Optima Health

providerNEWS
Fall 2021

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). The latest updates include:

1. Most benefit flexibilities and accommodations end **November 30, 2021**. We will notify providers of any extensions.
2. Standard member cost-share and prior authorization requirements resumed, effective July 1, 2021. *Note: Medicaid expiration dates are dictated by executive order, and for Medicare, select flexibilities and accommodations will be in effect until the end of the public health emergency.*

Continue reminding members and their loved ones that there are many reasons to get vaccinated, such as protecting themselves and their families and friends. If you have questions about the vaccine, please view our vaccine guidance page. If you have any additional questions, please contact your Optima Health network educator.

Where to Access Current Clinical Guidelines

Optima Health reviews and revises clinical guidelines bi-annually. The most up-to-date, evidenced-based clinical guidelines can be found in the Clinical Reference section of optimahealth.com/providers.

If you would like a printed copy of these guidelines or have questions, comments, or suggestions about the guidelines, please contact the Optima Health quality improvement department at 757-252-8400 or 1-844-620-1015.

Please note: Clinical data in a particular case may necessitate or permit deviation from these guidelines. Optima Health guidelines are institutionally endorsed recommendations and not intended as a substitute for clinical judgment.

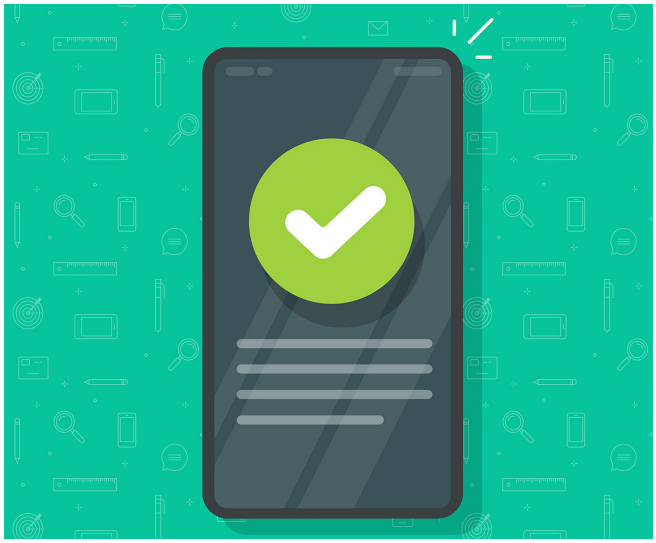
New Collaboration with Avalon Provides RTM Services

On August 2, 2021, we announced our collaboration with Avalon Healthcare Solutions (Avalon) on a new laboratory benefit management program, Routine Testing Management (RTM) services. RTM is an automated review of high-volume, low-cost laboratory tests, which promotes expert, guideline-based care through the application of evidence-based laboratory policies while remaining provider and member friendly.

Review the highlights of the RTM program using this link. **Effective November 1, 2021,** new and revised medical policies and guidelines take effect for select laboratory services, tests, and procedures. These policies and guidelines are now available for review at this link. A list of Frequently Asked Questions is also available for you to review and download.

Optima Health values your partnership as we work together to improve health every day, providing quality care and better outcomes for our shared members. If you have questions, please contact your network educator at 1-877-865-9075, option 2.

Keep Your Information Current with Our Online Provider Update Form

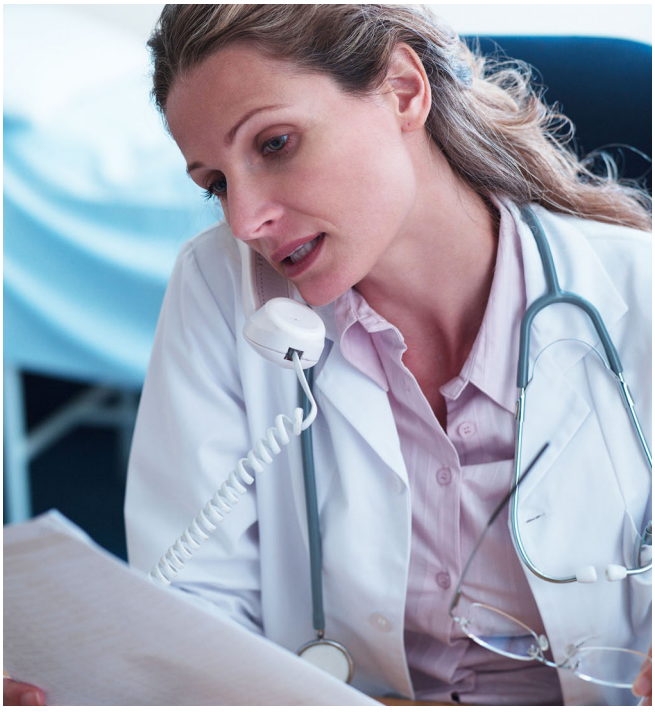


Optima Health recently launched a new online provider update form. This new approach offers a more convenient and efficient process for most providers and ensures faster updates to our systems.

Effective **September 6, 2021**, paper/PDF provider update forms submitted by email will no longer be accepted.

- Learn more about the provider update form.
- Update your information today.

Changes to the Peer-to-Peer Reconsideration Process Took Effect October 1



On **October 1, 2021***, Optima Health implemented the following changes to the provider peer-to-peer and reconsideration process:

- The time allowed to complete a peer-to-peer with an Optima Health medical director has changed from 30 days to five days for government plans and from 45 days to five days for commercial plans.
- For government programs, the provider will no longer be allowed to only send in additional clinical documentation for a reconsideration. The provider must schedule a peer-to-peer with an Optima Health medical director to have their authorization reviewed again prior to appeal.
- Optima Health will allow peer-to-peer conversations for both Medicare lines of business.

More information, including a printable guide, is available on the Optima Health website. Questions? Contact the Optima Health utilization management department to schedule a peer-to-peer:

- Medicare/Medicaid plans: 1-888-946-1167
- Commercial plans: 1-800-229-5522

**This change was originally announced on August 2, 2021, via a provider alert email.*

Optima Health News

Join Our Quarterly Provider Update Webinar

Plan to join Optima Health for our quarterly provider update webinar, from the convenience of your office. Learn what's new at Optima Health, receive refreshers on how to successfully partner with us, and have your questions answered.

Join our network team virtually for timely updates and a live opportunity to receive answers to your questions (click on the links below to register):

- November 3, 2021, 10 to 11 a.m.
- November 10, 2021, 1 to 2 p.m.

Diagnosis Submissions by Providers: What You Need to Know

According to the Centers for Medicare & Medicaid Services (CMS) Managed Care Manual Chapter 7, Section 40, health plans must "submit all required diagnosis codes for each beneficiary."

What this means for providers:

- Document and code to the highest specificity of the patient's condition.
- Document all submitted diagnosis codes submitted in the medical record.
- Ensure that all diagnoses generated during the encounter are included on the claims.

JIVA Implementation Scheduled for December 6: More Details Coming Soon

On **December 6, 2021**, Optima Health is replacing the current case management and utilization documentation platform, Symphony, with a new platform, JIVA by ZeOmega.

JIVA is an enhanced clinical management system that supports several of our key strategic imperatives such as improving the customer experience and provider experience, affordability, and quality outcomes. Additional information will be forthcoming, including details on existing authorizations and changes to the provider portal.

If you have questions, please contact your network educator by calling 1-877-865-9075, option 2.

Prior Authorization No Longer Required for In-Network Observation Stays

Effective July 12, 2021, for Optima Health government and commercial health plans, in-network observation stays will no longer require an authorization through the Optima Health utilization management department.

Providers may submit their claim directly to the claims department, without first obtaining authorization from Optima Health. Observation will continue to require an authorization for out-of-network facilities.

CareCentrix Post-Acute Care Services: Implementation Rescheduled for October 1

Beginning **October 1, 2021** (previously scheduled for implementation on September 1), CareCentrix will manage post-acute care services for Optima Health commercial product members. CareCentrix will manage authorizations for commercial members discharged from acute care hospitals who are admitted to skilled nursing facilities and inpatient rehabilitation facilities.

In addition, CareCentrix will provide up to 90 days of nurse coaching for eligible members after an acute care hospital discharge to support healing, help them achieve self-management, and reduce unnecessary readmissions. Optima Health will continue to manage authorizations for all other services.

After October 1, 2021, claims may be denied for commercial members if authorizations are not obtained from CareCentrix for these post-acute care services.

Claims processes have not changed. Optima Health will continue to process claims, answer claims questions, and handle claims appeals.

More information is available on the Optima Health website. If you have any questions about the CareCentrix implementation, please contact your Optima Health network educator.

Authorizations and Medical Policies

Announcing Changes to the Retroactive Authorization Process

Optima Health values your care in providing long-term support services to our members. Member care is a top priority, and your partnership is critical. To align with the Commonwealth Coordinated Care Plus waiver manual, Optima Health wants to make you aware of upcoming changes to the retroactive authorization process. The following will be effective for all requests received on or after **November 1, 2021***.

To initiate personal care services, providers may start services up to the maximum allowed for the individual's level of care (LOC) determined on the Department of Medical Assistance Services (DMAS) 97 A/B. Hours over the maximum allowed are not authorized or reimbursed retroactively. To ensure full reimbursement for all services rendered, the provider should notify Optima Health prior to the start date of the service.

For all new members who need personal care, services, the provider has 10 business days from the start of care to submit a request for service. If the request is received within 10 business days, the service will be reviewed for medical necessity and reimbursed for all hours approved from the start of care date.

If the authorization is received more than 10 business days after the requested start of care date, hours over the maximum allowed for the individual's LOC determined on the DMAS 97 A/B will not be authorized or reimbursed retroactively. Reimbursement for the hours approved by Optima Health will begin on the day the request is received.

Supervision time will be evaluated for medical necessity beginning on the day the authorization request is received and will not be retroactively authorized.

Please see example below for further explanation:

- Provider request received on 6/7/20XX, for a date of service starting 5/15/20XX, requesting 45 hours weekly
- DMAS 97A/B LOC score is seven; the maximum hours allowed is 30 hours weekly
- Medical necessity reviewed and met
- 5/15/20XX - 6/6/20XX: approve 30 hours weekly per LOC
- 6/7/2021 - 12/7/20XX: approve 45 hours weekly per medical necessity

**This change was originally announced on September 2, 2021, via a provider alert email.*

New HEDIS Measures for Measurement Years 2022

Each year, between February and May, data from the prior calendar year is collected on a number of standardized quality measures. Most of these measures remain the same year after year: preventive screenings, immunizations, and treatment of chronic conditions such as diabetes and hypertension. For certain measures, data is collected through claims or member surveys. Others are gathered through review of medical records, while some are extracted directly from electronic clinical data systems (ECDS). Occasionally, measures may be retired and new measures are added. Below are a few of the new or revised measures the National Committee on Quality Assurance (NCQA) has added for measurement year 2022:

New Measures

Deprescribing of benzodiazepines in older adults (DBO): The percentage of members 67 years of age and older who were dispensed benzodiazepines and achieved a 20% decrease or greater in benzodiazepine dose (diazepam milligram equivalent [DME] dose) during the measurement year.

- first year measure

Required exclusions:

- members with a history of seizure disorders, REM sleep behavior disorder, benzodiazepine, or ethanol withdrawal
- members receiving palliative care or using hospice services anytime during the measurement year

Antibiotic utilization for respiratory conditions (AXR): The percentage of episodes for members three months of age and older with a diagnosis of a respiratory condition that resulted in an antibiotic dispensing event.

Required exclusions:

- members in hospice or using hospice services during the measurement year

Advance care planning (ACP): The percentage of adults 65 to 80 years of age diagnosed with advanced illness (an indication of frailty) or receiving palliative care, and adults 81 years or older, who had advance care planning during the measurement year.

Required exclusions:

- members in hospice or using hospice services during the measurement year

Measures newly specified for ECDS Reporting:

- childhood immunization status (CIS-E)
- immunizations for adolescents (IMA-E)
- metabolic monitoring for children and adolescents on antipsychotics (APM-E)

Quality Improvement

Revised Measures

Comprehensive diabetes care (CDC) has been revised into three stand-alone measures:

- **Blood pressure control for patients with diabetes (BPD):** examines members 18 to 75 years of age with diabetes (types 1 and 2) whose blood pressure (BP) was controlled (<140/90 mm Hg) during the measurement year.
- **Hemoglobin A1c control for patients with diabetes (HBD):** examines members 18 to 75 years of age with diabetes (type 1 and 2) whose HbA1c was at the following levels during the measurement year.
    - HbA1c control (<8.0%)
    - HbA1c poor control (>9.0%)
- **Eye exam for patients with diabetes (EED)**: examines members 18 to 75 years of age with diabetes (types 1 and 2) who had a retinal eye exam.

Other revised measures:

- acute hospital utilization (AHU)
- identification of alcohol and other drug services (IAD) measure was revised to diagnosed substance use disorders (DSU)
- mental health utilization (MPT) measure was revised to diagnosed mental health disorders (DMH)
- initiation and engagement of alcohol and other drug abuse or dependence (IET)
- follow-up after emergency visit department visit for alcohol and other drug dependence (FUA); revised measure name: follow-up after emergency department (ED) visit for substance
- use of imaging studies for low back pain (LBP)

Telehealth Codes

The Centers for Medicare and Medicaid Services (CMS) relaxed some of its rules on telemedicine due to the COVID pandemic, adding 80 services to a list of services that could be provided using telehealth, instead of requiring in-person, face-to-face visits.

NCQA has also changed its requirements to allow telehealth visits, telephone visits, and e-visits or virtual check-ins to meet the specifications for many HEDIS® (Healthcare Effectiveness and Data Information Set) measures.

HEDIS® is a registered trademark of the National Committee for Quality Assurance.

These include well visits for babies, children and adolescents; attention deficit hyperactivity disorder (ADHD) medication follow-up visits; prenatal care visits; care for older adults; and follow-up visits after hospitalization and/or ED visits.

NCQA defines these different modalities as follows:

- Telehealth requires real-time, interactive audio and video telecommunications. Telehealth is billed using standard CPT and HCPCS codes for professional services along with a telehealth modifier (GT or 95) and/or a telehealth place of service code (02).
- A telephone visit is real-time interactive audio communication. CPT codes for telephone visits are: 98966-98968 and 99441-99443.
- An e-visit or virtual check-in is not real-time, but still requires two-way interaction between the member and provider. For example, a patient portal, secure text messaging or email (such as MyChart). CPT codes for these online assessments are: 98969-98972; 99421-99423; 99444 and 99458.

As physicians, you can help improve quality of care by:

- encouraging your patients to schedule preventive exams
- reminding your patients to follow up with ordered tests and procedures
- making sure necessary services are being performed in a timely manner
- submitting claims with proper HEDIS codes
- accurately documenting all services and results (if appropriate) in the patient's medical record

Let's work together to improve and maintain higher quality of care. When our members are healthy, everyone benefits.

Quality Improvement

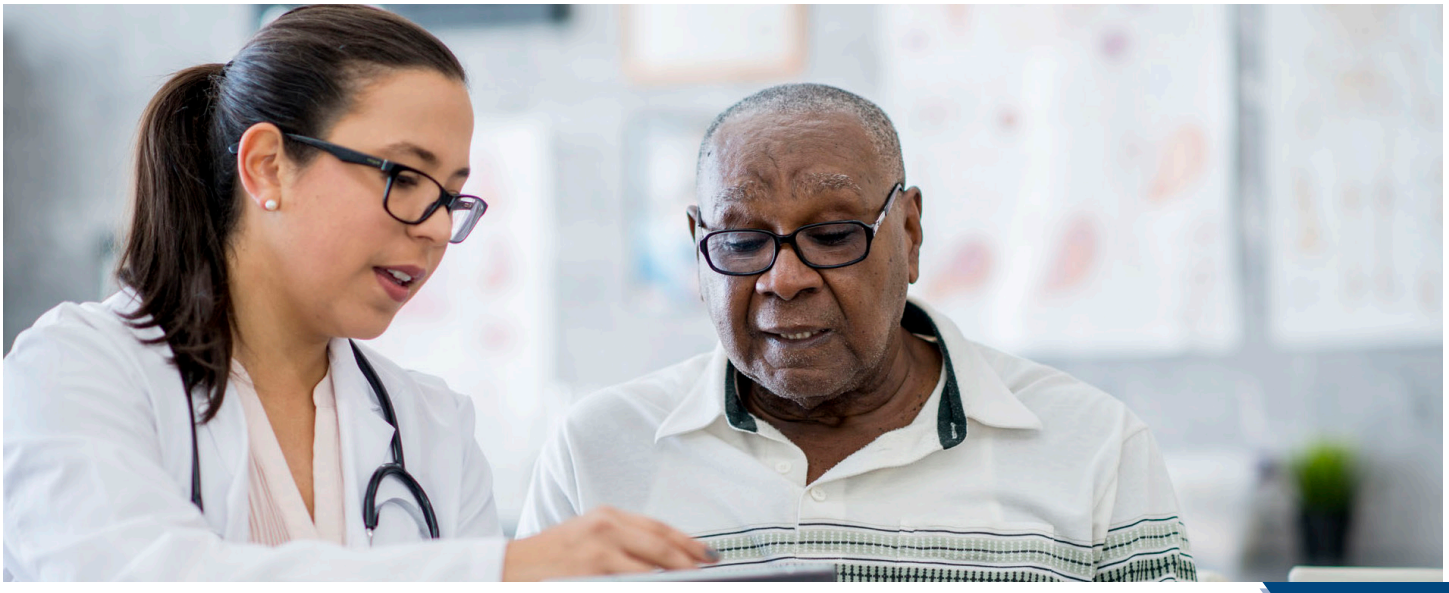
Understanding the CAHPS Survey and Improving the Patient Experience

The Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey is a patient experience survey that asks consumers to report on and evaluate their experiences with health plans, providers, and healthcare facilities. This survey is performed once a year on a sub-set of members to gauge their experiences. The survey questions cover aspects of care for which the patient is the best and only source of information. We use CAHPS surveys to assess the quality of the health plan and develop sound strategies that health plans and providers can collaboratively use to improve patients' experiences with care.

Beginning in 2022, the weight of CAHPS measures (from a Medicare Stars perspective) will increase to four times the weight of previous years – only further indicating the importance of the member's experience. To continue to improve the member's experience, below are a few tips on ways that you as a medical group can help!

Top tips:

- Reduce wait time perception (check on a patient, give them a health brochure to read, etc.).
- Offer to help schedule appointments with specialists or show patients what to do if the next available appointment time cannot be scheduled within a timeframe appropriate to their level of care needs.
- Review prescriptions with every patient.
- Suggest 90-day refill and home delivery services as convenient ways to receive prescriptions.
- Ask for a call back if the patient cannot fill a prescription to help them assess their next steps.
- Stay informed on patients' specialty care.
- Clearly identify a platform or way that the patient will receive their test results.
- Reserve priority appointment spots for new Medicare patients.



Key CAHPS Questions Optima Medicare is Focused on:	
CAHPS Measures	**Related Questions**
Getting Needed Care	In the last six months, how often was it easy to get the care, tests, or treatments you needed?
	In the last six months, how often did you get an appointment to see a specialist as soon as you needed?
Getting Appointments and Care Quickly	In the last six months, when you needed care right away, how often did you get care as soon as you needed?
	In the last six months, how often did you get an appointment for a check-up or routine case as soon as you needed?
	In the last six months, how often did you see the person you came to see within 15 minutes of your appointment time?
Care Coordination	In the last six months, when your personal doctor ordered a blood test, X-ray, or other test for you, how often did someone from your personal doctor's office follow-up to give you those results?
	In the last six months, when your personal doctor ordered a blood test, X-ray, or other test for you, how often did you get those results as soon as you needed them?
	In the last six months, how often did your personal doctor seem informed and up-to-date about the care you got from specialists?

Stars Measure Performance

With only a few months remaining in the performance year (ends December 31), it is imperative that our members get the necessary gaps closed. We have highlighted a few focus measures below for your review.

Annual Flu Vaccine	
Key Points:	Procedure Codes for Filing Claims:
• Remind members that they are eligible for a reward if they receive their annual flu shot. • Talk with members about the importance of receiving the flu vaccine. • Talk with members about the health risks related to flu when additional health concerns are noted.	• G2163, G8482

Quality Improvement

Controlling Blood Pressure:	
Key Points: • Talk with members about what a lower goal is for a healthy blood pressure reading. • Be sure to record the blood pressure in the medical record. • Controlled blood pressure is <140 systolic and <90 diastolic. • Be aware that the new guidelines allow self-reported blood pressures to be documented in the EMR during telehealth visits as long as the blood pressure was taken with a digital machine in the home.	Documentation Requirements: • If a blood pressure 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 blood pressure reading. • Member self-reported blood pressure 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 Health 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: blood pressure >= 140 • 3074F: systolic < 140 • 3080F: diastolic >=90 • 3079F: diastolic 80-90 • 3078F: diastolic < 80 • Remote blood pressure monitoring: 93784, 93788, 93790, 99091, 99453, 99454, 99457, 99473, 99474

Osteoporosis Management in Women Who Had a Fracture:

Key Points:

This impacts women 67 to 85 years of age as of December 31 of the measurement year.

Exclusions:

- women in hospice
- women who had a bone density test during the 730 days prior to the episode date
- women who received a dispensed prescription or had an active prescription to treat osteoporosis during the 365 days prior to the episode date
- women who received palliative care during the intake period through the end of the measurement year
- women who are enrolled in an institutional SNP any time during the measurement year or living long term in an institution any time during the intake period through the end of the measurement year

Documentation Requirements:

- CMS requires health plans to report treatment as a quality measure. Therefore, it is encouraged to have appropriate follow-up within six months after the diagnosis of a fracture and documentation provided in the patient's medical record.
- Appropriate follow-up may include completing a bone mineral density test and/or beginning treatment for osteoporosis with documentation provided in the patient's medical record.

CPT Category II Codes for Filing Claims:

- 77080 & 77081: DEXA bone density test
- 77078, 77081, 76977, & G0130: screening for osteoporosis

Important Phone Numbers

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 with 60 days' notice, 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 can now update their information electronically using our Provider Update Form. Please note that, **effective November 1, 2021**, we will discontinue 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!