BH providers



# Care Management

- Beneficiary is assigned a care manager from their health plan
- Care Manager is responsible for working with the beneficiary and providers to assemble the ICT
- Care Manager works with the beneficiary and providers to coordinate supports and services
- Care Manager is a resource to providers for authorizations





# AUTHORIZATIONS



**Need to know if precertification is required? Use our Precertification Lookup tool at <https://mediproviders.anthem.com/va/pages/precert.aspx> to:**

- **Determine if a service needs a precertification;**
- **Find additional information regarding precertification for DME, vision, transportation and other ancillary services; and**
- **Search by your market, the program in which the member participates and the CPT code. If you don't know the exact code, you can also search by description.**

**You can submit precertification requests via fax to:**

- **1-800-964-3627 for initial inpatient admissions**
- **1-800-505-1193 for behavioral health outpatient services**
- **1-877-434-7578 for behavioral health inpatient services**
- **1-888-280-3725 for therapies, home health, durable medical equipment and discharge planning**
- **1-888-280-3726 for concurrent review for inpatient**
- **By calling Customer Service at 1-855-817-5788**
- **By calling 1-804-382-5146 for LTSS**

# Humana Authorization and Notification

- Care coordinators (CC) are responsible for assessing member need and determining member plan of care.
  - ILS recognizes importance of providers input in the provision of care
- The care coordinator collaborates with members on their choice of a provider, mutually agree on services, hours, schedule and special skill set of the provider.
- The ILS Care Coordination Unit (CCU) assists care coordinators by contacting providers and advising of member needs, service requests and provide an authorization number.
- For authorization inquiries, call the CCU or CC by utilizing the provider number at 1-866-224-6947.

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# How to Reach Humana



## Provider Customer Service (Non-LTSS Services)

**1-855-280-4002**

## Provider Customer Service (LTSS Services)

**1-866-224-6947**

## Behavioral Health

**1-855-765-9704**

## Orthonet

**1-800-862-4006**

Dorinda Hunter, RN- Director, VA LTSS

804-852-9156 / [dhunter7@humana.com](mailto:dhunter7@humana.com)

Tracy Maitland-Martin, RN - Central Region LTSS Manager

804-564-3292 / [tmaitland-martin@humana.com](mailto:tmaitland-martin@humana.com)

Amy Antonucci, RN - Tidewater LTSS Regional Manager

757-469-0127 / [aantonucci@humana.com](mailto:aantonucci@humana.com)

Toni Proctor, RN- NOVA LTSS Regional Manager

[aproctor@humana.com](mailto:aproctor@humana.com)

Liz Welch, RN- Western LTSS Regional Manager

[ewelch1@humana.com](mailto:ewelch1@humana.com)

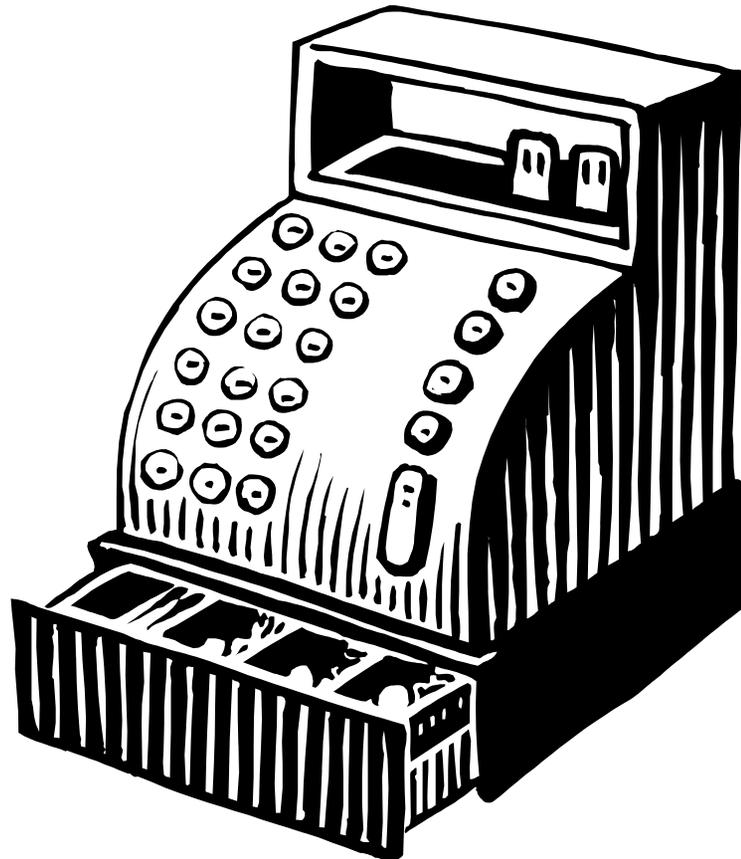
Angela Anthony, RN -Roanoke LTSS Regional Manager

[aanthony2@humana.com](mailto:aanthony2@humana.com)

## Getting an Authorization

### Call us!

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



# CLAIMS & PAYMENT



# Submitting Claims Electronically through EDI

**We encourage you to submit your claims electronically.**

- **Submit both CMS-1500 and UB-04 claims electronically by using a clearinghouse via Electronic Data Interchange (EDI). EDI allows providers to submit and receive electronic transactions from their computer systems.**
- **EDI is available for most common health care business transactions. For more information on EDI, please contact the Anthem EDI Solutions Helpdesk at 1-800-470-9630, Monday to Friday, 8 a.m. - 4:30 p.m., Eastern time or e-mail EDI Solutions at [ent.edi.support@anthem.com](mailto:ent.edi.support@anthem.com).**
- **If you are using your own clearing house, you must contact them directly to obtain the Payor ID. Anthem works with over 70 clearinghouses and vendors.**



# Submitting Claims via paper forms

**Paper claims must be submitted on original red claim forms (not black and white or photocopied forms) and laser printed or typed (not handwritten) in a large, dark font.**

**Submit a properly completed claim for all services performed or items/devices provided to:**

**Claims  
HealthKeepers, Inc.  
P.O. BOX 27401  
Richmond, VA 23279**



## Submitting Claims Electronically through Portal

For participating providers billing under a NPI please use this link:

[https://poc.anthem.com/POC/Login/POC\\_Login.jsp](https://poc.anthem.com/POC/Login/POC_Login.jsp)

- Using our electronic tool helps reduce claims and payment processing expenses and offers:
  - Faster processing than paper
  - Enhanced claims tracking
  - Real-time submissions directly to our payment system
  - HIPAA-compliant submissions
  - Reduced claim rejections
  - Reduced adjudication turnaround time
- Submit 837 batch files and receive reports through the website at no charge. You must register for this service first.

Portal access will be available for Participating Providers billing under an API during September 2014

# Clean Claims

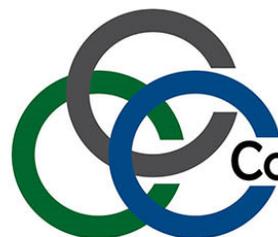
## Humana

- Humana and ILS can only process clean claim submissions. Incomplete claims will not be processed and will be returned to the provider for correction.
- A “clean claim” is defined as one that can be processed without obtaining additional information from the service provider or from a third party. It does not include claims submitted by providers under investigation for fraud or abuse or those claims under review for medical necessity.
- Providers may submit their claims in two ways:
  - 1) Electronic Claim Submission
  - 2) Paper Claim Submission

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# Electronic Claims

# Humana

Claims clearinghouses:

Emdeon	<a href="http://www.emdeon.com">www.emdeon.com</a>
Availity®	<a href="http://www.availity.com">www.availity.com</a>
ZirMed®	<a href="http://www.zirmed.com">www.zirmed.com</a>
Gateway EDI	<a href="http://www.gatewayedi.com">www.gatewayedi.com</a>
McKesson	<a href="http://www.mckesson.com">www.mckesson.com</a>
Capario <sup>SM</sup>	<a href="http://www.capario.com">www.capario.com</a>
SSI Group	<a href="http://www.ssigroup.com">www.ssigroup.com</a>
Inmediata (Puerto Rico only)	<a href="http://www.inmediata.com">www.inmediata.com</a>

Once registered, providers will be able to submit electronic claims following instructions from clearinghouse.

- ILS payer ID: 45048
- Humana payer ID: 61101
- Beacon Payer ID: 43324

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# Paper Claims

Humana

Providers can submit hard copy claims via U.S. mail at:

## Medicare SNF Claims:

Humana Claims  
P.O. Box 14601  
Lexington, KY 40512-4601

## Behavioral Health Claims:

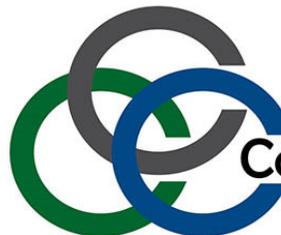
Beacon Health Strategies, LLC  
Attention Claims:  
10200 Sunset Drive  
Miami, FL 33173

## HCBS or Custodial Claims:

Smart Data Solutions/ILS  
P.O. Box 21596  
Eagan, MN 55121

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Humana



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# Clean Claims Time Frames

## Humana

- For electronic submissions, ILS will send electronic acknowledgment of the receipt of the claim within 24 hours after the next business day receipt of claim.
- Providers can check the status of claims by contacting ILS Provider Relations at 1-866-224-6947.
- Humana shall not deny claims for services delivered by Providers solely based on the period between the date of service and the date of clean claim submission, unless that period exceeds three hundred sixty-five (365) calendar days.
- Providers must collect Patient Pay when provider has the largest amount of services authorized. ILS will notify HCBS providers who need to collect Patient Pay.

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Humana



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# Our Clearinghouses

**VA Premier**  
**CompleteCare**  
a Commonwealth Coordinated Care Plan

We participate with:



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



- **To Enroll Contact RelayHealth Support:**
- **RelayHealth Support**
- **877-684-9625, Option 1**  
**[DBQTSHInsuranceSupport@relayhealth.com](mailto:DBQTSHInsuranceSupport@relayhealth.com)**

**Available EDI**

**Transactions:**

Claims – 837P and 837I

Remittances-835

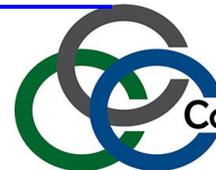
Claim Status- 276/277

Eligibility – 270/271

**CompleteCare Payer IDs:**

**For Institutional Claims: VPCCI**

**For Professional Claims: VPCCP**



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# PayerTransactions Portal



- Submit your claims directly to CompleteCare by utilizing our Provider Portal, located at:  
[www.payertransactions.com/vpcc](http://www.payertransactions.com/vpcc)
- API Providers:
  - Prior to submitting your first claim via the web portal, please contact:  
Rick Gordon: 804-819-5151 ext. 55075  
[rgordon@vapremier.com](mailto:rgordon@vapremier.com)
- Contact Provider Services if you need assistance  
[vphpnetdev@vapremier.com](mailto:vphpnetdev@vapremier.com) or by calling our Provider Services line at **1-855-338-6467**



# Paper Claims Submission **VA Premier CompleteCare** a Commonwealth Coordinated Care Plan

Paper Claims should be submitted to the following addresses:

<p><b>Primary Care Providers</b> CompleteCare by Virginia Premier P.O. Box 4468 Richmond, VA 23220-0207</p>	<p><b>Specialty Providers</b> CompleteCare by Virginia Premier P.O. Box 4468 Richmond, VA 23220-0208</p>
<p><b>Hospital Claims</b> CompleteCare by Virginia Premier P.O. Box 4468 Richmond, VA 23220-0120</p>	<p><b>Claims Appeals</b> CompleteCare by Virginia Premier P.O. Box 4468 Richmond, VA 23220-0307</p>
<p><b>Transportation Claims</b> CompleteCare by Virginia Premier P. O. Box 4468 Richmond, Virginia 23220-5287</p>	



## Getting Help with Claims



- Our Customer Service Team is standing by to assist you with any claim issues you may be having  
**1-855-338-6467**
- Check status & Submit your claims to CompleteCare by utilizing our Provider Portal, located at:  
[www.payertransactions.com/vpcc](http://www.payertransactions.com/vpcc)
- Contact Provider Services if you need assistance  
[vphpnetdev@vapremier.com](mailto:vphpnetdev@vapremier.com) or by calling our Provider Services line at **1-855-338-6467**





# JOINING THE NETWORKS



# Joining the Network

- Facilities and Physicians: Please contact Provider Engagement and Contracting
  - Central Region: 804-354-4126
  - Eastern Region: 757-326-5158
  - Northern/Western Region: 804-354-4441
- Ancillary Providers: Please contact Ancillary Contracting at 804-354-2338
- LTSS Providers: Please contact Provider Network Contracting LTSS via email at
  - [mari.dean@anthem.com](mailto:mari.dean@anthem.com)

As a member of the HealthKeepers, Inc. network, you have support from many different departments as you provide care for our members.

Our MMP Customer Service team offers assistance with claim issues, member enrollment, questions and general inquiries.

- MMP Customer Service team at 1-855-817-5788, Monday to Friday, 8 a.m. to 8 p.m. Eastern time.
- Medical and LTSS: Please call 1-855-817-5788 or your local Provider Relations representative
- Dental Provider Services: Please contact DentaQuest at 1-800-341-8478
- Vision Services: Please contact Davis Vision at 1-800-933-9371
- Transportation Services: Please contact Logisticare at 1-855-253-6861
- Lab Services: Please contact LabCorp at 1-800-762-4344

- Health care and HCBS providers must be credentialed to treat Humana members.
- Recredentialing occurs at least every three years.
- Some circumstances require shorter re-credentialing cycles.

For LTSS providers:

- To check the status of your credentialing or contract, please call Independent Living Systems Provider Relations at 1-866-224-6947, Monday through Friday, 8 a.m. to 5 p.m. EST.
- If you are already a Humana provider, and have questions regarding your contract or have changes to credentialing information, please contact 1-800-626-2741.

# Contracting Information

Humana

- Physician/practice/facility name
- Service address with phone, fax and email information
- Mailing address, if different than service address
- Taxpayer identification number (TIN)
- Specialty and services provided
- Medicaid provider number
- National Provider Identifier (NPI) or Atypical Provider Identifier (API)
- CAQH® number
- Lines of business (e.g., MMP)
- Type of contract (e.g., individual, group, facility)
- Disclosure of Ownership

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Humana



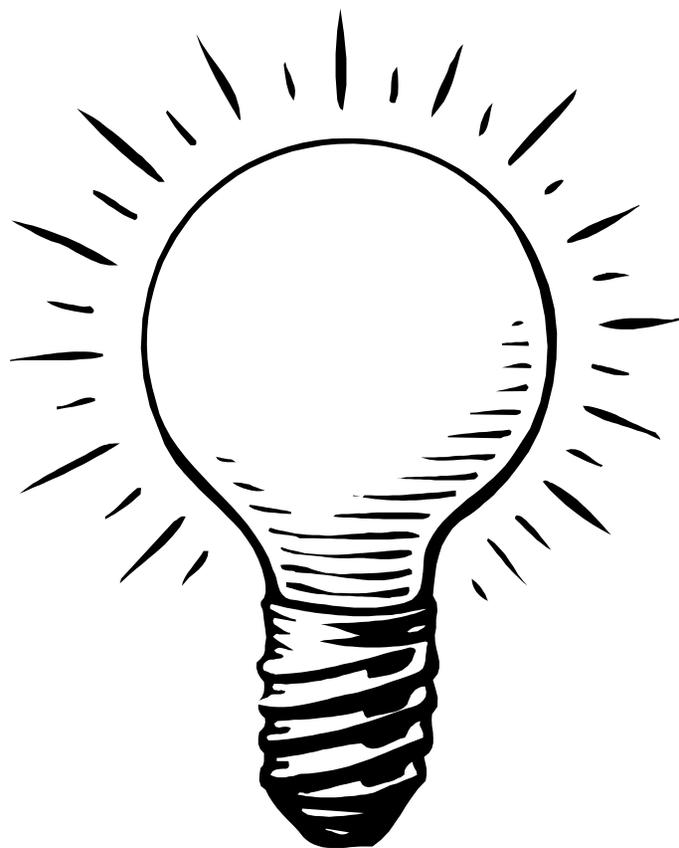
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# Joining Our Network



- Please visit our website  
[www.vapremier.com](http://www.vapremier.com)
- Complete the online Recruitment Request Form





## Q&A



Much of the information in this section is the same across all health plans as a result of collaboration with providers and agreement among the health plans



## NURSING FACILITY PROVIDERS



# Specific to Nursing Facilities



- Waived 3 day qualifying hospital stay for skilled care
- Pre-admission screening (PAS) with UAI is required for ALL NF admissions (skilled and custodial)
- 7 Day authorizations extended for all admissions
- Agreed upon billing codes

# Role of the Care Manager in the Nursing Facility

- MMPs agree to provide CM credentials, background checks, TB tests, etc for regulatory purposes
- CM does not document in the NF chart
- CM will review the minimum data set (MDS) at the facility or through mutually agreed upon electronic mechanisms



Transition services available through MMPs



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

- Physician Order that beneficiary needs inpatient SNF stay
- The following is required when a member is referred from the Community/ED/Observation Stay:
  - Physician Order;
  - History and Physical;
  - MDS;
  - Medication List;
  - Prior Level of Function; and
  - Projected discharge plan.
- Providers must submit via Fax or Online notification through the MMP web portal that patient met criteria and has been admitted
- PT,OT, ST-Evaluation must be completed at center within 48 hours of admission



# Long Term Care

- The Initial Level of Care (including custodial nursing home versus Skilled Nursing Facility) is determined by the Pre-Admission Screening Team.
- For members that reside in a nursing home, the care coordinator will complete a Health Risk Assessment within 60 days of plan enrollment via a face-to-face meeting. During this process the care coordinator will ensure to incorporate Minimum Data Set 2.0 (MDS 2.0) information into the Plan of Care. For members residing in nursing facilities, the Interdisciplinary Care Team (ICT) will vary depending on the nursing facility member's needs.
  - For members who plan to reside in the nursing facility for an extended period of time the focus of the ICT will be managing the member's skilled and daily care needs and maximizing independence within the nursing facility setting.
  - For nursing facility residents who anticipate discharge or who would like to relocate to the community, the ICT will focus on transition planning and successful transition to a community setting of the member's choice.

## Custodial Care Requirements for Humana

- Participating providers do not need to request authorizations as long as the member is approved for custodial care by DMAS.
- Non Participating Providers can obtain an authorization by calling Care Management: 1-800-559-3581 Option 5.

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Humana

 **INDEPENDENT**  
*Living Systems*



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# Humana Notification/Authorizations for Skilled Nursing Care

- Notifications are submitted via the Web on Humana.com. Clinical information can be attached immediately online or faxed to 1-888-618-2646.
- Face sheet should include: Member's name, date of birth and Humana member identification number.
- Notifications that follow the prior authorization process are approved for seven days based on medical necessity.
- Utilization management case managers are available seven days a week for initial authorization consideration. (except Holidays)

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# Humana Clinical Information Needed for SNF Review

- Nurse will compare clinical information for the SNF request to appropriate CMS guidelines *and* MCG (formerly *Milliman Guidelines*).
- Clinical information should include:
  - Confirmation of admit date.
  - Diagnosis and primary medical history.
  - Current orders, treatment plan and consults.
  - Daily skilled nursing and therapy-based services, including therapy evaluations and notes for the last 48 to 72 hours.
  - Prior level of function to include living arrangements prior to admit, family involvement, prior treatment/hospitalization in last 60 days.
  - Discharge plan.
  - Facility follow-up contact na

# Skilled Nursing

- Virginia Premier will use InterQual skilled nursing criteria to determine medical necessity.
- Providers can contact Virginia Premier's medical management department with dates of admission, expected length of stay and summary of treatment plan such as therapy, medications and/or wound care
- In addition, the UAI, DMAS 97 and DMAS -96 should be sent to Virginia Premier at the time of the admission. These forms are requested in the event that the member is transitioned to intermediate or custodial care
- Virginia Premier will authorize care for at least 14 days at each authorization unless the treatment plan requires less or more days

## Intermediate/ LTC Facility Care



- The Pre-Admission Screening team (PAS) (community or hospital) completes the UAI, DMAS 97 and DMAS 96 and submits to Virginia Premier's care manager.
- Once received, the Virginia Premier care manager will authorize admission to the nursing facility for care. Services will require re-authorization at least every 6 months.
- Virginia Premier will provide a thirty (30) day prior authorization for members who are discharged from an inpatient stay or ED after normal business hours and during weekends when there was not an opportunity to coordinate the discharge during normal business hours
- The Virginia Premier care manager will perform a face-to-face assessment with the member incorporating the information from the MDS
- A plan of care will be developed in collaboration with the nursing facility and the care manager will be a part of the facility's ICT meetings for the member
- Virginia Premier's care manager will actively assist the member and family in conjunction with the nursing facility to prepare members for return to the community if the member has a desire to return to the community or no longer meets criteria for nursing facility care
- Members requiring skilled services while in custodial care will be authorized by Virginia Premier care manager upon notification



# Virginia Premier



Call (Skilled Nursing Authorization)

(888) 251-3063



Fax

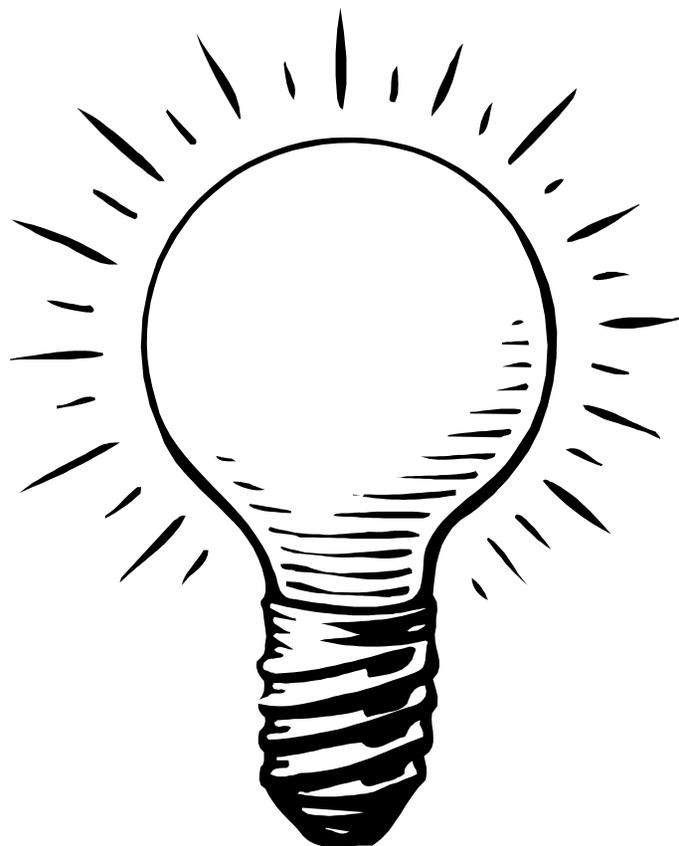
(877) 739-1364



To speak to a Care Manager

(855) 338-6497





# NURSING FACILITY Q&A

