Optima Health

providerNEWS
Spring 2022

Any policy changes communicated in this newsletter are considered official and effective immediately unless otherwise indicated, and will be reflected in the next edition of the Optima Health Provider Manual.

We have attempted to identify each policy change by placing a red push pin to the left of the corresponding language.

COVID-19 Coverage Extension Update

Optima Health has updated our robust list of COVID-19 provider frequently asked questions (FAQs). Flexibilities for telehealth services have also been extended until **June 30, 2022**. We will notify you of any extensions. In addition, we updated our COVID-19 Vaccine Guidance to add details about boosters and additional doses for the immunocompromised.

Optima Health was made aware of an instance where inaccurate information was communicated to some of our providers and members regarding telehealth services. We want to assure you that we are not discontinuing coverage for telehealth services. We also do not limit which providers our members should visit for telehealth offerings.

We understand that interest in and demand for telehealth services has increased due to the pandemic. We believe that now, more than ever, it is important to offer that option to our members and providers.

Optima Health News

Optima Health Launching Doula Benefit for Pregnant Members

In 2022, Optima Health will begin offering a doula benefit for members covered by Medicaid plans (Medallion and Commonwealth Coordinated Care Plus). Adding doula services can help address many of the drivers of poor maternal and child health outcomes. Based in the community, doulas offer a broad set of nonclinical, pregnancy-related services centered on continuous support throughout pregnancy and into the postpartum period. Emotional, physical, and informational support includes childbirth education, lactation support, and referrals for health or social services.

Benefits include up to eight prenatal and postpartum visits and support during labor and delivery. Doula support will be offered in addition to existing benefits, including OB/GYN and hospital labor and delivery services.

Let's Talk About Advance Care Planning With Our Patients

Sentara Healthcare and the Sentara Center for Healthcare Ethics are offering community members the opportunity to complete their advance care plan (advance directive) and register it, free of charge, with our national Advance Directive Registry through the U.S. Living Will Registry. Wherever the patient goes in the United States, their advance care plan will be accessible by healthcare professionals. When needed, the plan can guide medical care if the individual is unable to communicate their wishes or make their own decisions.

Advance care plan (advance directive) documents can include the patient's living will, which helps the healthcare team know what their wishes are, and their medical power of attorney or healthcare agent, who can speak for the patient if they can't speak for themselves.

Patients can appoint any adult over the age of 18 to be their healthcare agent, including a spouse, same-sex or domestic partner, an adult child, a family member, a friend, or any other adult they trust.

Avalon Genetic Testing Implementation Begins This Summer

As a reminder, Optima Health will continue our collaboration with Avalon by implementing a new laboratory benefit management program later this summer. In addition to the Routine Testing Management Services launched in October, Avalon will provide Genetic Testing Management services. This was previously announced via a provider email alert.

Avalon's Laboratory Benefit Management program promotes appropriate testing which helps to drive quality and cost-effective medical care. Avalon supports the enforcement of genetic testing policies through fully delegated Utilization Management for Genetic Testing Requests via an NCQA-compliant preservice review program.

We want to take this opportunity to increase awareness among providers of genetic laboratory services (both ordering and rendering) so that we can work together to ensure members receive high-quality services at the most affordable cost.

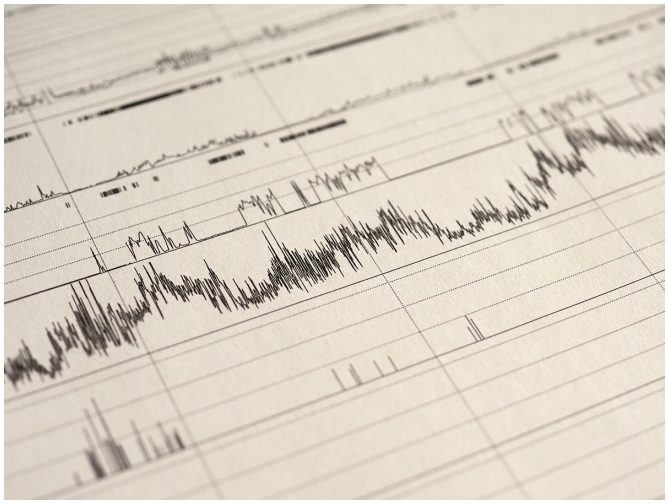
The program includes important changes affecting providers, such as new and revised medical policies, a new authorization request process, guidelines, and consistent preservice reviews for certain genetic testing services.

Optima Health News

These new and revised medical policies and guidelines will impact genetic testing. Here is what you need to know:

- Effective for dates of service on June 13 and beyond, providers will need to submit authorization requests for specific genetic tests using Avalon's Preservice Automated System (PAS).
- Policies and guidelines will be available for review on the Optima Health website.
- Avalon's preservice review program emphasizes peer-to-peer education to promote appropriate testing and reduce potential for otherwise avoidable denials, reconsiderations, and appeals.
- Policy review combines clinical, science-based research with innovative technology and is designed to ensure the consistent application of Optima Health policies and guidelines for genetic tests.
- As the implementation date draws closer, we will send a second announcement outlining additional details about the program.

Reminder: CareCentrix to Manage Sleep Testing Services



Effective August 1, 2022, Optima Health will partner with CareCentrix® to manage sleep testing services for our Commercial, Medicare, Dual Eligible Special Needs Plans (D-SNP), and Medicaid members. This was previously announced via a provider email alert.

Here is what you need to know about the CareCentrix sleep diagnostic testing program:

All requests for sleep diagnostic testing will require prior authorization from CareCentrix. This includes the following codes: 95782, 95783, 95805, 95807, 95808, 95810, 95800, 95801, 95806, G0398, G0399, and G0400.

- CareCentrix will contract, credential, and manage a network of home sleep testing (HST) providers rendering services to Optima Health members. CareCentrix contracted HST providers will submit claims to CareCentrix.
- Optima Health will continue to contract and manage the provider network for facility-based sleep tests. Facility-based sleep diagnostic providers will require authorization from CareCentrix and submit claims directly to Optima Health as you do today.
- All sleep diagnostic testing claims submitted without an authorization for dates of service on or after August 1, 2022, may be denied.

Additional information will be forthcoming regarding how to request authorizations for sleep diagnostic testing prior to the August 1, 2022, effective date. If you have questions about Optima Health services, please contact your Network Educator at 1-877-865-9075, option 2.

Reminder: Tutorial Available for New Jiva Clinical Management System

Jiva, an enhanced clinical management system, went live on May 1. If you have not already done so, complete the easy-to-follow tutorial today to learn how to navigate this new platform.

Important notes:

- You can view real-time decisions via the Optima Health provider portal under view authorization.
- Automated faxes are being phased out and will soon be discontinued.
- Make sure you are selecting clinical criteria as instructed in the tutorial.

Call Provider Customer Service for Jiva Portal questions. Give the agent your name, a return call number with area code and extension, and your question or description of the issue. If possible, write down error messages received or capture screen shots.

Medical Provider Customer Service	Behavioral Health Provider Customer Service
• Phone: 1-800-229-8822 • Monday–Friday • 8 a.m.–5 p.m.	• Phone: 1-800-648-8420 • Monday–Friday • 8 a.m.–7 p.m.

Tip: Get Credit for Attending Our Trainings

To ensure your practice receives credit for completing any of our trainings, please list your provider Tax ID in the first name field and your Practice Name in the last name field instead of the name of the individual completing the training.

Adhere to Our Appointment Access Standards

As a reminder, providers must adhere to appointment access standards. Please provide access to care for members, on a 24/7 basis and in accordance with the appointment access standards listed in the table below.

After-Hours Availability

Primary care physicians must provide emergency care access instructions for members 24/7 via a telephonic message or answering service

Optima Health Appointment Access Standards			
Product	**Appointment Type**		**Scheduling Standard** (time between member request and appointment availability)
Commercial, QHP, Optima Medicare, and Optima Family Care	Emergency (Medical and Behavioral Health)		Immediately upon request
	Urgent/Symptomatic		24 hours or as quickly as symptoms demand
	Routine Medical Care*/Follow-Up Behavioral Health Care/Well Care		30 days
	Initial Behavioral Health		7 days
	Prenatal Care	First Trimester	7 days
		Second Trimester	7 days
		Third Trimester	3 days
		High-Risk Pregnancy	3 days or immediately if emergency
	Postpartum		Within 60 calendar days of delivery
Optima CCC Plus	Emergency		Immediately upon request
	Urgent/Symptomatic		24 hours or as quickly as symptoms demand
	Routine Primary Care*		30 days
	Behavioral Health		5 business days or as quickly as symptoms demand
	Prenatal Care	First Trimester	14 days
		Second Trimester	7 days
		Third Trimester	5 days
		High-Risk Pregnancy	3 days or immediately if emergency
	Postpartum		Within 60 calendar days of delivery

**The Medallion 4.0 and CCC Plus standard for routine primary care does not apply to routine physical examinations; regularly scheduled visits to monitor a chronic medical condition if the schedule calls for visits less frequently than once every 30 days; or for routine specialty services like dermatology, allergy care, etc.*

Resuming Normal Eligibility and Enrollment Operations: Ask Your Patients to Update Their Contact Information

Virginia Department of Medical Assistance Services (DMAS) has assembled a toolkit of information and materials to assist Medicaid members as the agency resumes normal eligibility and enrollment operations. Government agencies sometimes refer to this process as "unwinding" the Federal continuous coverage requirements established in response to COVID-19.

While DMAS does not yet know the official date for resuming normal operations, they are preparing Virginians through outreach and communications reminding Medicaid members to ensure their contact information is current if they have moved or updated their mailing address/phone number(s).

Please remind your Medicaid patients to update their contact information so they can maintain their Medicaid coverage and continue receiving high-quality medical care. They should contact their health plan to make updates; Optima Health members can call 1-833-261-2367 (TTY: 711), Monday through Friday, 8 a.m. to 5:30 p.m.

DMAS will continue to send additional resources prior to and during the unwinding period. The member toolkit and other resources for members and stakeholders are available on the Cover Virginia/Cubre Virginia websites. Please share this information with Medicaid members and display appropriate materials in your office(s).

If you have any questions or require additional information regarding DMAS plans for resuming normal Medicaid enrollment operations or outreach efforts and resources, please visit coverva.org/en, cubrevirginia.org/es.

DMAS Updates

Update to Durable Medical Equipment and Supplies, Appendix B Update

A recent memo highlights changes and additions the Department of Medical Assistance Services (DMAS) made to several sections of Appendix B in the "Durable Medical Equipment and Supplies Listing" of the Durable Medical Equipment and Supplies Manual. Please refer to each section of the Appendix B for changes to that section.

All changes are noted in **bold** with effective dates noted at the bottom of each appendix. The start date of Appendix B update took effect January 1, 2022. To learn more, review the DMAS memo in its entirety.

DMAS Launches PRSS System, Discontinues Paper Remittances

The Virginia Medicaid agency launched a new technology platform in April. Providers credentialed in one or more managed care organizations (MCOs) will use the new Provider Services Solution (PRSS) to complete enrollment and maintenance processes. This change is part of the Medicaid Enterprise System (MES) project.

PRSS will be more efficient and make it easier for you to access information you need as a Medicaid provider. You will be able to update licenses and certifications and submit required attachments through the secure portal. You will also be able to request participation with MCO health plans during the enrollment/revalidation process through the portal. The new system will also allow Virginia to comply with federal requirements for the 21st Century Cures Act.

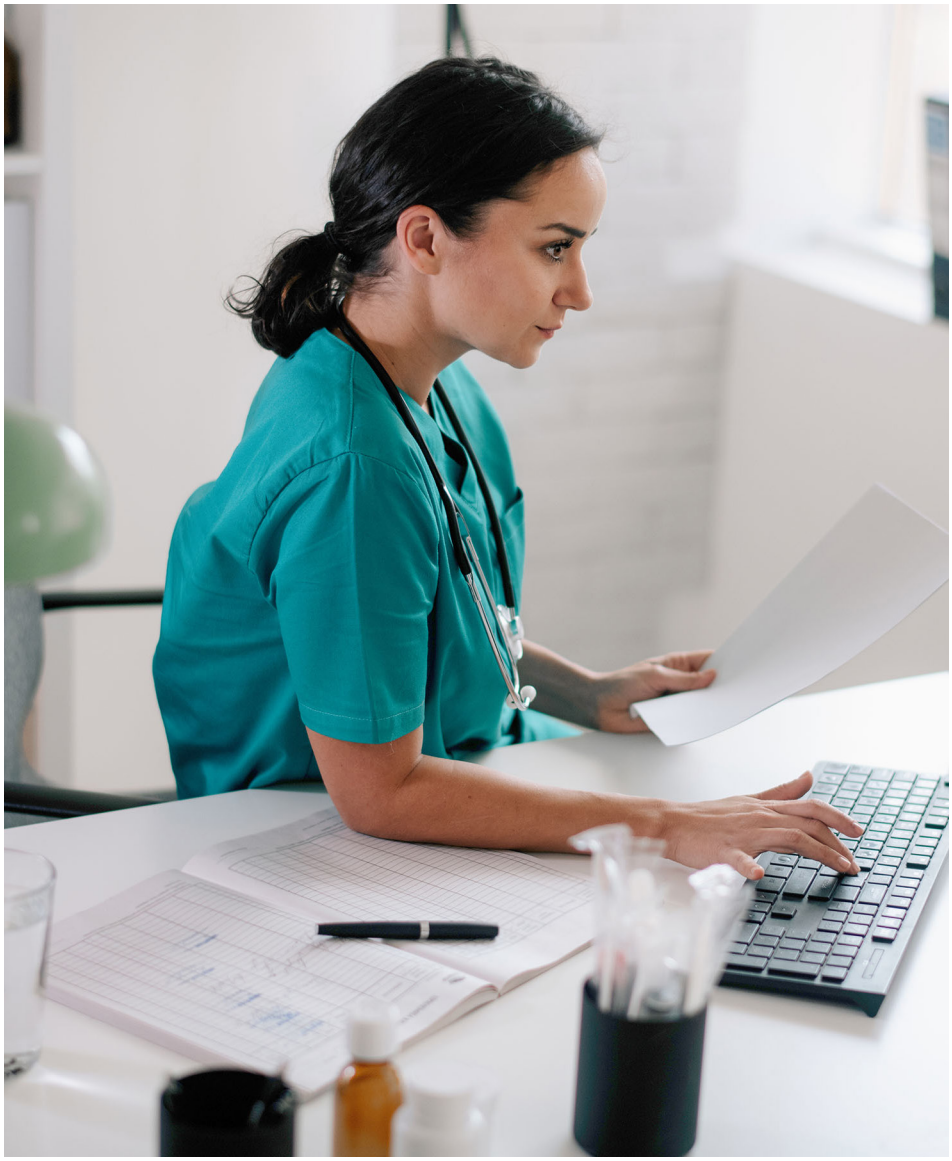
We need your help to ensure that this transition is a success. If you need to enroll through PRSS, we will let you know, and we will send you a schedule in the coming months telling you when to take this action. To ensure an efficient process, the Virginia Medicaid agency is working with us to schedule enrollments for our providers beginning in the summer of 2022.

If you participate in more than one MCO network, you will receive information and instructions from each managed care health plan. If you serve Medicaid fee-for-service members, you will also receive information directly from the Virginia Department of Medical Assistance Services (DMAS).

Paper Remittance Advices Ended on March 25

Fee-for-service providers will no longer receive paper remittance advices (RAs) for claims submitted after 8 p.m. on March 25, 2022. All providers with MES credentials can access RAs through the new provider portal, found on the MES website, which launched on April 4. The RAs will be available in PDF format and providers can download the documents for convenience.

Providers may submit a hardship request to receive paper RAs by sending a signed letter on company letterhead to this address: Virginia Medicaid Provider Enrollment Services, P.O. Box 26803, Richmond, VA 23261-6803. You can also fax your letter to 1-888-335-8476. The hardship request should include a reason for the request as well as any efforts the provider is taking to transition from printed to electronic remittances and a timeline for that process. The Virginia Medicaid agency will review hardship requests and providers will receive a notice of the outcome.



Resources: The MES provider document download functionality is described in the PRSS-121 Provider Portal Overview self-paced video and PRSS-121 Provider Portal User Guide, both available on this training page. Select download type "Remittance Advice" on the Search Criteria. Review Frequently Asked Questions and answers about provider claims, enrollment, and training.

Quality Improvement

Preparing for CAHPS: Take Steps to Improve Healthcare Experiences

It's CAHPS® season, and what does this mean? The Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey, sent to randomly-selected Optima Health members from all lines of business, allows us as providers to improve upon our members'/patients' healthcare experience.

This year and moving forward, member/patient experience plays an even more significant role in the health plan's National Committee for Quality Assurance (NCQA) accreditation and Medicaid Stars rating. Member/patient experience embodies all interactions the member/patient has within the healthcare system, including their care from health plans and doctors, nurses, and staff in hospitals, physician practices, and other healthcare facilities.

Patient experience includes several aspects of healthcare delivery that patients value when they seek and receive care, such as getting timely appointments, easy access to information, and good communication with healthcare providers.

CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

Understanding patient experience is a critical step in moving toward patient-centered care. Evaluating patient experience, and other components such as effectiveness and safety of care, is essential to providing a complete picture of healthcare quality. By looking at various aspects of patient experience, we can assess how patients receive care respectful of and responsive to individual patient preferences, needs, and values.

How, as a provider, can you improve the member/patient experience? A few simple steps include:

- Promote effective provider-patient communication.
  - Ask open-ended questions.
  - Provide take-home literature that speaks to the patient in non-medical terms.
- Adopt shared decision making.
  - Patients who feel ownership in their healthcare decisions experience greater satisfaction with the healthcare received, resulting in better patient outcomes.
- Implement patient comfort measures.
  - Simply explaining all aspects of a procedure before they are performed can provide comfort and lessen anxiety for a patient.
- Improve employee satisfaction.
  - When staff are happy and enjoy their job, it shows and often sets the tone for the member/patient experience.

Improving the member/patient experience is a joint endeavor. As healthcare professionals, we must work together to provide cost-efficient, quality-driven, member-centered healthcare to all those we encounter.

Sources:

- AHRQ: What is Patient Experience
- Ease the Way Blog: 5 Ways Physicians Can Improve Patient Experience

Medicare Stars: Focus Measures for Star Year 2024 (MY 2022)

As we continue to close gaps throughout the measure year, we want to emphasize the importance of timely and accurate billing as it impacts gap closure initiatives and has a direct impact on the overall Medicare Stars Rating. Accurate documentation through claims reduces the chart retrieval process during hybrid season for the health plan and gives back time to provider practices to focus on patient care versus chart retrieval.

Below are a few measures Optima Medicare is focusing on in the beginning of the new measure year. Helpful tips, documentation requirements, and codes for claim submission are listed below to help practices capture all the information they need to successfully close gaps.

Controlling Blood Pressure

What is the measure? The percentage of patients with a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90) during the measurement year. Patients are identified by event and diagnosis.

Controlling Blood Pressure	

Key Points:
• Patients of Optima Medicare have an over-the-counter (OTC) benefit allowance they can utilize to purchase a digital/remote blood pressure (BP) cuff.
• Encourage patients to get a BP cuff that takes readings higher on the arm for better accuracy; wrist cuffs are not recommended.
• Consider communicating to patients the positive effects of monitoring blood pressure frequently.
• Utilize digital/remote BP cuffs during telehealth visits to help capture data for this measure.
• Talk with patients about what a lower goal is for a healthy BP reading.
• Controlled BP is <140 systolic and <90 diastolic.
• Be sure to record the BP in the medical record.
• Be aware that the new guidelines allow self-reported BPs to be documented in the EMR during telehealth visits as long as the BP was taken with a digital machine in the home.
• Don't round up or down when recording the BP. If the initial BP was elevated, take it a second time after a few minutes rest.
	Documentation Requirements:
	• If a BP is listed on a vital flow sheet, it must have date of service listed as well.
	• If your office uses manual blood pressure cuffs, don't round up the BP reading.
	• Patient self-reported BP should be documented during the telehealth visit with a note saying the blood pressure was obtained with a digital cuff in the home.
	• The use of CPT Category II codes helps Optima Medicare identify clinical outcomes such as diastolic and systolic readings. It can also reduce the need for some chart review.
	• Please note, CPT II codes are for reporting purposes only and are not separately reimbursable. If you receive a claim denial, your reporting code will still be included in the quality measure.
	• CPT category II codes for filing claims:
	  ◦ 3077F: BP >= 140
	  ◦ 3074F: systolic < 140
	  ◦ 3080F: diastolic >=90
	  ◦ 3079F: diastolic 80-90
	  ◦ 3078F: diastolic < 80
	• Remote BP monitoring: 93784, 93788, 93790, 99091, 99453, 99454, 99457,99473, 99474

Quality Improvement

Changes to Diabetes Care - Kidney Disease Monitoring

What is the measure? The measure evaluates adults with diabetes (type 1 and type 2) who have received an annual kidney health evaluation defined by an estimated glomerular filtration rate (eGFR) and a urine albumin-creatinine ratio (uACR) during the measurement year.

Comprehensive Diabetes Care - Kidney Health Evaluation for Adults with Diabetes	
Key Points: • Replaced the medical attention for nephropathy measure • Patients with type 1 diabetes and type 2 diabetes are eligible for this measure **Best Practices:** • Consider prescribing ACE/ARB inhibitors for diabetic patients as appropriate • Use the appropriate CPT II code to report patient is on treatment for nephropathy • For point-of-care nephropathy testing, document the date of the in-office test with the result • Submit the CPT code for test performed and CPT II codes to report nephropathy result value	**Documentation Requirements:** • Patients who had a quantitative urine albumin test and a urine creatinine test within four days during the measure year meet the criteria **The above tests must have service dates documented within four days or less apart from each other* • **Exclusions:** Patients with end-stage renal disease (ESRD), on dialysis, or receiving hospice or palliative care are exempt from this measure **CPT Category II Codes for Filing Claims:** • estimated glomerular filtration rate (eGFR): • 80047 – basic metabolic panel (calcium, ionized) • 80048 – basic metabolic panel (calcium, total) • 80050 – general health panel 80053 – comprehensive metabolic panel • 80069 – renal function panel • 82565 – blood creatinine level • urine albumin-creatinine ratio (uACR): • 82043 – urine microalbumin • 82570 – urine creatinine

Follow-up After ED Visit with Multiple Chronic Conditions

What is the measure? The percentage of emergency department (ED) visits between January 1 and December 24 of the measurement year for patients who have multiple high-risk chronic conditions and who had a follow-up service within seven days of the ED visit (eight days total).

Follow-up After ED Visit with Multiple High Risk Chronic Conditions (within seven days)	
Best Practices: • Schedule post-ED follow-up visit three to five days after discharge. • Assist patients as they navigate the health system to lessen the impact of barriers. • Recommend that patients utilize their transportation benefit to get to their follow-up appointment. • Encourage patients to have regular office visits with primary care provider to monitor and manage chronic disease conditions. • Develop a daily process to schedule patients who have been discharged from the ED or an inpatient stay.	**Documentation Requirements:** **Eligible Population (Denominator):** • A patient had an ED visit within the timeframe of January 1 through December 24. • The patient had two or more of the below chronic conditions documented prior to the ED visit: ◦ COPD, Alzheimer's disease and related disorders, chronic kidney disease, depression, heart failure, acute myocardial infarction, atrial fibrillation, stroke, transient ischemic attack **If a patient has more than one ED visit within an eight-day period, include only the first eligible visit.* **Numerator:** • A follow-up service within seven days after the ED visit (eight total days). Visits that have occurred on the date of the ED visit qualify.

Quality Improvement

HOS Season Is Approaching!

What is HOS? The Medicare Health Outcomes Survey (HOS) is the first patient-reported outcomes measure used in Medicare managed care. All managed care organizations with Medicare contracts must participate. This survey is distributed annually to a cohort of patients and involves a two-part survey – the baseline and follow up two years later.

Why Does HOS Matter? The goal of the Medicare HOS is to gather clinically meaningful health status data to use in quality improvement activities, pay for performance, program oversight, public reporting, and to improve health. The two-part survey is meant to measure whether a patient's health has improved in specific areas over time. This data is helpful to monitor health plan performance based on patient-reported outcomes and affects the Medicare Star rating.

Timeline: HOS survey timing has changed due to COVID impacts and now occurs from late July through early November. When published as measure results, the HOS scores affect the rating for the year following the survey. Outlined below are four measures that are found within the HOS survey. These measures are considered HEDIS® (Healthcare Effectiveness Data and Information Set) effectiveness of care measures. Providers can help impact HOS results by starting important conversations during office visits to help create recall and encourage action.

HOS Measure	Actions You Can Take

1. Overall	• Provide discussion starters for members during office visits.
	  ◦ Provide an office visit checklist with HOS-related questions to patients at check-in at each office visit to guide discussion.
	  ◦ Hang posters in the exam room with HOS topics highlighted.
	• Due to the sensitive nature of some of the HOS topics, members may be reluctant to bring them up. These checklists and posters can help open and encourage dialogue between the patient and provider.

2. Monitoring Physical Activity in Older Adults	• Discuss how to start, increase, or maintain activity. • Refer patients with limited mobility or walking/balance issues to physical therapy to learn safe and effective exercises.
3. Improving Bladder Control	• Discuss treatments for bladder control issues that may arise as patient ages, such as behavioral therapy, exercises, medications, medical devices, or surgery.
4. Reducing Fall Risk	• Discuss balance problems, falls, difficulty walking, and other fall risks. • Suggest cane or walker. • Check blood pressure with patient standing, sitting, and reclining. • Suggest vision/hearing test.

HEDIS is a registered trademark of the National Committee for Quality Assurance (NCQA).

Learn How New Initiatives Support Member Health

We strive to have healthy members as part of our quality improvement initiatives, and we have three annual campaigns to bring to your attention:

At-Home Diabetes Testing (A1C and Urine Microalbumin) Partnership with BioIQ®

- This campaign offers easy to monitor, no-cost diabetes testing for hemoglobin A1C and urine microalbumin at home.
- Testing measures blood sugar and kidney function.
- Materials are sent to members who have a gap in their diabetes testing.
- Results are distributed by mail to participating members and their primary care physician (PCP). Members will also have access to their results via an online member portal: optima.bioiq.com.
- Up to three phone calls will be made to contact members with abnormal results. Members will be advised to immediately follow up with their PCP for further evaluation.
- If the A1C value is greater than nine, a population care nurse will also contact the member's PCP directly.
- In the near future, we plan to provide urine albumin-creatinine ratio (uACR) and estimated glomerular filtration rate (eGFR) kits to measure kidney failure risk among members with diabetes.

At-Home Colorectal Cancer Screening Partnership with BioIQ

- A no-cost Fecal Immunochemical Test (FIT) will be sent to members who have seen a PCP in the past two years but still have not received recommended colorectal cancer screening.
- Annual FIT is recommended for people at average risk for colorectal cancer.
- FIT is a preferred screening option based on features, cost, and performance.
- All at-home test kits are ordered by an Optima Health nurse practitioner.
- Results are sent to members and their PCP by mail. Members will also have access to their results via an online member portal: optima.bioiq.com.
- Members with abnormal results will also be contacted by phone, in addition to receiving a letter.
- Three phone attempts are made to contact members with abnormal results. Members are advised to immediately follow up with their PCP for further evaluation.

Statin Therapy Program

Through our Statin Therapy Program, led by the Optima Health population care department, nurses contact members who have tried a cholesterol medication in the past but experienced a side effect. During these outreach calls, nurses not only provide education, but also encourage members to follow-up with a PCP. We may also help members schedule a telehealth visit to document side effects. This initiative includes members who should be taking a statin medication due to a diagnosis of diabetes or cardiovascular disease but do not appear to be taking a statin due to missing claims data.

Quality Improvement

We will contact members to offer education regarding who may benefit from a statin medication and advise them to have a conversation with their PCP.

Those who report a side effect to statin medications, but have no claim with a diagnosis of a statin side effect, may be referred to telehealth to ensure statin-induced side effects are documented. If your practice offers in-house telehealth, we will attempt to refer members to the service offered by your practice.

Statin therapy benefits your patients by lowering cholesterol and reducing risk of atherosclerotic cardiovascular disease (ASCVD). Exclusions for statin therapy include diagnoses of pregnancy, end-stage renal disease, and cirrhosis.

To assist us in our quality initiatives related to statin therapy, please include appropriate diagnosis codes on claims for patients who may need to stop a statin medication due to myopathy or myalgia. ICD-10 codes for myalgia/myositis/myopathy include: G72.0; G72.2; G72.9; M60.80-M60.812; M60.819; M60.821-M60.822; M60.829; M60.831-M60.832; M60.839; M60.841-M60.842; M60.849; M60.851-M60.852; M60.859; M60.861-M60.862;M60.869; M60.871-M60.872; M60.879; M60.88-M60.89; M60.9; M62.82; M79.1-M79.12; and M79.18.

Please also document exclusions, which include:

- pregnancy/IVF
- ESRD or dialysis
- cirrhosis
- myalgia, myositis, myopathy, or rhabdomyolysis
- dispensed a dementia medication
- members in hospice or using hospice services anytime during the measurement year
- members receiving palliative care during the measurement year

Diabetic Eye Exams

- Each month, our vendor makes interactive voice response calls to members who are due for a diabetic eye exam. The Optima Health population care team follows up with direct calls to encourage members to schedule an exam.
- We partner with eye care providers to attempt to schedule an in-office visit for members

Please encourage your patients to participate in these free preventive care services. If you have any questions, leave a message on the confidential population care voicemail, 757-687-6334 (1-833-736- 6546 toll-free), or email popcare@sentara.com.

Recent Authorization Updates: Learn More About Recent Policy Changes

Optima Health would like to notify you of the following authorization updates made since the last version of providerNews:

Policy	Determination/Coverage
BH 01 Repetitive Transcranial Magnetic Stimulation (rTMS)	Archived policy: Use Milliman
BH 14 Crisis Intervention	Archived per DMAS: use new BH policy
BH 15 Crisis Stabilization	Archived per DMAS: use new BH policy
BH 25 Behavioral Therapy	Archived per DMAS: use new BH policy
BH 27 Sensory-Weight Vest	New policy: Covered for CCC+ Waiver only. Considered not medically necessary for all other LOBs
BH 31 Mobile Crisis Response	New policy: coverage for Optima Virginia Medicaid only
BH 32 Community Stabilization	New policy: coverage for Optima Virginia Medicaid only
BH 33 23-Hour Crisis Stabilization	New policy: coverage for Optima Virginia Medicaid only
BH 34 Residential Crisis Stabilization Unit (RCSU)	New policy: coverage for Optima Virginia Medicaid only
BH 35 Multisystemic Therapy	New policy: coverage for Optima Virginia Medicaid only
BH 36 Functional Family Therapy	New policy: coverage for Optima Virginia Medicaid only
BH 37 Applied Behavioral Analysis	New policy: coverage for Optima Virginia Medicaid only
BH 38 Musical Therapy	New policy: Considered not medically necessary for all LOBs
DME 05 Battery Replacement	Archived policy: items placed in their respective specific Optima policies
DME 10 Continuous Glucose Monitors	Updated policy: CPT codes 95249, 95250, and 95251 removed from policy and pay upon request for all LOBs
DME 12 Cranial Orthotic Devices	Archived policy: Use Milliman
DME 27 PortableConnect	Updated policy: PortableConnect added as not medically necessary for all LOBs
DME 58 Medical Car Seats	New policy: coverage for Medicaid only. Considered not medically necessary for all other LOBs
Imaging 06 Positron Emission Tomography (PET) for Oncological Conditions	Archived policy: Use Milliman

Authorizations and Medical Policies

Recent Authorization Updates: Learn More About Recent Policy Changes

Policy	Determination/Coverage
Imaging 07 Virtual Colonoscopy	Archived policy: Use Milliman
Imaging 29 Cerebral Perfusion Analysis Computed Tomography	Archived: pay upon request
Imaging 56 Bone Density Studies	Archived policy: Use Milliman
Medical 29 Non-Surgical Treatment of Temporomandibular Joint Syndrome & Treatment of Temporomandibular Disorders	Archived policy
Medical 34A CSF3R Gene	New coverage for Optima Medicare only, considered not medically necessary for all other LOBs
Medical 34A DetermaRX	Updated Policy: DetermaRX Testing considered not medically necessary
Medical 34A Genetic Testing Panel FoundationOne Liquid CDx for blood tumor mutational burden, microsatellite instability, and tumor fraction values	Updated policy: Genetic Testing Panel FoundationOne Liquid CDx considered not medically necessary
Medical 34A Genetic Testing DecisionDx- Uveal Melanoma (UM)	Criteria updated: Coverage removed for Virginia Optima Medicaid plans; coverage criteria added for Optima Medicare. Considered not medically necessary for all other LOBs
Medical 34C Invitae Alternating Hemiplegia of Childhood Panel (genes ATP1A2 and ATP1A3)	Updated policy: Invitae Alternating Hemiplegia of Childhood Panel considered not medically necessary
Medical 34C SERPINC1	Updated policy: SERPINC1 Genetic Testing considered not medically necessary
Medical 34C L1CAM gene	Updated policy: L1CAM gene Testing considered not medically necessary
Medical 34E Genetic Testing EYA1 Genetic Testing	Updated Policy: EYA1 Genetic Testing considered not medically necessary
Medical 99 AlloMap Molecular Expression Testing	Criteria updated: New coverage for AlloSure Heart when used in conjunction with AlloMap Heart added for Medicare only
Medical 103 Tinnitus Therapy and Devices	Archived policy: Policy was not being used for denial of devices
Medical 107 Home-Based Electroencephalogram (EEG) Video Monitoring	Archived policy: Use Milliman
Medical 166 Tumor Treating Fields Therapy	Updated policy: Treatment planning software (i.e., NovoTAL) considered not medically necessary

Recent Authorization Updates: Learn More About Recent Policy Changes

Policy	Determination/Coverage
Medical 168 Private Duty Nursing	Archived: Use DMAS manual for Medicaid, Member benefits, job aides and for commercial plans use Milliman
Medical 203 Ambulatory Cardiac Arrhythmia Detection Monitors	Archived policy: Use Milliman
Medical 287 Anti-Phospholipid Antibody Testing	Updated policy: Testing for PROTHROMBIN Antibodies IGG considered not medically necessary
Medical 321 Non-Medical Transportation for the Chronically Ill	Archived policy: use benefits for coverage
Medical 330 Near-infrared spectroscopy	New policy: Near-infrared spectroscopy considered not medically necessary
Medical 332 Erector Spinae Plane Block	New policy: Erector Spinae Plane Block considered not medically necessary
Medical 333 Immunoglobulin Light Chains	New policy: Immunoglobulin Light Chains considered medically necessary for monoclonal plasma cell proliferative disorder, systemic amyloidosis (AL), multiple myeloma and not medically necessary for iron deficiency anemia and pperipheral neuropathy
OB 10 Fetal Surgeries In Utero	Updated policy: Amniotic band syndrome; aqueductal stenosis (i.e., hydrocephalus); congenital heart defects (e.g., mitral valve dysplasia); and cleft lip and/or cleft palate considered not medically necessary
Surgical 04 Varicose Vein Treatments/Vulvar and Scrotal Varicosity Treatments	Updated policy: removed coverage for Medicare for mechanochemical endovenous ablation (MOCA)
Surgical 10 Reconstruction Breast Surgery-Areola Tattoo	Updated policy: ARTIA Reconstructive Tissue Matrix (4100) considered not medically necessary
Surgical 15 Endometrial Ablation	Updated policy with more restrictive criteria. Endometrial sampling or D&C has been performed within the year prior to the procedure
Surgical 10 Reconstruction Breast Surgery-Areola Tattoo	Updated policy: Nerve reimplantation or nerve repair in conjunction with reconstructive breast surgery considered not medically necessary
Surgical 21 Liver Transplant	Archived policy: Use Milliman

Authorizations and Medical Policies

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Surgical 52 Foot Surgeries	Updated policy: First metatarsophalangeal (MTP) joint Interpositional arthroplasty with fascia lata allograft implant considered not medically necessary
Surgical 60 Ophthalmic Procedures 0507T - Near-infrared dual imaging	Updated policy: Near-infrared dual imaging considered not medically necessary
Surgical 82 Cryoablation	Updated policy: Bone and soft tissue carcinomas, cryoneurolysis nerve block, endometrial cancer all added as not medically necessary for all LOBs
Surgical 82 Cryoablation	Updated policy: Clarifix added as not medically necessary for all LOBs
Surgical 103 Headache Treatments	Updated policy: Nerivio device considered not medically necessary for all LOBs
Surgical 106 Genicular Ablation- Substernal implantable cardioverter-defibrillator system	Updated policy: Substernal implantable cardioverter-defibrillator system considered not medically necessary for all LOBs
Surgical 119 Facet Joint Procedures	Criteria update: Added specific criteria for facet joint injections. These will no longer be paid upon request for all LOBs. Codes: 0213T, 0214T, 0215T, 0216T, 0217T, 0218T, 64490, 64491, 64492, 64493, 64494, 64495
Surgical 123 Vertebral Body Tethering	New policy: Vertebral Body Tethering considered not medically necessary
Surgical 124 Peripheral Nerve Stimulator	New policy: Coverage criteria for all LOBs
Surgical 125 Uterus Transplant	New policy: Considered not medically necessary
Surgical 126 Leadless Cardiac Pacemaker	New policy: Considered not medically necessary
Surgical 106 Genicular Ablation- Substernal implantable cardioverter-defibrillator system	Updated policy: Substernal implantable cardioverter-defibrillator system considered not medically necessary.
Surgical 127 Sports Hernia Repair (Athletic Pubalgia Surgery)	New policy: Considered not medically necessary for all LOBs

Provider Relations	757-552-7474 or 1-800-229-8822 OHCC: 1-844-512-3172
Provider Relations Fax	757-961-0565
Behavioral Health Provider Relations	757-552-7174 or 1-800-648-8420
Medical Care Management (Pre-Authorization)	Commercial and individual products: 757-552-7540 or 1-800-229-5522 OHCC, OFC, Medicare HMO and OCC:1-888-946-1167
Network Educators	757-552-7085 or 1-877-865-9075, option #2
Health and Preventive Services	757-687-6000
Proprium Pharmacy	1-855-553-3568
Proprium Pharmacy Fax	1-844-272-1501

Keep Your Practice Information Up to Date

Please notify Optima Health of any changes to provider or practice information within 60 days, or as soon as possible, especially changes to:

- provider rosters
- panel status
- address/phone numbers
- practice email address for official communication from Optima Health

Medical providers should now update their information electronically using our Provider Update Form. Please note that, **effective November 1, 2021**, we discontinued accepting and processing Provider Update Forms that have not been submitted online. Please notify the appropriate individuals in your practice of this information.

Thank you for your partnership in providing accurate information to our members!