This supplement is provided for Providers that participate with Optima Health Community Care (OHCC). Information contained in this supplement details additional information and exceptions that are specific to the OHCC program as of January 1, 2018. Unless otherwise indicated in this supplement, information in the core Provider Manual applies to OHCC as well as Optima Health Commercial plans. Please continue to refer to the core Provider Manual for policies and procedures not addressed in this supplement and contact Provider Relations or your Network Educator for questions regarding OHCC.
OPTIMA HEALTH COMMUNITY CARE KEY CONTACTS

The contacts listed below are for Optima Health Community Care Members only. Please see the Optima Health core Provider Manual, Key Contacts page, for other Optima Health product contacts and any Optima Health departments or services not listed here.

PROVIDER RELATIONS - OHCC
Provider Relations & Eligibility Verification
Phone: 1-844-512-3172

CLINICAL CARE SERVICES - OHCC
Prior Authorization
Fax numbers for specific services are located on the authorization fax form
Phone: 1-888-946-1167
LTSS Authorizations Fax: 1-844-828-0600

Behavioral Health
Phone: 1-888-946-1168
Inpatient Fax: 1-844-348-3719
Outpatient Fax: 1-844-895-3231

Care Coordination
Phone: 1-866-546-7924
Medical Reports, etc. Fax: 1-844-552-8398

After Hours Program
Phone: 1-844-387-9420

TELEPHONE FOR DEAF AND DISABLED – OHCC
Phone: 1-844-552-8148

CENTIPEDE
Phone: 1-855-359-5391
Fax: 1-866-421-4135
E- Mail: joinecentipede@heops.com
CENTIPEDE Credentialing: CENTIPEDE Health
P.O. Box 291707
Nashville, TN 37229

MEMBER TRANSPORATION
Phone: 1-855-325-7558

OPTIMA HEALTH WEB SITE
Provider Manual, Policies and Procedures, Credentialing Forms and Updates
www.Optimahealth.com/providers
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OPTIMA HEALTH COMMUNITY CARE OVERVIEW

The DMAS Commonwealth Coordinated Care Plus (CCC Plus) program incorporates medical, behavioral health and Long Term Services and Support (LTSS) services, including Home and Community Based Services (HCBS) waivers. It emphasizes care coordination and person centered care. Participation is mandatory for eligible populations. DMAS has chosen several managed care companies to participate in this program, including Optima Health. CCC Plus is a state-wide program and participation by managed care companies may vary by region.

Optima Health participates in CCC Plus under the name, Optima Health Community Care (OHCC). OHCC operates in all six regions of the Commonwealth. OHCC offers fully integrated medical, social and behavioral health services to Members with intensive care coordination, including coordination with Medicare. OHCC provides timely access, enhanced capacity, improved quality management and aligns incentives for efficient outcomes.

<table>
<thead>
<tr>
<th>HMO Plan Type</th>
</tr>
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<tbody>
<tr>
<td>• Primary Care Physician (PCP) selection required</td>
</tr>
<tr>
<td>• Member ID cards include PCP name and phone number</td>
</tr>
<tr>
<td>• No referrals required</td>
</tr>
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</table>

OHCC
- See Eligible Individuals in the MEMBER IDENTIFICATION INFORMATION section of this Supplement for a listing of Virginia residents who are included in OHCC
- No Copayments required

Managed Long Term Services and Supports Benefits

Managed Long Term Services and Supports (MLTSS) is designed to expand home and community-based services, promote community inclusion, and ensure quality and efficiency. The program provides comprehensive services and supports, whether at home, in an assisted living facility, in community residential services, or in a nursing home. OHCC coordinates all services for Members. Managed Long Term Services and Supports (MLTSS) include:

- Care Coordination
- Community Residential Services
- Home and Vehicle Modifications
- Community Mental Health Rehabilitation Services
- Mental Health and Addiction Treatment Services
- Nursing Home Care
- Personal Care
- Personal Emergency Response Systems
- Respite Care
Specific benefit information for OHCC is available 24 hours a day on the OHCC Provider Web Portal or by speaking with a Provider Service Representative during OHCC business hours. OHCC, Medallion 3.0 and FAMIS programs have separate benefits.

**Enhanced Services**

OHCC provides the following Enhanced Benefits that are not generally covered through Medicaid–fee-for-service:

- Smoking cessation
- Assistive devices
- Extended respite care for caregivers
- Pest control
- Adult dental services
- Adult vision
- Adult hearing
- Diabetic foot care
- Wellness rewards
- Home delivered meals
- Weight management
- Home security – memory care
- Free cell phones

All enhanced benefits are coordinated through the Member’s assigned Care Coordinator.

**Carved Out Services**

The following services are carved out of the contract between OHCC and DMAS. These services are reimbursed directly to Providers under the DMAS fee for service program:

- Dental Services (Smiles for Children)
- School Health Services
- Developmental Disabilities (DD) Waiver Services such as Building Independence Waiver, Family and Individual Support Waiver, Community Living Waiver, Targeted Case Management and Transportation to/from DD Waiver Services (non-waiver services are included in the CCC Plus Program)
- Preadmission screening for nursing facilities
- IACCT (Independent Assessment, Certification and Coordination Team)
- Therapeutic Group Home (formerly Level A and B Group Home)
- Treatment Foster Care – Case Management
Dual Special Needs Plan (D-SNP)

OHCC offers a Medicare Advantage Dual-Eligible Special Needs Plan (D-SNP). Among the most important features of the D-SNP are:

- A team of doctors, specialists and Care Managers working together for the D-SNP Member
- A Model of Care (MOC) that calls for individual care plans for Members
- The same Member rights available to Medicare and Medicaid recipients

Dual eligible Members enrolled in OHCC may receive their Medicare benefits from OHCC’s companion D-SNP, Medicare fee-for-service, or through another Medicare Advantage (MA) Plan. Please reference the Optima Health Dual Eligible Special Needs Plan (D-SNP) Supplement for details regarding this Plan.

OHCC Plus Requirements per DMAS Contract

As a Participating OHCC Provider you have agreed to abide by all rules and regulations in the contract between OHCC and DMAS. Providers are required to:

1. Abide by all applicable provisions of Optima Health’s CCC Plus Contract with the Department of Medical Assistance Services, CMS regulations and any other relevant state and federal laws or regulations
2. Have a National Provider Identifier (NPI) number
3. Meet the Optima Health standards for licensure, certification, and credentialing, as included in the Optima Health Provider Agreement
4. Comply with all applicable Federal and State laws and regulations including Title VI of the Civil Rights Act of 1964; Title IX of the Education Amendments of 1972 (regarding education programs and activities); the Age Discrimination Act of 1975; the Rehabilitation Act of 1973; the Americans with Disabilities Act of 1990 as amended; Health Insurance Portability and Accountability Act of 1996 (HIPAA) security and privacy standards, section 1557 of the Patient Protection and Affordable Care Act (including but not limited to, reporting overpayments pursuant to state or federal law) and the Deficit Reduction Act of 2005 (DRA) requiring that emergency services be paid in accordance with the DRA provisions [Pub. L. No. 109- 171, Section 6085], and as explained in CMS State Medicaid Director Letter SMDL #06- 010
5. Maintain records for ten (10) years from the close of the Provider Agreement. For children under age 21 enrolled in the CCC Plus Waiver, records shall be maintained for the greater period of a minimum of ten (10) years or at least six (6) years after the minor has reached 21 years of age per 12VAC30-120-1730
6. Provide copies of Member records and access to their premises to representatives of Optima Health, as well as duly authorized agents or representatives of the Department, the U.S. Department of Health and Human Services, and the State Medicaid Fraud Unit
7. Provide a copy of the Member’s medical records to Members and their authorized representatives as required by law within no more than 10 business days of the
Member’s request
8. Disclose the required information, at the time of application, credentialing, and/or re-credentialing, and/or upon request, in accordance with 42 CFR § 455 Subpart B, as related to ownership and control, business transactions, and criminal conviction for offenses against Medicare, Medicaid, CHIP and/or other Federal health care programs.

9. Screen employees and contractors initially and on an ongoing monthly basis to determine whether any employees/contractors have been excluded from participation in Medicare, Medicaid, SCHIP, or any Federal health care programs (as defined in Section 1128B(f) of the Social Security Act) and not employ or contract with an individual or entity that has been excluded or debarred. Providers are required to immediately report to Optima Health any exclusion information discovered. Civil monetary penalties may be imposed against Providers who employ or enter into contracts with excluded individuals or entities to provide items or services to OHCC Members.

10. Submit utilization data for Members enrolled with Optima Health in the format specified by Optima Health, consistent with Optima Health obligations to the Department as related to quality improvement and other assurance programs as required in the DMAS contract.

11. Comply with corrective action plans initiated by Optima Health.

12. Clearly specify referral approval requirements in any sub-subcontracts.

13. Hold the Member harmless for charges for any Medicaid covered service, accept Optima Health payment as payment in full except for patient pay amounts and not bill or balance bill a Medicaid Member for Medicaid covered services provided during the Member’s period of OHCC enrollment. The collection or receipt of any money, gift, donation or other consideration from or on behalf of an OHCC Member for any Medicaid covered service provided is expressly prohibited. This includes those circumstances where Providers fail to obtain necessary referrals, service authorization, or fail to perform other required administrative functions.

14. Should an audit by Optima Health or an authorized state or federal official result in disallowance of amounts previously paid to the Provider, the Provider will reimburse Optima Health upon demand. The Provider cannot bill the Member in these instances.


16. Any conflict in the interpretation of Optima Health policies and the OHCC Provider Agreement shall be resolved in accordance with Federal and Virginia laws and regulations, including the State Plan for Medical Assistance Services and Department memos, notices and Provider manuals. Provider shall comply with Federal contracting requirements described in 42 CFR Part 438.3, including identification of/non-payment of Provider-preventable conditions, conflict of interest safeguards, inspection and audit of records requirements, physician incentive plans, recordkeeping requirements, etc.
MEMBER IDENTIFICATION INFORMATION

Optima Health Community Care
Member ID Card Sample

**Front**

- **Product Indicator for Optima Health Community Care**
- **Optima Health Community Care Member ID Number – Starts with 2000**

**Optima HEALTH COMMUNITY CARE**
Member Name: JOHN DOE
Member Number: 20000999901
Group Number: 999999
Member Effective Date: 99-99-99
PCP Name: 9999999999999999999999
PCP Phone: 999-999-9999

Optima Health

Member Number: 20000999901
Medicaid #: 999999999999
DOB: 99-99-99

Group Number: 999999
DOB: 99-99-99

Member Effective Date: 99-99-99

PCP Name: 9999999999999999999999
PCP Phone: 999-999-9999

### Detailed benefit information is available at optimahealth.com

**Back**

**Contact Numbers Specific to Optima Health Community Care**

Detailed benefit information is available at optimahealth.com
**Eligible Individuals**

The Virginia residents who fall into the following categories are included within OHCC:

- Dual eligible individuals with full Medicaid and any Medicare A and/or B coverage.
- Non-dual eligible individuals who receive LTSS, either through an institution or HCBS 1915 waivers. Individuals enrolled in the Building Independence, Community Living, and Family and Individual Supports Waivers will be enrolled in CCC Plus program for their non-waiver services only (e.g., acute, behavioral health, pharmacy, and non-LTSS waiver transportation services). This includes individuals who will transition from the Medallion 3.0 health and acute care (HAP) program.
- Individuals enrolled in the Commonwealth Coordinated Care (CCC) program transition to CCC Plus program on January 1, 2018.
- Remaining ABD population (non-duals and those who do not receive LTSS) transition from DMAS’s Medallion 3.0 program to the CCC Plus program on January 1, 2018.
- The CCC Plus program populations listed above may include individuals enrolled in the Medicaid Works program, Native Americans, individuals with other comprehensive insurance, children in foster care and adoption assistance, individuals with Alzheimer’s disease and persons with dementia, and individuals approved by DMAS as inpatients in long-stay hospitals (DMAS recognizes two facilities: Lake Taylor (Norfolk) and Hospital for Sick Children (Washington, DC).
- DMAS reserves the right to transition additional populations and services into the CCC Plus program in the future.

**Populations Excluded From CCC Plus**

Individuals in the following Programs are not eligible to participate with CCC Plus:

- Medicaid Medallion 3 and FAMIS Managed Care Members
- PACE (Program of All-Inclusive Care for the Elderly)
- Money Follows the Person (MFP)
- Alzheimer’s Assisted Living Waiver (AAL)
- Health Insurance Premium Payment (HIPP)

Individuals in Limited Coverage Groups are not eligible to participate with CCC Plus:

- Governor’s Access Plan (GAP)
- Qualified Medicare Beneficiaries only
- Special Low-Income Medicare Beneficiaries
- Qualified Disabled Working Individuals

Individuals in Specialized Settings are not eligible to participate with CCC Plus:

- Intermediate Care Facilities for Individuals with Intellectual Disability
- Veterans Nursing Facilities
• Virginia Home
• Psychiatric Residential Treatment Facilities
• State Facilities: Piedmont, Catawba, and Hancock
• Local Government-Owned Nursing Facilities

Please see the Hospice section of this Manual Supplement for information on Hospice enrolled individuals.

**Enrollment and Assignment Process**

DMAS has sole responsibility for determining the eligibility of an individual for Medicaid funded services; enrollment for eligible individuals is mandatory. There is no retroactive enrollment in the CCC Plus program.


To verify eligibility for OHCC, providers should utilize the Optima Health Interactive Voice Response System (IVR), the Optima Health Provider Web Portal or call OHCC Provider Relations.

**Enrollment Process for Newborns:** When an OHCC Member gives birth during enrollment with OHCC, the newborn’s related birth and subsequent charges are not covered by OHCC. In order for the newborn to be covered, the mother/parent/guardian must report the birth of the child by calling the Cover Virginia Call Center at (855) 242-8282 or by contacting the Member’s local Department of Social Services. Once Medicaid enrolled, the newborn is the responsibility of FFS Medicaid until such time as the newborn is enrolled in one of the Department’s Medicaid managed care programs.

**Enrollment Process for Foster Care and Adoption Assistance Children:** OHCC provides services for enrolled foster care & adoption assistance children (designation codes 076 and 072, respectively). Foster Care and Adoption Assistance children are considered one of the OHCC vulnerable sub-populations. OHCC, and our Provider network, are required to comply with the following rules:

- For decisions regarding the foster care child’s medical care, OHCC and our Provider network work directly with either the social worker or the foster care parent (or group home/residential staff person, if applicable). For decisions regarding the adoption assistance child’s medical care, OHCC and our Provider network—work directly with the adoptive parent
- The social worker is responsible for changes to MCO enrollment for foster care children. The adoptive parent is responsible for changes to MCO enrollment for adoption assistance children
- Coverage extends to all medically necessary EPSDT or required evaluation and treatment services of the foster care program
• OHCC and our Provider network work with DMAS in all areas of care coordination. OHCC provides covered services until DMAS dis-enrolls the child from our plan. This includes circumstances where a child moves out of our service area.

**CCC Plus Member Rights and Responsibilities**

OHCC Members have the right to:

• Receive timely access to care and services;
• Take part in decisions about their health care, including their right to choose their Providers from OHCC network Providers and their right to refuse treatment;
• Choose to receive long term services and supports in their home or community or in a nursing facility;
• Confidentiality and privacy about their medical records and when they get treatment;
• Receive information and to discuss available treatment options and alternatives presented in a manner and language they understand;
• Get information in a language they understand - they can get oral translation services free of charge;
• Receive reasonable accommodations to ensure they can effectively access and communicate with Providers, including auxiliary aids, interpreters, flexible scheduling, and physically accessible buildings and services;
• Receive information necessary for them to give informed consent before the start of treatment;
• Be treated with respect and dignity;
• Get a copy of their medical records and ask that the records be amended or corrected;
• Be free from restraint or seclusion unless ordered by a physician when there is an imminent risk of bodily harm to themselves or others or when there is a specific medical necessity. Seclusion and restraint will never be used as a means of coercion, discipline, retaliation, or convenience;
• Get care without regard to disability, gender, race, health status, color, age, national origin, sexual orientation, marital status or religion;
• Be informed of where, when and how to obtain the services they need from OHCC, including how they can receive benefits from out-of-network Providers if the services are not available in the OHCC network.
• Complain about OHCC to the State. Members can call the CCC Plus Helpline at 1-844-374-9159 or TDD 1-800-817-6608 to make a complaint about OHCC.
• Appoint someone to speak for them about their care and treatment and to represent them in an Appeal;
• Make advance directives and plans about their care in the instance that they are not able to make their own health care decisions;
• Change their CCC Plus health plan once a year for any reason during open enrollment or change their Managed Care Organization after open enrollment for an approved reason.
• Appeal any adverse benefit determination (decision) by OHCC that they disagree with that relates to coverage or payment of services;
• File a complaint about any concerns they have with OHCC customer service, the services they have received, or the care and treatment they have received from an OHCC network Provider;
• To receive information from OHCC about their plan, covered services, Providers in the OHCC Network, and about their rights and responsibilities;
• To make recommendations regarding the OHCC Member rights and responsibility policy, for example by joining the OHCC Member Advisory Committee.

OHCC Members have the responsibility to:

• Present their OHCC Membership card whenever they seek medical care
• Provide complete and accurate information to the best of their ability on their health and medical history
• Participate in their care team meetings, develop an understanding of their health condition, and provide input in developing mutually agreed upon treatment goals to the best of their ability
• Keep their appointments. If they must cancel, call as soon as they can
• Receive all of their covered services from the OHCC network
• Obtain authorization from OHCC prior to receiving services that require prior authorization
• Call OHCC whenever they have a question regarding their Membership or if they need assistance, toll-free at one of the numbers on their ID card
• Tell OHCC when they plan to be out of town so OHCC can help arrange their services
• Use the emergency room only for real emergencies
• Call their PCP when they need medical care, even if it is after hours
• Tell OHCC when they believe there is a need to change their plan of care
• Tell OHCC if they have problems with any health care staff. Members should call Member Services at one of the phone numbers listed on their ID card
• Call Member Services at one of the phone numbers listed on their ID card about any of the following:
  ▪ Changes to their name, their address, or their phone number. Members should also report these to their case worker at their local Department of Social Services
  ▪ If they have any changes in any other health insurance coverage, such as from their employer, their spouse’s employer, or workers’ compensation
  ▪ If they have any liability claims, such as claims from an automobile accident
  ▪ If they are admitted to a nursing facility or hospital
  ▪ If they get care in an out-of-area or out-of-network hospital or emergency room
  ▪ If their caregiver or anyone responsible for them changes
  ▪ If they are part of a clinical research study

**Cultural Competency**

OHCC promotes the delivery of services in a culturally competent manner to all Members including those with limited English proficiency and diverse cultural, gender identity, and ethnic backgrounds. OHCC requires Providers demonstrate cultural competency in all forms of communication and ensure that cultural differences between Providers and Members do not impede access and quality health care.
All OHCC Providers must attest to completion of Cultural Competency training by either completing the Optima Health Cultural Diversity Training or The U.S. Department of Health & Human Services “Think Cultural Health” training at [https://cccm.thinkculturalhealth.hhs.gov/](https://cccm.thinkculturalhealth.hhs.gov/)

**Member Services**

OHCC Members, Providers, their family members, caregivers or representatives, may contact Member Services through the phone number listed on the back of their Member ID card. Member Services Representatives are available to respond to various Member concerns, health crises, inquiries (e.g., covered services, Provider network), complaints, and questions regarding the OHCC program. Information for Members is also available on the Member website.

**Continuity of Care for New Members**

OHCC will provide or arrange for all medically necessary services during care transitions for new OHCC Members to prevent interrupted or discontinued services throughout the transition.
MEMBER ACCESS TO CARE

OHCC network adequacy is an important component of quality care and is assessed on an ongoing and recurring basis along a number of dimensions, including: number of providers, mix of providers, hours of operation, accommodations for individuals with physical disabilities (wheelchair access) and barriers to communication (translation services); and geographic proximity to beneficiaries (provider to Members or Members to provider).

**OHCC Appointment Standards**

<table>
<thead>
<tr>
<th>OHCC Service</th>
<th>Standard</th>
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<tbody>
<tr>
<td>Emergency</td>
<td>Immediately upon request</td>
</tr>
<tr>
<td>Urgent</td>
<td>24 hours or as quickly as symptoms demand</td>
</tr>
<tr>
<td>Routine Primary Care*</td>
<td>30 days</td>
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<tr>
<td>Prenatal Care</td>
<td></td>
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<tr>
<td>First Trimester</td>
<td>14 days</td>
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<tr>
<td>Second Trimester</td>
<td>7 days</td>
</tr>
<tr>
<td>Third Trimester</td>
<td>3 days</td>
</tr>
<tr>
<td>High-Risk Pregnancy</td>
<td>3 days or immediately if emergency</td>
</tr>
</tbody>
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The standard for routine primary care does not apply to appointments for routine physical examinations, for regularly scheduled visits to monitor a chronic medical condition if the schedule calls for visits less frequently than once every thirty calendar days, or for routine specialty services like dermatology, allergy care, etc.

**Telemedicine Services**

OHCC provides coverage for telemedicine services for OHCC Members. Telemedicine is defined as the real time or near real time two-way transfer of medical data and information using an interactive audio/video connection for the purposes of medical diagnosis and treatment.

Physicians, nurse practitioners, certified nurse midwives, clinical nurse specialists-psychiatric, clinical psychologists, clinical social workers, licensed and professional counselors are permitted to use medical telemedicine services and one of these types of providers at the main (hub) and satellite (spoke) sites is required for a telemedicine service to be reimbursed. Federal and state laws and regulations apply; including laws that prohibit debarred or suspended providers from participating in the Medicaid program.

The decision to participate in a telemedicine encounter will be at the discretion of the OHCC Member and/or their authorized representative(s), for which informed consent must be provided, and all telehealth activities must be compliant with Health Insurance Portability and Accountability Act of 1996 (HIPAA) and DMAS’s program requirements. All telemedicine services must be provided in a manner that meets the needs of vulnerable and emerging high-risk populations and consistent with integrated care delivery. Telemedicine services can be provided in the home or another location if agreeable with the OHCC Member.
Transportation Program

OHCC provides urgent and emergency transportation. Non-emergency transportation (NEMT) for covered services requires prior authorization, including air travel and services reimbursed by an out-of-network payer.
OHCC MODEL OF CARE

The elements of the OHCC Model of Care include:

- Specific biopsychosocial approaches for subpopulations
- Staff and Provider training
- Provider networks with specialized expertise and use of clinical practice guidelines and protocols
- Comprehensive assessments
- Interdisciplinary care teams
- Individualized care plans
- Care coordination
- Transition programs

The OHCC program:

- Provides for comprehensive care coordination that integrates the medical and social models of care through a person centered approach
- Promotes Member choice and rights
- Engages the Member and family members throughout the process
- Prioritizes continuity of care, and seamless transitions, for Members and providers, across the full continuum of physical health, behavioral health, and LTSS benefits.

Care Coordination

OHCC care coordination is locally and regionally based. Care coordinators are assigned to individual Members to conduct care coordination activities in every region across Virginia and act as advocates for Members and Providers helping Members. The Care Coordinator works closely with the Member as a point of contact to identify medical and behavioral health needs and Member strengths and supports. The Care Coordinator also works with the Member to develop an understanding of the services they are receiving, ensure appropriate authorizations are in place and to resolve barriers to care such as transportation issues.

Person Centered Individualized Care Plan (ICP)

The Care Coordinator works with the Member to develop a comprehensive individualized care plan (ICP). OHCC uses a Health Risk Assessment (HRA) as a tool to develop the OHCC Member’s person-centered Individualized Care Plan (ICP). The ICP is tailored to the OHCC Member’s needs and preferences and based on the results of OHCC’s risk stratification analysis. The Health Risk Assessment must be completed and the ICP developed prior to the end of the Members service authorization.
**Interdisciplinary Care Team**

OHCC will arrange the operation of an interdisciplinary care team (ICT) for each OHCC Member, in a manner that respects the needs and preferences of the Member. Each OHCC Member’s care (e.g., medical, behavioral health, substance use, LTSS, early intervention and social needs) must be integrated and coordinated within the framework of an ICT and each ICT member must have a defined role appropriate to his/her licensure and relationship with the Member. The OHCC Member is encouraged to identify individuals that he/she would like to participate on the ICT. The ICT must be person-centered, built on the OHCC Member’s specific preferences and needs, and deliver services with transparency, individualization, respect, linguistic and cultural competence, and dignity.

An OHCC care coordinator will lead the ICT. The ICT must include the Member and/or their authorized representative(s) and may include the following as appropriate:

- PCP/Specialist
- Behavioral health clinician, if indicated
- LTSS provider(s) when the Member is receiving LTSS
- Targeted case manager, if applicable. TCM includes ARTS, mental health, developmental disabilities, early intervention, treatment foster care, and high risk prenatal and infant case management services
- Pharmacist, if indicated
- Registered nurse
- Specialist clinician
- Other professional and support disciplines, including social workers, community health workers, and qualified peers
- Family members
- Other informal caregivers or supports
- Advocates
- State agency or other case managers

**Reassessments**

The OHCC Care Coordinator will conduct reassessments to identify any changes in the specialized needs of OHCC Members. Re-assessments will be conducted pursuant to routine timeframes and upon triggering events.

The ICT must be convened subsequent to all routine re-assessments, within 30 calendar days and in the following circumstances:

- Subsequent to triggering events requiring significant changes to the Member’s ICP (e.g. initiation of LTSS, BH crisis services, etc.)
- Upon readmissions to acute or psychiatric hospitals or Nursing Facility within 30 calendar days of discharge; and,
• Upon Member request.

**Care Coordination with Transitions of Care**

OHCC provides transition coordination services to include: the development of a transition plan; the provision of information about services that may be needed, prior to the discharge date, during and after transition; the coordination of community-based services with the care coordinator; linkage to services needed prior to transition such as housing, peer counseling, budget management training, and transportation. Transition support services will be provided to OHCC Members who are transitioning:

• From a Nursing Facility to the Community
• Between Levels of Care
 UTILIZATION MANAGEMENT

The OHCC Utilization Management (UM) program reflects the UM standards from the most current NCQA accreditation standards:

- Utilization Management decision-making is based only on appropriateness of care and service.
- OHCC does not compensate practitioners or others individuals conducting utilization review for denials of coverage or service.
- Financial incentives for UM decision-makers do not encourage denials of coverage or service.
- Members have access to all covered services, in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services as provided under FFS Medicaid.

OHCC has mechanisms in place to detect and correct potential under and over utilization of services, including provider profiles. Processes include:

- Analytics reports bases on provider performance and accurate billing.
- Active committee review of clinical services and cost data.
- Authorizations based on evidenced-based criteria for clinical services.

**Medical Necessity Criteria**

OHCC uses evidence-based national standard(s) in making medical necessity determinations. Coverage decisions are based upon medical necessity and are in accordance with 42 CFR §438.210. OHCC:

1. Will not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the Member
2. May place appropriate limits on a service on the basis of medical necessity criteria for the purpose of utilization control, provided that the services furnished can reasonably achieve their purpose
3. Will ensure that coverage decisions for individuals with ongoing or chronic conditions or who require long-term services and supports are authorized in a manner that fully supports the Member's ongoing need for such services and supports and considers the Member’s functional limitations by providing services and supports to promote independence and enhance the Member’s ability to live in the community
4. Will ensure that coverage decisions for family planning services are provided in a manner that protects and enables the Member's freedom to choose the method of family planning to be used consistent with 42 CFR §441.20
5. Will ensure that services are authorized in a manner that supports:

- The prevention, diagnosis, and treatment of a Member’s disease, condition, and/or disorder, health impairments and/or disability,
• Ability for a Member to achieve age-appropriate growth and development,
• Ability for a Member to attain, maintain, or regain functional capacity,
• In the case of EPSDT, correct, maintain, or ameliorate a condition.
• Opportunity for a Member receiving long-term services and supports to have access to the benefits of community living, to achieve person-centered goals, and live and work in the setting of their choice.

**Critical Incident Reporting**

Critical incidents include the following incidents: medication errors, severe injury or fall, theft, suspected physical or mental abuse or neglect, financial exploitation, and death of a Member. OHCC requires its staff and contracted OHCC Providers to report, respond to, and document critical incidents to OHCC.

The incident must be reported to OHCC within twenty-four hours. Providers should call the OHCC Care Coordination Department, fill out the Critical Incident Reporting Form on the Optima Health Provider Portal and FAX the form to Optima Health using the FAX number listed on the form.
Additional/Ancillary Services (A-Z)

Addiction and Recovery Treatment Services (ARTS)

The Addiction and Recovery Treatment Services program (ARTS) is an enhanced and comprehensive benefit package developed by DMAS to cover addiction and recovery treatment services. OHCC offers a variety of services through ARTS that help individuals struggling with substances, including drugs and alcohol. Services include inpatient, outpatient, residential, and community-based treatment. Medication assisted treatment options are available for Members using prescription or non-prescription drugs. Peer services and case management services are also available to Members.

The ARTS program improves the benefit and delivery systems for individuals with a substance use disorder. Goals for the ARTS benefit and delivery system include ensuring that a sufficient continuum of care is available to effectively treat individuals with a substance abuse disorder. OHCC’s criteria are consistent with the American Society for Addiction Medicine (ASAM) criteria as well as DMAS criteria for the Addiction and Recovery Treatment Services (ARTS) benefit as defined in 12 VAC 30-130-5000 et al.

More information about ARTS is available in the ARTS Supplement to the Optima Health Provider Manual.

Audiology

Audiology services are provided as inpatient, outpatient hospital services, outpatient rehabilitation agencies, or home health services. Benefits include coverage for acute and non-acute conditions and are limited based upon medical necessity. There are no maximum benefit limits on audiology services. These services are covered regardless of where they are provided.

Behavioral Health Services

Behavioral health services, including inpatient and outpatient individual, family, and group psychotherapy services are covered. Services range from outpatient counseling to hospital care, including day treatment and crisis services.

Community Mental Health Rehabilitation Services are provided through OHCC as of January 1, 2018.

Chiropractic

Chiropractic Services are not covered.
Behavioral health services known as Community Mental Health Rehabilitation Services (CMHRS), listed in the table below may be provided in the Member’s home or in the community.

<table>
<thead>
<tr>
<th>Community Mental Health Rehabilitation Services</th>
<th>Procedure Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Health Case Management</td>
<td>H0023</td>
</tr>
<tr>
<td>Therapeutic Day Treatment (TDT) for Children</td>
<td>H0035 HA/ H0032 U7</td>
</tr>
<tr>
<td>Day Treatment/ Partial Hospitalization for Adults</td>
<td>H0035 HB / H0032 U7</td>
</tr>
<tr>
<td>Crisis Intervention and Stabilization</td>
<td>H0036</td>
</tr>
<tr>
<td>Intensive Community Treatment</td>
<td>H0039 / H0032 U9</td>
</tr>
<tr>
<td>Mental Health Skill-building Services (MHSS)</td>
<td>H0046 / H0032 U8</td>
</tr>
<tr>
<td>Intensive In-Home</td>
<td>H2012 / H0031</td>
</tr>
<tr>
<td>Psychosocial Rehab</td>
<td>H2017 / H0032 U6</td>
</tr>
<tr>
<td>Crisis Stabilization</td>
<td>H2019</td>
</tr>
<tr>
<td>Behavioral Therapy/Assessment</td>
<td>H2033 / H0032 UA</td>
</tr>
<tr>
<td>Mental Health Peer Support Services – Individual</td>
<td>H0025</td>
</tr>
<tr>
<td>Mental Health Peer Support Services – Group</td>
<td>H0024</td>
</tr>
</tbody>
</table>

Credentialing
All CHMRS Providers are contracted as an organization (agency) type and all services are billed under the organization’s NPI. Except for ABA practitioners, individuals do not complete Credentialing applications for CHMRS. CHMRS organizational Providers are required to submit the following documents:

- Completed OBH CMHRS Application
- A completed W-9
- Clinical Staff Roster (must include last name, first name, DOB, NPI – if applicable, and services provided)
- A copy of the DBHDS License and Licensed Services Addendum. Each service/location on the application requires verification by DBHDS
- Copies of all other licensure and/or certifications held by the organization
- A copy of their profession liability Certificate of Insurance (face sheet)
- Additional Locations Forms.
- In addition, Behavioral Therapy services require each ABA practitioner to complete a Behavioral Health Provider Credentialing Packet

Detailed instructions and forms are available on the Optima Health website.

Continuity of Care
Prior to April 1, 2018, Members may maintain their current CMHRS Provider for up to 90 days (30 days after April 1, 2018). Service Authorizations issued prior to CCC Plus enrollment will
remain for up to 90 days or until the expiration date. Authorizations will be extended as necessary to ensure a safe and effective transition to a qualified In-Network Provider.

**Authorizations**

All CMHRS Services require authorization. OHCC utilizes the DMAS defined medical necessity criteria for CMHRS. Members must meet service specific medical necessity criteria. Requests are reviewed on an individual basis to determine the length of treatment and service limits based on the Member’s most current clinical presentation.

Forms may be submitted on the Optima Health Provider Web Portal or faxed to the Behavioral Health Authorization Outpatient FAX number.

OHCC uses the following DMAS Standardized CMHRS Service Authorization /Registration forms for CCC Plus. These forms are specific to the service provided. They are available on the Optima Health Provider Portal and the DMAS Website.

- CCC Plus Service Registration Form
- CMHRS & Behavior Therapy Services CONTINUED STAY Service Authorization Request Form
- Day Treatment/Partial Hospitalization (H0035 HB) INITIAL Service Authorization Request Form
- EPSDT Behavioral Therapy INITIAL Authorization Request Form
- Intensive Community Treatment (ICT) H0039 INITIAL Service Authorization Request Form
- Intensive In-Home (IIH) H2012 INITIAL Service Authorization Form
- Mental Health Skill-Building (MHSS) H0046 INITIAL Service Authorization Request Form
- Psychosocial Rehabilitation (PSR) H2017 INITIAL Service Authorization Request Form
- Therapeutic Day Treatment (TDT) H0035 INITIAL Service Authorization Request Form

The following chart indicates when a service requires a Registration Form and when the service requires an Authorization Form:

<table>
<thead>
<tr>
<th>CMHRS Service</th>
<th>Code</th>
<th>Initial Request</th>
<th>Continued Stay Request</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Health Case Management</td>
<td>H0023</td>
<td>Registration</td>
<td>Registration</td>
</tr>
<tr>
<td>Mental Health Peer Support Services - Individual</td>
<td>H0025</td>
<td>Registration</td>
<td>Authorization</td>
</tr>
<tr>
<td>Mental Health Peer Support Services - Group</td>
<td>H0024</td>
<td>Registration</td>
<td>Authorization</td>
</tr>
<tr>
<td>Crisis Intervention</td>
<td>H0036</td>
<td>Registration</td>
<td>Authorization</td>
</tr>
<tr>
<td>Crisis Stabilization</td>
<td>H2019</td>
<td>Registration</td>
<td>Authorization</td>
</tr>
<tr>
<td>Intensive Community Treatment</td>
<td>H0039</td>
<td>Authorization</td>
<td>Registration</td>
</tr>
<tr>
<td>Intensive In-Home</td>
<td>H2012</td>
<td>Authorization</td>
<td>Authorization</td>
</tr>
<tr>
<td>Therapeutic Day Treatment for Children *TDT School Day</td>
<td>H0035 *HA</td>
<td>Authorization</td>
<td>Authorization</td>
</tr>
<tr>
<td>Therapeutic Day Treatment for Children *TDT After School</td>
<td>H0035 <em>HA</em>UG</td>
<td>Authorization</td>
<td>Authorization</td>
</tr>
<tr>
<td>Therapeutic Day Treatment for Children *TDT</td>
<td>H0035</td>
<td>Authorization</td>
<td>Authorization</td>
</tr>
</tbody>
</table>
Billing
All CHMRS services may be billed using the CMS 1500 claim form for outpatient services. In addition, Therapeutic Day Treatment (TDT) for Children and Day Treatment /Partial Hospitalization for Adults may also utilize the UB-04 Claim Form for hospitals/facilities as appropriate.

Providers may submit paper or electronic claims. CMHRS Providers may submit electronic claims through AllScripts/PayerPath or Availity.

Residential Treatment Services
Residential Treatment Services include Psychiatric Residential Treatment Facility Services (Level C) and Therapeutic Group Home Services (TGH) (Levels A & B) and are administered by the DMAS Behavioral Health Services Administrator (Magellan of Virginia). Members admitted to a Residential Treatment Facility will be temporarily excluded from the CCC Plus program until they are discharged. Members admitted to a Therapeutic Group Home (TGH) are not excluded from the CCC Plus Program and any professional medical service rendered to Members in a TGH are provided through OHCC. OHCC works closely with Magellan to coordinate care and provides coverage for transportation and pharmacy services for these carved out services. Members admitted to a Residential Treatment Center for Substance Use Disorder are not excluded from CCC Plus and all services continue to be provided through OHCC.

Dental
The Smiles for Children program covers diagnostic, preventive, restorative/surgical procedures, for OHCC children and pregnant women as well as orthodontia services for OHCC children. The program also provides coverage for limited medically necessary oral surgery services for adults (age 21 and older). Contact Smiles For Children at 1-888-912-3456.

OHCC covers:

- Anesthesia and hospitalization services when deemed medically necessary to effectively and safely provide dental care. Services require prior authorization
- Transportation and medication related to all covered dental services
- CPT codes billed by an MD as a result of an accident, and CPT and “non-CDT” procedure codes billed for medically necessary procedures of the mouth for adults and children
- Dental fluoride varnish provided by a non-dental medical provider in accordance with the American Academy of Pediatrics guidelines and billed on a HCFA 1500 form

Dental Screenings: An oral inspection must be performed by the EPSDT screening provider as part of each physical examination for a child screened at any age. Tooth eruption, caries, bottle
tooth decay, developmental anomalies, malocclusion, pathological conditions or dental injuries must be noted. The oral inspection is not a substitute for a complete dental evaluation provided through direct referral to a dentist.

PCPs or other screening Providers must make an initial direct referral to a dentist when the child receives their six month/biannual screening. The dental referral must be provided at the initial medical screening regardless of the periodicity schedule on any child age three or older, unless it is known and documented that the child is already receiving regular dental care. When a screening indicates a need for dental services at any earlier age, referral must be made for dental services.

**Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)**

All EPSDT services for Members under age twenty-one (21) are covered. OHCC complies with EPSDT requirements, including providing coverage for all medically necessary services for children needed to correct, ameliorate, or maintain health status.

Where it is determined that otherwise excluded services/benefits for a child are medically necessary services that will correct, improve, or are needed to maintain the child's medical condition, OHCC will provide coverage through EPSDT for medically necessary benefits for children outside the basic Medicaid benefit package including, but not limited to:

- Extended behavioral health benefits
- Nursing care (including private duty)
- Personal care
- Pharmacy services
- Treatment of obesity
- Neurobehavioral treatment
- Other individualized treatments specific to developmental issues

Per EPSDT guidelines, OHCC covers medical services for children if it is determined that the treatment or item would be effective to address the child’s condition. The determination whether a service is experimental will be reasonable and based on the latest scientific information available.

Providers are encouraged to contact care coordinators to explore alternative services, therapies, and resources for Members when necessary. No service provided to a child under EPSDT will be denied as “out-of-network” and/or “experimental” or non-covered,” unless specifically noted as non-covered or carved out of this program.

**Documentation of screenings**

EPSDT services are subject to OHCC documentation requirements for network provider services. EPSDT services are also subject to the following additional documentation requirements:
- The medical record must indicate which age-appropriate screening was provided in accordance with the AAP and Bright Futures periodicity schedule and all EPSDT related services whether provided by the PCP or another provider; and,
- Documentation of a comprehensive screening must, at a minimum, contain a description of the components utilized.

**Early Intervention Services**

Early Intervention (EI) services are covered. Children from birth to age three who have:

- A 25% developmental delay in one or more areas of development
- Atypical development; or,
- A diagnosed physical or mental condition that has a high probability of resulting in a developmental delay is eligible for EI services. EI services are designed to address developmental delay in one or more areas (physical, cognitive, communication, social or emotional, or adaptive).

Children are first evaluated by the local lead agency to determine if they meet requirements. If determined eligible, the local lead agency enters the data in the Infant and Toddler Online Tracking System (ITOTS). Based upon ITOTS information, the Department of Behavioral Health and Developmental Services (DBHDS) staff enters the EI level of care (LOC) in the DMAS system. Once the LOC is entered, the EI services are billable based upon the Physician’s order on the Individualized Family Service Plan (IFSP). All EI service Providers must be enrolled with OHCC prior to billing. Service authorization is not required.

EI services are provided in accordance with the child’s IFSP, developed by the multidisciplinary team, including the OHCC Care Coordinator and EI service team. The multidisciplinary team will address the developmental needs of the child while enhancing the capacity of families to meet the child’s developmental needs through family centered treatment. EI services are performed by EI certified providers in the child’s natural environment, to the maximum extent appropriate. Natural environments can include the child’s home or a community based setting in which children without disabilities also participate.

OHCC provides coverage for EI services as described in the Member’s IFSP developed by the local lead agency. OHCC works collaboratively as part of the Member’s multidisciplinary team to:
- Ensure the Member receives the necessary EI services timely and in accordance with Federal and State guidelines
- To coordinate other services needed by the Member, and
- To transition the Member to appropriate services.

The child’s Primary Care Provider approves the IFSP. The PCP signature on the IFSP or a letter accompanying the IFSP or an IFSP Summary letter within 30 days of the first visit for the IFSP service is required for reimbursement of those IFSP services. If PCP certification is delayed, services are reimbursed beginning the date of the PCP signature.
When a developmental delay has been identified for children under age 3, OHCC will collaborate with the Provider to ensure appropriate referrals are made to the Infant and Toddler Connection and documented in the Member’s records. OHCC will work with DMAS to refer Members for further diagnosis and treatment or follow-up of all abnormalities uncovered or suspected. If the family requests assistance with transportation and scheduling to receive services for early intervention, OHCC will provide this assistance.

OHCC EI policies and procedures, including credentialing, follow Federal and State EI regulations and coverage and reimbursement rules in the DMAS Early Intervention Services Manual.

**Gynecological Care**

Obstetrician/Gynecologists qualify as Primary Care Providers. Any female Member of age thirteen or older has direct access to a participating obstetrician-gynecologist for annual examinations and routine health care services, including pap smears, without service authorization from the primary care physician. Health care services means the full scope of medically necessary services provided by the obstetrician-gynecologist in the care of or related to the female reproductive system in accordance with the most current published recommendations of the American Congress of Obstetricians and Gynecologists.

**Obstetrical Services**

Prenatal and postpartum services for pregnant Members are covered services. OHCC does not require the Member to obtain a referral prior to choosing a provider for family planning services. Members are permitted to select any qualified family planning provider without referral.

OHCC covers case management services for its high-risk pregnant women. OHCC provides, to qualified Members, expanded prenatal care services, including patient education; nutritional assessment, counseling and follow-up; homemaker services; and blood glucose meters. Infant programs are covered for enrolled infants. Pregnancy-related and post-partum services are covered for sixty days after pregnancy ends for enrolled Members.

In cases in which the mother is discharged earlier than forty-eight (48) hours after the day of delivery, at least one (1) early discharge follow-up visit indicated by the guidelines developed by the American College of Obstetricians and Gynecologists is covered. The early discharge follow-up visit is provided to all mothers who meet DMAS criteria and the follow-up visit must be provided within forty-eight (48) hours of discharge and meet minimum requirements.

**Hospice**

Hospice utilizes a medically directed interdisciplinary team. A Hospice program provides care to meet the physical, psychological, social, spiritual, and other special needs, which are experienced during the final stages of illness, and during dying and bereavement.
Individuals receiving Hospice at time of enrollment will be excluded from OHCC program participation. OHCC Members who elect Hospice will remain enrolled in the OHCC program. A Member may be in a waiver and also be receiving Hospice services.

All services associated with the provision of Hospice services are covered services. Hospice care must be available twenty-four hours a day, seven days a week.

**Immunizations / Vaccines**

Providers are required to render immunizations, in accordance with the EPSDT periodicity schedule specified in the most current Advisory Committee on Immunization Practices (ACIP) Recommendations, concurrently with the EPSDT screening and ensure that Members are not inappropriately referred to other Providers for immunizations. Primary care Providers are not permitted to routinely refer Members to the local health department to receive vaccines. To the extent possible, and as permitted by Virginia statute and regulations, Providers must participate in the statewide immunization registry database.

All PCPs who administer childhood immunizations are encouraged to enroll in the Virginia Vaccines for Children program (VVFC), administered by the Virginia Department of Health. The VVFC program supplies vaccines to Physicians at no charge. OHCC will reimburse Physicians for administration of the vaccine if the vaccine code is billed. Immunizations provided to OHCC Members should be billed using the appropriate CPT code to OHCC. There is no Copayment for immunizations provided to OHCC Members.

OHCC will reimburse Physicians at the contracted rate for the administration of the vaccine only, (and an office visit if billed), based on the Provider’s submission of the appropriate vaccine code.

The listing of vaccines provided through VVFC is subject to changes by VVFC. Coverage for specific vaccines (e.g., influenza) is subject to VVFC eligibility criteria and the other specified vaccines are special order vaccines that require VVFC approval.

The process for VVFC Provider Enrollment is:

- Call the VVFC program at 1-800-568-1929 or 1-804-864-8055 to receive an Enrollment Packet or go to [http://www.vdh.state.va.us/Epidemiology/immunization/VFC/Enroll.htm](http://www.vdh.state.va.us/Epidemiology/immunization/VFC/Enroll.htm) to print an Enrollment Form
- Complete the VVFC Enrollment Form. Keep a copy and mail the original to the VVFC office
- It will take five business days for VVFC to process your enrollment and assign your practice a VVFC Practice Identification Number (PIN). You will use your PIN to identify your practice when communicating with the VVFC office
- Once your enrollment is processed, a VVFC consultant will contact you and VVFC will schedule an enrollment visit to introduce the program to you
Medical Supplies and Medical Nutrition

Medical supplies and equipment are covered to the extent covered by DMAS. DME benefits are limited based upon medical necessity. There are no maximum benefit limits on DME. Nutritional supplements and supplies are covered benefits. OHCC covers specially manufactured DME equipment that was prior authorized per DMAS requirements. Additional information can be found in the Durable Medical Equipment & Supplies Provider Manual available on the DMAS web portal at: www.virginiamedicaid.dmas.virginia.gov

Physical Therapy/Occupational Therapy/ Speech Pathology

Physical therapy (PT), occupational therapy (OT), and speech pathology (SLP) services that are provided as an inpatient, outpatient hospital service, by outpatient rehabilitation agencies, or home health service are covered services. Benefits include coverage for acute and non-acute conditions and are limited based upon medical necessity. There are no maximum benefit limits on PT, OT, and SLP services. These services are covered regardless of where they are provided. Prior authorization for these services is not required unless they are part of home health services.

All Medically Necessary, intensive physical rehabilitation services in facilities that are certified as Comprehensive Outpatient Rehabilitation Facilities (CORFs) are also covered. Prior authorization is required for acute inpatient rehabilitation.

Preventive Care

OHCC encourages and supports the primary care physician (PCP) relationship as the OHCC Member’s Provider “health home.” This strategy will promote one Provider having knowledge of the Member’s health care needs, whether disease-specific or preventive care in nature.

PCPs may include pediatricians; family and general practitioners; internists; and specialists who perform primary care functions such as surgeons; and, clinics including, but not limited to, health departments, Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), etc.

Routine physicals for children up to age twenty-one are covered benefits under EPSDT.

Private Duty Nursing

Medically necessary PDN services for children under age 21; in accordance with DMAS criteria described in the DMAS EPSDT Manual are covered benefits. Individuals who require continuous nursing that cannot be met through home health may qualify for PDN. EPSDT PDN differs from home health nursing, which provides for short-term, intermittent care where the emphasis is on Member or caregiver teaching. Under EPSDT PDN, the individual’s condition must warrant continuous nursing care, including but not limited to, nursing level assessment, monitoring, and skilled interventions. Prior authorization is required.
**Prosthetic Devices**

Prosthetics (arms and legs and their supportive attachments, breasts, eye prostheses) are covered benefits, to the extent that they are covered under Medicaid. Medically necessary orthotics for children under age 21 and for adults and children are covered benefits, when recommended as part of an approved intensive rehabilitation program. Custom or orthotics over $1,000 for a single item requires prior authorization.

**Transplants**

Transplants for OHCC are covered according the OHCC contract with DMAS. Necessary procurement/donor services are covered. Children under 21 years of age are covered for transplants per EPSDT guidelines. Prior authorization is required.

Those OHCC Members in need of solid organ transplants should have their physician specialists treating the underlying condition notify OHCC. Members will be directed to an appropriate transplant facility for care. OHCC uses the Optum Health Care Solutions Centers of Excellence Network and certain local and regional transplant Providers for organ transplants.

**Vision**

Vision services, including diagnostic examination and optometric treatment procedures and services by ophthalmologists, optometrists, and opticians, are covered services. Eyeglasses for children under age 21 are also a covered benefit. OHCC’s benefit limit for routine refractions is once every twenty-four (24) months.
LTSS SERVICES

Long Term Services and Supports (LTSS) are a variety of services and supports that assist individuals with health or personal needs and activities, activities of daily living, and instrumental activities of daily living over a period of time. Long term services and supports can be provided at home, in the community, or in various types of facilities, including Nursing Facilities.

LTSS Service Authorization

All LTSS Services require a prior authorization/notification number. The appropriate DMAS form should be attached to the OHCC prior authorization form. Forms are available on the DMAS website.

Authorizations for LTSS must be resubmitted every 6 months unless the authorization has been previously updated by the Care Coordinator.

Patient pay for LTSS

When an OHCC Member’s income exceeds an allowable amount, he/she must contribute toward the cost of his/her LTSS: this contribution is known as the Patient Pay amount. The local DSS will identify OHCC Members who are required to pay a Patient Pay amount and the amount of the obligation as part of the monthly transition report.

The following are examples of services qualify for Patient Pay:

- Nursing Facility
- Private Duty Nursing
- Adult Day Care
- Personal Care
- Respite Care
- Environmental Modification

Waivers

Individuals enrolled in the Commonwealth Coordinated Care Plus waiver receive waiver services furnished by OHCC as well as medically necessary non-waiver services. Individuals enrolled in the Building Independence (BI), Community Living (CL), and Family and Individual Supports (FIS) waivers are covered only for their medically necessary non-waiver services:

- Acute and primary
- Behavioral health
- Pharmacy
- Non-LTSS waiver transportation services
Individuals enrolled in DMAS’s Alzheimer’s Assisted Living (AAL) HCBS Waiver are excluded from the CCC Plus program.

Home and Community Based Services
Home and Community Based Services allow Members to receive care in their home or community and prevent institutionalization. LTSS may be provided through the 1915(c) Home and Community Based Services (HCBS) waiver.

Developmental Disability (DD) Waiver
Individuals enrolled in one of DMAS’s Developmental Disability (DD) waivers (the Building Independence (BI), Community Living (CL), and Family and Individual Supports (FIS) waivers) will be enrolled in the CCC Plus program for their non-waiver services (e.g., acute and primary, behavioral health, pharmacy, and non-LTSS waiver transportation services). DD Waiver services (including when covered under EPSDT), targeted case management and transportation to the waiver services, are paid through Medicaid fee-for-service as “carved-out” services.

Services are based on assessed needs and are included in a person-centered Individual Care Plan (ICP). Individuals receiving home and community based services through one of these waivers have a variety of choices of both types of services and Providers.

OHCC manages Members that are enrolled in the BI, CL or FIS waivers, in addition to all individuals with a diagnosis of a developmental disability as identified in the Vulnerable Subpopulations criteria. OHCC collaborates with Providers to coordinate acute, behavioral health, pharmacy, and non-LTSS waiver transportation services by working with the Member’s Interdisciplinary Care Team (ICT) and residential Provider, as applicable, to support the individual’s health and well-being.

Commonwealth Coordinated Care (CCC) Plus Waiver
The CCC Plus Waiver covers a range of community support services for individuals who are aged, who have a disability, or technology-dependent individuals who rely on a device for medical or nutritional support (e.g. ventilators, feeding tube, or tracheostomy). Individuals who are technology-dependent are chronically ill or severely impaired, having experienced loss of a vital body function, and require substantial and ongoing skilled nursing care to avert death or further disability.

In order to be enrolled in the CCC Plus Waiver, an individual must meet the level of care (LOC) required for a Nursing Facility, specialized Nursing Facility for technologically dependent individuals or long stay hospital. Enrollment into the CCC Plus Waiver requires a Pre-Admission Screening (PAS). As part of the PAS, individuals that are technology dependent must also receive an age appropriate DMAS Technology Adult Referral form (DMAS 108) or Technology Pediatric Referral form (DMAS 109). The CCC Plus Waiver is offered to individuals who meet criteria. The individual must choose to receive services through the CCC Plus Waiver in lieu of facility placement. The PAS includes:

- Uniform Assessment Instrument (UAI),
- DMAS-96 (Medicaid Funded Long-Term Care Service Authorization Form)
- DMAS-97 (Individual Choice - Institutional Care or Waiver Services Form)
• DMAS 108 (Adults) or DMAS 109 (Children) for individuals who are technology dependent.

All individuals requesting community based or nursing facility LTSS, must receive a screening to determine if they meet the level of care needed for Nursing Facility services. DMAS has contracts with the Virginia Department of Health (VDH), Department of Aging and Rehabilitation Services (DARS), and hospitals to conduct screenings for individuals. In the community, screeners are members of the local health departments (LHD) that may include physicians and nurses along with social workers and family services specialists within the local departments of social services (LDSS). Acute care hospitals utilize discharge planners to complete the screening. Details about the screening process can be found in the Department’s Screening Provider Manual on the Virginia Medicaid Provider Portal.

For Members enrolled in the CCC Plus Waiver, OHCC covers all services that provide Members an alternative to institutional placement. This includes:

• Adult day health care
• Personal care (agency-directed and/or consumer-directed)
• Skilled private duty nursing
• Personal emergency response systems and medication monitoring
• Respite care (agency-directed and/or consumer-directed) or skilled private duty respite care (agency directed)
• Assistive technology
• Environmental modifications
• Transition services (for those Members meeting criteria who are transitioning back to the community from a Nursing Facility or long stay hospital)

Waiver services may be agency-directed (AD) or consumer-directed (CD). CD services afford individuals the opportunity to act as the employer in the self-direction of personal care or respite services. This involves hiring, training, supervision, and termination of self-directed personal care assistants.

OHCC covers CCC Plus Waiver services when: the Member is present; in accordance with an approved person-centered Individualized Care Plan; the services are authorized; and, a qualified Provider is providing the services to the Member. Services rendered to or for the convenience of other individuals in the household (e.g., cleaning rooms, cooking meals, washing dishes or doing laundry etc. for the family) are not covered.

Adult Day Health Care (ADHC)
OHCC covers long-term maintenance or supportive services offered by a community-based day care program providing a variety of health, therapeutic, and social services designed to meet the specialized needs of those waiver individuals who are elderly or who have a disability and who are at risk of placement in a nursing facility. The program must be licensed by the Virginia Department of Social Services (VDSS) as an adult day care center (ADCC).
Personal Care Services

Assistance with Activities of Daily Living (ADL): eating, bathing, dressing, transferring, and toileting, including medication monitoring and monitoring of health status and physical condition. This service does not include skilled nursing services with the exception of skilled nursing tasks that may be delegated. When specified in the individual service plan, personal care services may include assistance with Instrumental Activities of Daily Living (IADL), such as dusting, vacuuming, shopping, and meal preparation, but does not include the cost of meals themselves.

OHCC provides coverage for personal care services for work-related or school-related personal assistance when medically necessary. This allows the personal care Provider to offer assistance and supports for individuals in the workplace and for those individuals attending post-secondary educational institutions. This service is only available to individuals who require personal care services to meet their ADLs. Workplace or school supports through the CCC Plus Waiver are not provided if they are services provided by the Department for Aging and Rehabilitative Services, required under IDEA, or if they are an employer's responsibility under the Americans with Disabilities Act of Section 504 of the Rehabilitation Act.

Individuals are afforded the opportunity to act as the employer in the self-direction of personal care services. This involves hiring, training, supervision, and termination of self-directed personal care assistants. For Consumer Directed services, as defined by the Code of Virginia, “any person performing state or federally funded health care tasks directed by the consumer which are typically self-performed for an individual who lives in a private residence and who, by reason of disability is unable to perform such tasks but who is capable of directing the appropriate performance of such tasks” is exempted from the Nurse Practice Act and nurse delegation requirements.

There are no maximum limitations to the number of personal care hours that an individual may receive. Personal care hours are limited by medical necessity. OHCC manages requests in accordance with criteria listed in 12VAC30-120–927 and contract standards.

Personal care is not a replacement of PDN services and the two must not be provided concurrently. Personal care cannot be used for ADL/IADL tasks expected to be provided during Private Duty Nursing (PDN) hours by the RN/LPN. Trained caregivers must always be present to perform any skilled tasks not delegated.

State and Federal laws and regulations require prospective Personal Care Assistants to pass background checks. Background checks include Virginia State Police Criminal Background checks; Virginia Department of Social Services Child Abuse and Neglect Central Registry checks when the Member is under the age of 18; the Federal list of Excluded Individuals and Entities (LEIE) database checks; and, employment eligibility checks.

Respite Care Services

Respite care services are provided to Members who are unable to care for themselves and are furnished on a short-term basis because of the absence or need for relief of those primary unpaid caregivers who normally provide care. Respite care services may be provided in the Member’s
home or place of residence or children’s residential facility. Respite services include skilled nursing respite and unskilled respite.

Individuals may choose to use agency directed (AD), consumer directed (CD), or a combination of these models of service delivery. CD respite is only available to Members requiring unskilled respite care services. Unskilled respite is not available to individuals who have 24 hours skilled nursing needs.

Respite care services are limited to 480 hours per household per state fiscal year (July 1st through June 30th).

**Consumer Direction**
Eligible CCC Plus Waiver Members may choose the Consumer-Directed model of service delivery for their personal care and respite services. Through Consumer Direction, the Member, or someone designated by the Member, employs attendants and directs their care. The Member will receive financial management support in their role as employer by DMAS’s contracted Fiscal/Employer Agent (F/EA).

**Services Facilitation (SF)**
SF is a function that assists the Member (or the Member’s family or representative, as appropriate) when consumer directed services are chosen. The SF Provider serves as the agent of the individual or family and the service is available to assist in identifying immediate and long-term needs, developing options to meet those needs, accessing identified supports and services, and training the Member/family to be the employer. Practical skills training is offered to enable families and Members to independently direct and manage their waiver services. Examples of skills training include providing information on recruiting and hiring personal care workers, managing workers, and providing information on effective communication and problem solving. The services include providing information to ensure that Members understand the responsibilities involved with directing their services.

**Environmental Modifications (EM)**
Environmental Modifications not covered under Medicaid’s State Plan durable medical equipment benefit may be covered under the CCC Plus Waiver. Modifications may be made to a Member’s primary residence or primary vehicle and must be of a remedial nature or medical benefit to enable the Member to function with greater independence. EM may not be used for general maintenance or repairs to a home, or to purchase or repair a vehicle.

**EM must be provided in conjunction with at least one other CCC Plus Waiver service. EM is covered up to a maximum of $5,000 per household per calendar year. Costs for EM cannot be carried over from one calendar year to the next.**

**Assistive Technology (AT)**
Assistive Technology provided outside of the Medicaid State Plan durable medical equipment benefit may be covered under the CCC Plus Waiver. Assistive Technology is covered for Members who have a demonstrated need for equipment for remedial or direct medical benefit primarily in the Member’s residence to specifically increase their ability to perform ADLs/IADLs, or to perceive, control or communicate with the environment in which they live.
AT is considered a portable device, control, or appliance, which may be covered up to a maximum of $5,000 per Member per calendar year. The costs for AT cannot be carried over from one calendar year to the next. When two or more Members live in the same home, (congregate living arrangement), the AT must be shared to the extent practicable, consistent with the type of AT.

AT must be provided in conjunction with at least one other CCC Plus Waiver service. All AT requires an independent evaluation by a qualified professional who is knowledgeable of the recommended item before authorization of the device. Individual professional consultants include speech/language therapists, physical therapists, occupational therapists, physicians, certified rehabilitation engineers or rehabilitation specialists.

**Personal Electronic Response System (PERS)**

PERS is an electronic device that enables Members to secure help in an emergency. The system is connected to the person's phone and programmed to signal a response center once a "help" button is activated. PERS services are limited to Members who live alone, or who are alone for significant parts of the day, and have no regular caregiver for extended periods of time. PERS services are also limited to those individuals ages 14 and older. When medically appropriate, the PERS device can be combined with a medication monitoring system to monitor medication compliance.

**Skilled Private Duty Nursing (PDN)**

Skilled PDN are nursing services ordered by a physician in the Plan of Care and provided by a licensed Registered Nurse (RN) or by a Licensed Practical Nurse (LPN). This service is provided to individuals in the technology dependent subgroup who have serious medical conditions and complex health care needs. Skilled PDN is used as hands-on Member care, training, consultation, and oversight of direct care staff, as appropriate. Examples of Members that may qualify for Skilled PDN coverage include, but are not limited to, those with health conditions requiring: mechanical ventilation, tracheostomies, prolonged intravenous administration of nutritional substances (TPN/IL) or drugs, peritoneal dialysis, continuous oxygen support, and/or continuous tube feedings.

PDN hours are determined by the scores on the appropriate objective assessment based on the Member’s age. The pediatric assessment is utilized for a Member less than 21 years of age. PDN hours for adult Members are determined by medical necessity.

**Transition Services**

OHCC covers Transition Services, meaning set-up expenses, for OHCC Members who are transitioning from an institution or licensed or certified Provider-operated living arrangement to a living arrangement in a private residence, which may include an adult foster home, where the person is directly responsible for his own living expenses. These services could include:

- Security deposits
- Utility deposits
- Essential/basic household furnishings (furniture, appliances, window coverings, bed/bath linens or clothing)
- Items necessary for the individual's health, safety, and welfare such as pest eradication and one-time cleaning prior to occupancy
- Fees to obtain a copy of a birth certificate or an identification card or driver's license
- Other reasonable one-time expenses incurred as part of a transition

Transition Services are furnished only to the extent that they are reasonable and necessary as determined through the transition plan development process, are clearly identified in the transition plan and the person is unable to meet such expense, or when the services cannot be obtained from another source.

**Nursing Facility and Long Stay Hospital Services**

OHCC covers skilled and intermediate Nursing Facility (NF) care for OHCC Members including for dual eligible Members after the Member exhausts their Medicare covered days. OHCC will pay NFs directly for services rendered.

OHCC works with NFs to:

- Adopt evidence-based interventions to reduce avoidable hospitalizations, and include management of chronic conditions, medication optimization, prevention of falls and pressure ulcers, and coordination of services
- Ensure that individuals in nursing facilities are assessed for, have access to, and receive medically necessary services for medical and behavioral health conditions

NFs must cooperate with OHCC for OHCC to attend (either in person or via teleconference) all care plan meetings for OHCC Members who are receiving NF services. Attendance at the care plan meetings will ensure that the NF is current with the care needs of the Member and will provide access to OHCC by NF staff to discuss service options.

**LTSS Provider Credentialing**

Optima Health delegates and provides oversight for credentialing and re-credentialing of OHCC LTSS Providers to HEOPS-Centipede per requirements. OHCC ensures that HEOPS-Centipede credentials and re-credentials Providers per DMAS and OHCC requirements and ensures that all Providers comply with provisions of the CMS Home and Community-Based Settings Rule.

Providers already contracted and credentialed with Optima Health for provision of medical services, that also provide LTSS services, must also contract with HEOPS-Centipede for provision of LTSS services to OHCC Members.
HOSPITAL/ANCILLARY

Inpatient stays in general acute care and rehabilitation hospitals for all OHCC Members are covered. OHCC also covers preventive, diagnostic, therapeutic, rehabilitative or palliative outpatient services rendered by hospitals, rural health clinics, or federally qualified health centers. Prior authorization is required for inpatient acute care and rehabilitation Hospitals.

Hospital Payment Using Diagnosis Relative Grouping (DRG) Methodology

If OHCC has a contract with a facility to reimburse the facility for services rendered to its OHCC Members, at time of admission, based on a Diagnosis Relative Grouping (DRG) payment methodology, OHCC will cover 100% of the full inpatient medical hospitalization from time of admission to discharge. This is effective for any actively enrolled OHCC Member on the date of admission regardless if the OHCC Member is disenrolled during the course of the inpatient hospitalization.

OHCC covers payment of practitioner services rendered during the hospitalization for any dates in which the OHCC Member was enrolled with Optima on the related date of service.

PHARMACY

OHCC covers Food and Drug Administration (FDA) approved drugs for OHCC Members. Drugs for which Federal Financial Participation is not available are not covered.

OHCC accepts telephonic, facsimile, or electronic submissions of service authorization requests that are delivered from e-prescribing systems, electronic health records, and health information exchange platforms that utilize the National Council for Prescription Drug programs’ SCRIPT standards for service authorization requests.

After Hours Urgent Outpatient Pharmacy Requests

The Member should contact the After Hours Program if they require an urgent prior authorization after hours, due to a health condition that could jeopardize their life, physical or mental health, or their ability to attain, maintain or regain maximum function. A pharmacist will be paged to assist with the urgent matter.

Preferred Drug List

OHCC has adopted the DMAS Preferred Drug List (PDL) for all OHCC Members. This formulary does not apply to dual eligible OHCC Members who have a pharmacy benefit covered by a Medicare Part D plan. The DMAS PDL is not an all-inclusive list of drugs available and covered for OHCC Members; OHCC will cover all medically necessary, clinically appropriate, and cost-effective drugs that are federally reimbursable.
**Benefit Exclusions**

OHCC excludes coverage for the following:

- Drugs used for anorexia or weight gain
- Drugs used to promote fertility
- Agents used for cosmetic purposes or hair growth
- Agents used for the treatment of sexual or erectile dysfunction, unless such agents are used to treat a condition other than sexual or erectile dysfunction, for which the agents have been approved by the FDA
- All DESI (Drug Efficacy Study Implementation) drugs as defined by the FDA to be less than effective. Compound prescriptions, which include a DESI drug, are not covered
- Drugs which have been recalled
- Experimental drugs or non-FDA-approved drugs
- Any drugs marketed by a manufacturer who does not participate in the Medicaid Drug Rebate program

**Long Acting Reversible Contraception (LARC)**

OHCC provides coverage for OHCC Members for all methods of family planning including but not limited to:

- Barrier methods
- Oral contraceptives
- Vaginal rings
- Contraceptive patches
- Long acting reversible contraceptives (LARCs)

Members are free to choose the method of family planning.

**Patient Utilization Management and Safety Program**

The Patient Utilization Management and Safety Program (PUMS) is a DMAS requirement for all Medicaid managed care organizations, designed to keep Members safe from misuse and overdose of controlled substances. This tiered program monitors Members who are using controlled substances: Members in the program are only able to fill their prescriptions at one pharmacy and may be only able to receive controlled prescriptions from their designated PUMS Provider. Members may be locked into the PUMS program due to:

- Use of multiple pharmacies
- Multiple prescribers
- Complex drug regimen
- Suboxone use
Providers that are assigned to be the sole prescriber of controlled substances for a member must:

- Be the only one able to prescribe controlled substances
- Ensure these Members have been prescribed necessary medications when you plan to be out of the office

**Opioid Treatment Management**

Opioid Treatment, including individual, group counseling and family therapy and medication administration is a covered benefit. For additional details regarding the required elements of Opioid Treatment, please refer to the ARTS Supplement to the Provider Manual.

**Specialty or Biotech Drugs**

The preferred specialty care pharmacy available to OHCC Members is Sentara Norfolk General Outpatient Pharmacy. The OHCC program with Sentara Norfolk General Outpatient Pharmacy is called OptionSelect. This program includes most self-injected drugs and also includes transplant medication and medications for the treatment of HIV. A complete list of specialty drugs is available on the Provider Web Portal. OHCC Members should contact Sentara Norfolk General Outpatient Pharmacy at 1-877-349-6337. Sentara Norfolk General Outpatient Pharmacy does not provide services for medication administered in the Physician office. If the OHCC Member declines to participate with Sentara Norfolk General Outpatient Pharmacy, their information will be forwarded to Proprium Pharmacy or BriovaRx to supply their specialty drugs.
CLAIMS AND COORDINATION OF BENEFITS

OHCC Members who are covered by employer sponsored health plans should not be enrolled in a Medicaid managed care plan. It is important that if an OHCC Member is identified as having a commercial product, that initial claim should be sent to the commercial plan for payment. Medicaid is always a secondary payer. Until the Member is disenrolled by DMAS, OHCC will coordinate benefits.

For children with commercial insurance coverage, Providers must bill the commercial insurance first for covered early intervention services except for:

- Those services federally required to be provided at public expense as is the case for
  - Assessment/EI evaluation,
  - Development or review of the Individual Family Service Plan (IFSP); and,
  - Targeted case management/service coordination;
- Developmental services; and,
- Any covered early intervention services where the family has declined access to their private health/medical insurance.

Under these circumstances, and in following with federal regulations, OHCC requires the Early Intervention Provider to complete the Notification to the Department of Medical Assistance Services: Family Declining to Bill Private Insurance form (http://infantva.org/documents/ovw-st-TaskF-Mtg-20090520Form-DecliningPriv_Ins.pdf) and submit it with the bill to OHCC.

Payment Coordination with Medicare

In accordance with 42 CFR §438.3(t), OHCC has entered a Coordination of Benefits Agreement (COBA) with Medicare and participates in the automated claims crossover process for claims processing for its Members who are dually eligible for Medicaid and Medicare.

Nursing Facility, LTSS, ARTS, Community Behavioral Health and Early Intervention Claim Payments

Clean claims from Nursing Facilities, LTSS (including when LTSS services are covered under ESPDT), Community Behavioral Health, ARTS and Early Intervention Providers are processed within fourteen (14) calendar days of receipt as an exception to payment within 30 calendar days of receipt for other services. If the service is covered under Medicare other than by Optima Health, the 14 day time period starts post adjudication of the Medicare claim by the other payer.

Specific claim payment information is detailed in Provider Connection on the Optima Health Provider website or by calling Provider Services.

NDC Number

The National Drug Code (NDC) number is required for any OHCC physician claim that includes a billed amount for drugs. The NDC number is required in addition to the appropriate HCPC
code. The most current NDC numbers are available from the FDA’s NDC Directory or from the RJ Health Systems listing.

**NPI**

OHCC Providers are required to register their NPI number with DMAS.
MEMBER COMPLAINTS AND APPEALS

OHCC has distinct grievances, appeals, and claims procedures to resolve disagreements between OHCC Members, doctors and/or OHCC. Disputes may involve OHCC’s benefits, the delivery of services or OHCC’s operation. This procedure includes both medical and non-medical (dissatisfaction with the plan of care, quality of Member services, appointment availability, or other concerns not directly related to a denial based on medical necessity) issues. A complaint, by phone or in writing, can usually be resolved by contacting Member Services.

The complaint/grievance procedure is available to all Providers; timely resolution will be executed as soon as possible and will not exceed 72 hours from initiation of the complaint for urgent cases and 30 days for all other issues.

An OHCC Member or the Member’s authorized representative (Provider, family Member, etc.) acting on behalf of the Member, may file a grievance either orally or in writing at any time.

**Member Complaint Procedure**

OHCC Members have the right to express a complaint about service or clinical issues at any time. Members may register an internal complaint by calling OHCC Member Services during business hours or by submitting a complaint in writing to:

Optima Health Community Care
Appeals Department
P.O. Box 62876
Virginia Beach, VA 23466-2876

OHCC will notify the Member no later than 30 calendar days after receipt of a standard complaint.

Members may also register a complaint externally to the CCC Plus Helpline at 1-844-374-9159 or TDD 1-800-817-6608, the Department of Human Services Office for Civil Rights (http://www.hhs.gov/ocr) or Office of the State Long-Term Care Ombudsman (http://www.ElderRightsVA.org).

Providers must respond to requests from the Plan for information regarding a Member’s complaint within five business days. OHCC will notify the Member within 2 days if additional information is needed. Member Services or Provider Relations will respond to the Member within 30 days. If a complaint is deemed clinically urgent, the complaint will be addressed no later than 72 hours (working days) from receipt of the request. If a complaint is not resolved to the Member’s satisfaction, the Member may be eligible for an appeal.

**Member Appeal Procedure**

Appeals of adverse determinations must be submitted within 60 days of the decision. Members may file the request by phone or in writing. For expedited requests, Providers may be contacted
to confirm that the Member’s health condition requires an expedited review. Members may continue to receive services that were denied during the review process. Members must ask for an appeal within 10 days of the denial or the change in services. Members may have to pay for continued benefits if the appeal results in another denial.

Members will receive written notice of receipt of their appeal. Clinical appeals will be reviewed by qualified health professionals with appropriate clinical expertise who were not involved in the initial decision. Member and authorized representatives may obtain and review the case file prior and during the appeal and provide information for the appeal decision in person or in writing.

Standard appeals will receive a decision with 30 days and expedited appeals will receive a decision with 72 hours. If additional information is required the Member will be notified within 2 days.

If OHCC extends an expedited appeal timeframe or refuses a request for an expedited appeal, the Member will be notified in writing or orally within 24 hours of OHCC receiving the grievance.

If more information is needed to reach a decision during the review, the Member will be notified and a decision will be made within 14 additional days of the standard timeframes. Members may also request additional time for the decision. Members may file a complaint regarding the OHCC request for additional time through the CCC Plus Help Line.

A written notice will be sent to the Member and Provider if the request was denied or approved in an amount less than requested.

**State Fair Hearing**

If the Member disagrees with the Appeal decision they may appeal directly to DMAS by submitting a request for a State Fair Hearing. The Appeals process above must be exhausted before a Member or their Authorized Representative may submit a request for a State Fair Hearing. DMAS will resolve a standard request with 90 days and an expedited request with 72 hours.

The State Fair Hearing Request may be submitted by internet, mail, fax, email, telephone, in person or other electronic means. It must be submitted no more than 120 calendar days from the final appeals decision. Members may write a letter or submit a Virginia Medicaid Appeal Request Form and send it to:

- Appeals Division
- Department of Medical Assistance Services
- MLTSS External Review Request Health Care Division
- 600 Broad Street
- Richmond, Virginia 23219
- Fax: (804) 452-5454
- (804) 371-8488
DMAS will notify the Member of the date, time and location of the scheduled hearing. Most hearings will occur by telephone.

A decision to uphold or reverse the decision will be issued within 90 days for a standard appeal and with 72 hours of receiving a letter from the Provider for an expedited appeal.

Members may continue to receive services that were denied during the State Fair Hearing process. Members may have to pay for continued benefits if the appeal results in another denial.

If the State Fair Hearing decision is to reverse the denial, OHCC will authorize or provide the services as quickly as the condition requires but not later than 72 hours from receipt of notice from the State reversing the denial. If services were denied during the appeal OHCC will pay for those services.

If the OHCC Member is not in agreement with the resolution by DMAS, they may appeal such a decision to the Circuit Court.