Sentara®
Health Plans

Provider Newsletter

Winter 2024

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Health Plans

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Welcome to Sentara Health Plans

As of January 1, 2024, Optima Health and Virginia Premier consolidated under our new name, Sentara Health Plans. This transition seamlessly transfers all agreements and responsibilities to Sentara Health Plans, reflecting our growth, resilience, and commitment to innovation. Despite the name change, our dedication to delivering top-quality healthcare remains unwavering. Stay informed through our provider newsletter and email alerts, and visit **sentarahealthplans.com/providers** for details.

As a reminder, please update your accepted insurance lists and all internal collateral to reflect our name change to Sentara Health Plans.

Our core mission, "We Improve Health Every Day," remains unchanged, propelling us toward a healthier future. Thank you for your continued support and collaboration.

2024 Welcoming Baby Update

OB Registration Program:

Providers are eligible to receive a $25 incentive for referring pregnant patients to Sentara Community Plan's Welcoming Baby member outreach team upon identification of pregnancy.

All providers need to do is fill out a **Welcoming Baby OB Registration Form** and fax it to Outreach at **1-804-799-5117** and submit a claim using the code G9001.

Welcoming Baby℠

Welcoming Baby is Sentara Community Plan's incentive-based maternal healthcare program for our members. It includes:

- pregnant members from conception
- birth
- postpartum care up to 12 months
- Watch Me Grow outreach to 15 months postpartum

What do your patients receive from this program?

- one-on-one supportive services from a certified community health worker (outreach representative)
- screening and referral to maternity case managers/ care coordinators for care planning and goal setting
- education: community referrals for identified needs
- family planning: long-acting reversible contraception (LARC) and birth spacing education
- baby showers (virtual and in person)
- breast pumps
- maternal/child education series classes
- referrals to parenting and breastfeeding classes and lactation services
- hospital tours (virtually and in person)
- OB Provider Registration Program
- timeliness of care incentives

Welcoming Baby Outreach Team:
Monday–Friday, 8 a.m.–5 p.m.
Phone: **1-844-671-2108 (TTY: 711)**
Email: **welcomingbaby@sentara.com**

Timeliness of Care:

Our members are encouraged to seek timely and consistent prenatal and postpartum care with their providers! Through the Welcoming Baby Program, members receive reminders and education. There are also incentives available if they receive their first prenatal visit within 42 days of enrolling with Sentara Community Plan (or within their first trimester). Members receive reminders and education and are eligible for an incentive if they receive their timely postpartum provider visit (within 7–84 days of giving birth).

Payspan Update: Remit Consolidation

Effective January 1, 2024, consolidated remits will be listed in Payspan for all lines of business that are processed on the QNXT claim payment platform. This update includes the consolidation of negative balances.

- Former Virginia Premier Health Plan users will be required to utilize their new Payspan sign in.
- Sentara Health Plans users will access their current Payspan sign in.

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DMAS Updates

- Electronic Visit Verification (EVV)
- OB/GYN Providers - Doula Balance Billing
- 2024 Medicaid Value Performance Program Update

Electronic Visit Verification (EVV)

The Department of Medical Assistance Services (DMAS) has extended the Electronic Visit Verification (EVV) requirements for Home Health Care Services (HHCS) go-live date from **December 1, 2023, to January 1, 2024**. Soft edits were implemented for noncompliance claims beginning July 1, 2023, in an effort to help prepare and educate providers. Effective January 1, 2024, claims not compliant with the EVV requirements will be denied. Sentara Health Plans providers may choose an EVV system that best suits their needs if it meets the requirements outlined by DMAS. The following HHCS billing codes must use EVV:

REV Codes:

- 0550 Skilled Nursing Assessment
- 0551 Skilled Nursing Care, Follow-up Care
- 0559 Skilled Nursing Care, Comprehensive Visit
- 0571 Home Health Aide Visit (no PA required)
- 0424 Physical Therapy, Home Health Assessment
- 0421 Physical Therapy, Home Health Follow-up Visit
- 0434 Occupational Therapy, Home Health Assessment
- 0431 Occupational Therapy, Home Health Follow-up Visit
- 0444 Speech-Language Services, Home Health Assessment
- 0441 Speech-Language Services, Home Health Follow-up Visit

No other revenue codes will require EVV.

For more information on EVV, please visit the DMAS website and review the 837I companion guide. This guide is important for your billing systems to submit HHCS claims compliant with Virginia's EVV requirements. For technical assistance on EVV claims, please email **editeam@sentara.com**.

OB/GYN Providers - Doula Balance Billing

The Department of Medical Assistance Services (DMAS) notified Sentara Health Plans that they are continuing to receive complaints that some providers are charging members for completion of the Doula Recommendation and Verification of Pregnancy forms required to access doula care. This is considered balance billing.

Please be reminded that it is not permissible to balance bill Medicaid members for covered services. Providers must reimburse members who have been charged for the completion of the Doula Recommendation and Verification of Pregnancy form—a covered Medicaid service.

If you have any questions regarding this notice, please contact your assigned network educator at **1-877-865-9075**, option 2.

2024 Medicaid Value Performance Program Update

For providers participating with our Medicaid Value Performance Program, DMAS Performance Withhold Program (PWP) measures, weights, and calculations will remain constant for the 2024 calendar year.

Sentara® Health Plans

Quality Improvement

- Dr. Melvin T. Pinn Quality Excellence Award
- Medicare Patient Experience Tips for Success
- 2024 Healthy Rewards
- Tips To Improve the Rate of Well-care Visits for Children Ages 3–21
- Provider Quality Care Workgroup
- Time To Prepare for HEDIS® Medical Record Review

Dr. Melvin T. Pinn Quality Excellence Award

Formerly known as the Practitioner Golden Globe Award, this prestigious award is newly named the ***Dr. Melvin T. Pinn Quality Excellence Award***, in honor of the late Dr. Melvin T. Pinn who established this award in 2006 for former Virginia Premier providers. This award was created to recognize physicians for demonstrating their commitment to quality care. Sentara Health Plans will continue this legacy and annually recognize an outstanding participating practitioner who promotes safe clinical practice and delivery of quality care and who voluntarily broadens his or her scope of practice through education and community involvement. Contracted and/or affiliated physicians, physician office staff, and members are encouraged to complete the nomination form located on the Sentara Health Plans website for review and consideration to be recognized for ***Quality Excellence.***

Nominations for this prestigious award will be accepted throughout the measurement calendar year from January 1 through December 31 and will be awarded the following award year after all nominations are reviewed annually. The quality department will select the winner of this award based on improving outcomes for the HEDIS information supplied in the nomination. The winner will be announced through our provider and member newsletters. Additionally, a press release will be issued to local newspapers in recognition of the award recipient. In honor of the practitioner, Sentara Health Plans will provide an office site team luncheon, as a token of appreciation for the delivery of optimal care and improving outcomes for our members.

Sentara Health Plans is honored to continue this legacy. Please take a brief moment to complete the nomination form to elect a deserving physician who you feel is the epitome of ***Quality Excellence*** and goes the extra mile for their patients and the community. The Sentara Health Plans quality department is waiting to receive your nomination and is excited to present this award to the next award recipient!

Medicare Patient Experience Tips for Success

Why is patient experience important?

Focusing on patient experience can lead to patient retention and improved health outcomes. Patients want their healthcare experience to be seamless, easy, and like their other consumer experiences.

The Centers for Medicare & Medicaid Services (CMS) administers patient experience surveys as an important part of the evaluation of health plan performance. One survey conducted each year is the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey. The 2024 survey starts in March and collects data directly from members to evaluate their experience and satisfaction with the health plan, providers, and their care.

CAHPS Fast Facts:

- Results from CAHPS are used toward the health plan's overall Medicare Stars rating.
- The questions cover important aspects of the patient's experience with access and quality of care from their providers.
- Using results from CAHPS can allow health plans and providers to work together to improve patient experience and health outcomes.

Tips for how providers help improve their patients' experience:

Getting Appointments and Care Quickly

- Develop new patient onboarding processes to ensure high-risk patients are seen quickly.
- Encourage patients to use telehealth appointments and explain how it can help them manage their care.

Getting Needed Care

- Educate patients on other ways to access care, such as nurse advice lines, after-hours call service, secure email, or telehealth.
- Offer to help schedule specialist appointments, or tell patients what to do if the next available appointment time is longer than their level of care requires.

Care Coordination

- Promote patient portals or mobile apps that give patients access to manage their care.
- Be clear and specific with patients about how they will receive their test results.

A Focus on Health Equity:

The CMS Final Rule, published in spring of 2023, finalized the Health Equity Index Reward to incentivize Medicare Advantage and Part D plans to focus on improving care for members with social risk factors, such as low income and disability status.

Individuals with low income or disability may be facing:

- limited education
- food insecurity
- lack of social support
- lack of digital access
- lack of transportation
- functional limitations

Data from 2021 shows that former Optima Medicare members receiving a low-income subsidy (LIS) or with disability fared worse than those without LIS or disability on many important HEDIS measures:

Diabetes Care – Blood Sugar Controlled:

- LIS 21% lower than non-LIS
- disabled 14% lower than nondisabled

Breast Cancer Screening:

- LIS 15% lower than non-LIS
- disabled 12% lower than nondisabled

Colorectal Cancer Screening:

- LIS 17% lower than non-LIS
- disabled 9% lower than nondisabled

Controlling Blood Pressure:

- LIS 11% lower than non-LIS
- disabled 4% lower than nondisabled

Patient-centered Practices for Improving the Care of Individuals With Social Risk Factors:

Incorporate reminders and recall systems to flag at-risk participants. Consider a biopsychosocial approach, and trigger more holistic care.

- Treat patients with dignity and respect and create safe spaces for disclosure. Be open to different cultural backgrounds and avoid stereotyping.
- Take a few extra minutes per consultation to address complex health and social needs. Increasing consultation time by two to three minutes can improve patient enablement.
- Maintain a locally relevant and user-friendly internet directory of community resources so that practitioners and office staff can better support patients.

Sources: *ahrq.gov/health-literacy/improve/precautions/tool10.html ncbi.nlm.nih.gov/pmc/articles/PMC2688060/ pubmed.ncbi.nlm.nih.gov/18252071/ ncbi.nlm.nih.gov/pmc/articles/PMC3080219/*

2024 Healthy Rewards

Sentara Medicare's Healthy Rewards are a way for members to earn gift cards for completing healthy actions and activities. Remind your patients that they may be eligible for rewards for completing certain screenings and tests.

Please note that the Annual Wellness Visit (AWV) reward has increased in value for 2024, and you may experience an influx of patients attempting to schedule these appointments. We recommend completing the AWV in the first six months of the year to allow time for testing and follow-ups resulting from that appointment. Sentara Medicare allows the AWV to be scheduled each calendar year, and there is no requirement for members to wait 365 days between visits so long as they are in different years.

Here are some of the rewards Sentara Medicare is offering for 2024:

Reward Category	Reward Amount	Reward Type	Eligibility* Excludes Savings Members	Quick Notes
Advance Care Planning	$25	Grocery Reward	All members	Captured through provider claim.
Annual Wellness Visit	$50–$100	Grocery Reward	All members	
Bone Density Scan (Osteoporosis)	$25	Standard Reward	Females ages 65+	
Breast Cancer Screening	$50	Standard Reward	All members	
Colorectal Cancer Screening	$25	Standard Reward	All members	At-home testing kits are eligible.
Diabetic Management	$40	Standard Reward	Members with diabetes	Must complete three screenings/ exams: Diabetic Eye Exam, Diabetic HbA1c Test, Diabetic Kidney Monitoring. At-home testing or exam are eligible.
Post Hospital Discharge Visit	$25	Standard Reward	Members with hospital inpatient admission. Visit must be completed within 30 days.	Follow-up visit can be with PCP or nurse.

Key Notes

- ***Sentara Medicare Savings (HMO) members are not eligible for Healthy Rewards.**
- ***Check additional eligibility notes for each reward.**
- Advance Care Planning and Annual Wellness Visit are grocery rewards and can only be used to purchase approved grocery item at approved locations. All other rewards are standard and can be used to purchase nearly anything.
- Rewards cannot be used to buy tobacco or alcohol. Rewards cannot be converted to cash.
- Members can only receive one reward per applicable service per year.
- Rewards take 8–10 weeks to process following the receipt of the claim.
- Services must be completed in 2024 using in-network providers.

Tips To Improve the Rate of Well-care Visits for Children Ages 3–21

Below are a few tips providers should consider to help improve the rate of well-care visits for children ages 3-21:

- Offer well-care appointments outside of standard business hours one or two evenings a week or on a weekend day by allowing a provider to flex their hours to cover these. This allows parents to come in during nonwork hours and students to be present for school and after-school activities.
- Consider what well visits are called by clinic staff: the term "well-child" visit may be off-putting to preteens and older children.
- Parents report that clinic reminders get attention—especially text messages. Provide information on how parents can opt in for text messaging reminders.
- Informal research suggests that reminders sent out three weeks in advance, with reminders three days and three hours in advance, are effective in getting appointments rescheduled and reducing missed appointments.
- Clinics report that including a link or phone number in a text or email to contact scheduling is highly successful.
- Keep in mind that parents may attempt to schedule appointments on their work break. Monitor hold time needed to reach a scheduler.
- Schedule the next well-care visit as soon as they check in for any appointment. Give schedulers and receptionists the ability to tell when a well-care visit is needed. If a well visit is needed, it can be scheduled during the check-in process when parents are less hurried and children are likely to be more cooperative.
- Allow scheduling the next annual checkup at this year's checkup.
- Make "no show" reminders friendly, and use them to build the relationship with the patient/parent. Frame them as the "[Provider Name] missed you and wants to be sure you are okay. They also want to check and see when would be good to reschedule."

- When a well-child visit is due, let the nurse and/or provider know so it can be mentioned to the parent/guardian; if one has been scheduled, have the nurse and/or provider comment that they see it is scheduled and are glad to know that the parent/guardian is practicing preventive care to ensure the child is on target and growing in all the right ways.
- Mention that managed care organizations (MCOs) offer incentives to the patient or parent. Sentara Health Plans offers a $25 gift card to **Medicaid** and marketplace members.

Time To Prepare for HEDIS® Medical Record Review

Each year, Sentara Health Plans performs a review of a sample of our members' medical records as part of the HEDIS[1] quality review study. HEDIS is part of a nationally recognized quality improvement initiative and is used by the Centers for Medicare & Medicaid Services (CMS), the National Committee for Quality Assurance (NCQA), and several states to monitor the performance of MCOs.

We will begin requesting medical records for 2023 in February 2024. No special authorization is needed for you to share member medical record information with us, since HEDIS is a quality improvement initiative and is a routine part of healthcare operations.

HEDIS review is time sensitive, so please submit the requested medical records within the time frame that will be indicated in the initial HEDIS request letter sent to your office. **Per NCQA's timeline, the data submission deadline for all HEDIS data collection is May 3, 2024.**

Please feel free to contact the Sentara Health Plans quality improvement office at **757-252-8400** or toll-free at **1-844-620-1015** if you have any questions. We greatly appreciate your continued participation in providing high-quality care to Sentara Health Plans members.

Provider Quality Care Workgroup

Why are care gaps important? Is your staff aware of the value of closing care gaps? Look out for our Provider Quality Care Workgroup Sessions coming in 2024. Closing care gaps is crucial and has a direct impact on your patients', our members', healthcare outcomes. We encourage your designated quality subject matter expert(s), key clinical representative(s), and other staff members to join us virtually and learn how you can identify and address care gaps effectively. Find out how you can decrease no-shows, improve health outcomes by educating and engaging members, and emphasize the vital role preventive care plays in long-term health and overall quality of life.

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

Sentara® Health Plans

Authorizations, Medical Polices, and Billing

- Brain Injury Services (BIS) Update
- Sentara Health Plans Payment Policies Update
- Primary Coordination of Benefits (COB) for Dual-eligible Special Needs Plan (D-SNP) Members
- New Quarterly CPT/HCPCS Codes
- New Annual CPT/HCPCS Codes, Effective January 1, 2024
- New Sentara Health Plans Provider Web Portal
- Behavioral Health Code Updates for Medicaid
- Prior Authorization Updates, Effective April 1, 2024
- Authorization Updates
- Offshore Attestation

Brain Injury Services (BIS) Update

Effective January 1, 2024, Sentara Health Plans launched its targeted case management service—Brain Injury Services (BIS)—which aims to develop the ability to achieve the desired lifestyle for those who have sustained a severe traumatic brain injury and meet the medical necessity criteria.

The BIS Case Management Program is designed to coordinate services and provide a person-centered plan for members who have suffered a traumatic brain injury. Among the services offered are targeted case management, medical and behavioral health, social, educational, employment, residential, and other essential support for living in the community.

The member eligibility requirements are:

- must be age 18 or older and reside in the community with a physician-documented diagnosis of traumatic brain injury (TBI)
- must meet MPAI-4 scoring requirements

There are two procedure codes associated with this benefit, and prior authorization is required:

- S0280: Initial assessment code, which is reassessed every six months or 180 days
- S0281: Continuation of services for Brain Injury Services

For more information on Brain Injury Services, please refer to the **DMAS BIS Provider Information Sheet** and the DMAS manual for additional billing requirements, service limitations, exclusions, and provider criteria.

Sentara Health Plans Payment Policies Update

Sentara Health Plans successfully published our payment policies on November 1, 2023, through the provider portal. The payment policies include acceptable billing and coding practices to assist in accurate submission of claims. Providers must ensure they are registered to access the portal before accessing the policies.

The link to access the portal will navigate the user to Compliance 360 where the payment policies are stored for viewing:

Step 1: Navigate to the left sidebar and click on "payment policies."

Step 2: Click on "Access Payment Policies."

Step 3: Search for payment policies in Compliance 360.

Primary Coordination of Benefits (COB) for Dual-eligible Special Needs Plan (D-SNP) Members

When submitting claims for members with both Medicare and Medicaid, always file Medicare as primary. Doing so will avoid processing delays. Claims must include the member's Medicare ID number. Following these steps allows our team to process these claims in a timely manner. If the claim is not filed with the Medicare number first, it will be denied D95, stating the provider needs to resubmit with the Medicare number.

New Quarterly CPT/HCPCS Codes

New CPT and HCPCS codes went into effect October 1, 2023, for drugs, professional services and procedures, supplies, durable medical equipment, and quality measures. Coverage determination and authorization requirements, Medicare and Medicaid, are available via the Prior Authorization List on the Sentara Health Plans website.

- 47 new HCPCS codes
- 19 new CPT codes
- 8 description changes
- 69 deleted codes
- 64 COVID-19 codes termed effective November 1, 2023
- 5 codes termed effective October 1, 2023

Note: Code changes and deleted codes are also updated on the **Sentara Health Plans website.**

New Annual CPT/HCPCS Codes, Effective January 1, 2024

New CPT and HCPCS codes became effective January 1, 2024, for medicine, proprietary lab analyses, surgery, radiology, drugs, professional services and procedures, supplies, durable medical equipment, and quality measures. Nine codes became effective January 2, 2024. Coverage determination and authorization requirements for both Medicare and Medicaid are available via the Prior Authorization List on the Sentara Health Plans website.

- 343 new HCPCS codes
- 145 new CPT codes
- 248 description changes (CPT and HCPCS combined)
- 171 deleted codes (CPT and HCPCS combined)
- codes termed effective December 31, 2023

Note: Code changes and deleted codes are also updated on the **Sentara Health Plans website**.

New Sentara Health Plans Provider Web Portal

The Sentara Web Portal **Prior Authorization List (PAL) Tool** is now available on our website.

Please note that code changes and deleted codes that went into effect January 1, 2024, were updated on the portal. Any changes to code descriptions and/or deleted codes prior to January 1, 2024, will require providers to access the corresponding legacy PAL by selecting the appropriate radio button for that specific plan.

Behavioral Health Code Updates for Medicaid

The codes listed below have been updated to reflect No Authorization Required until the limit has been reached, effective date January 1, 2024.

Procedure Code–Code Description:

H0040 – Assertive Community Treatment Program Per Diem

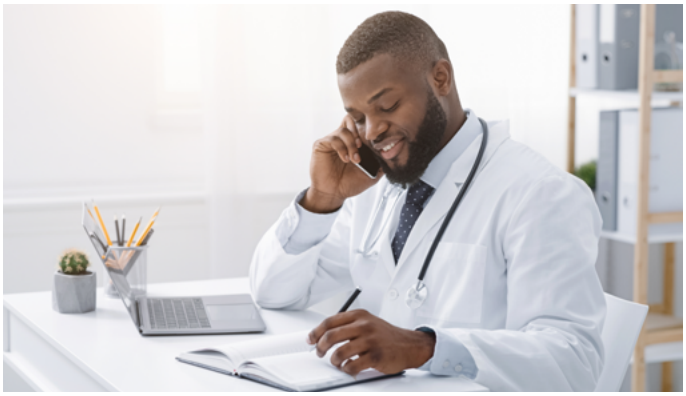
H0036 – Functional Family Therapy (FFT)

H2033 – Multisystemic Therapy (MST)

Providers may access the **PAL tool** for the most recent update to authorization requirements.

Prior Authorization Updates, Effective April 1, 2024

Authorization requirements for 74 CPT/HCPCS codes are listed on sentarahealthplans.com to reflect Authorization Required, effective April 1, 2024.



Authorization Updates (changes will go into effect 60 days from provider notification)

In keeping with CMS Final Rule 4201F, Sentara Health Plans will be archiving applicable Medicare policies in favor of utilizing the NCD/LCD when appropriate. **Visit our website to view the most recent authorization updates.**

Sentara Health Plans has a new medical policy weblink available to access all current behavioral health, durable medical equipment, imaging, medical, obstetrics, pharmacy, and surgical polices. You can access this at **sentarahealthplans.com/providers/clinical-reference/medical-policies**.

Offshore Attestation

CMS requires all providers and vendors, any contractor or subcontractor, to disclose the use of an offshore entity through an attestation process. If you perform or subcontract with an entity located offshore, we require you to complete an attestation and disclosure form. An offshore subcontractor is defined by CMS: "The Centers for Medicare & Medicaid Services (CMS) defines an offshore subcontractor as the following: The term 'subcontractor' refers to any organization that a Medicare Advantage Organization or Part D sponsor contracts with to fulfill or help fulfill requirements in their Part C and/or Part D contracts. Subcontractors include all first-tier, downstream, and/or related entities. The term 'offshore' refers to any country that is not one of the fifty United States or one of the United States territories (American Samoa, Guam, Northern Marianas, Puerto Rico, and Virgin Islands). Examples of countries that meet the definition of 'offshore' include Mexico, Canada, India, Germany, and Japan."

If you engage in offshore activities or subcontracting that involves the transmission, handling, storing, receiving, or accessing protected health information, you need to complete an attestation and submit it to the health plan. If you do not, then please complete the form responding to the first two questions as "no."

Please visit our website to download the form. Upload your completed form to the provider portal.

Sentara®
Health Plans

Pharmacy

- Pharmacy: 90-day Fill Reminder
- Pharmacists as Providers Initiative
- Pharmacy Formulary Updates

Pharmacy: 90-day Fill Reminder

We understand the importance of convenience and consistency in managing your patients' health. The 90-day refill process is designed to provide convenience for individuals who take maintenance medications regularly. Use of 90-day fills to treat chronic conditions can help minimize multiple pharmacy visits and costs and improve adherence.

Once it is determined that a maintenance medication is well-tolerated, effective, and at the proper dose, it is recommended to provide a 90-day prescription with refills for the next year.

If your patients have a hard time with losing their medications, reinforce the importance of safeguarding their supply. Encourage patients to keep track of their doses and take their medications regularly and as prescribed. The benefits of improved adherence outweigh the costs of potentially lost medications as many generics are inexpensive.

Tips:

- Screen your patients for financial burdens that may decrease adherence.
- Use 90-day fills to reduce practice refill burden and improve patient adherence and cost savings.
- Refer patients who require more intensive support to Sentara Medicare for assistance.

Pharmacists as Providers Initiative

In accordance with the provisions of § 54.1-3303, effective January 1, 2024, for Medicaid and commercial members, Virginia law allows pharmacists to initiate treatment with, dispense, or administer certain drugs and devices to members 18 years of age or older with whom the pharmacist has a bona fide pharmacist-patient relationship in accordance with a statewide protocol developed by the Board in collaboration with the Board of Medicine and the Department of Health and set forth in regulations of the Board.

Pharmacists who initiate treatment with, dispense, or administer a drug or device in accordance with state law should counsel members regarding the benefits of establishing a relationship with a primary healthcare provider. To provide medical services, pharmacists must meet Sentara Health Plans contracting and credentialing requirements.

Pharmacy Formulary Updates

The Sentara Health Plans Pharmacy and Therapeutics Committee (P&T) meets at least bimonthly to provide strategic clinical direction on formulary management and clinical programs. Clinical recommendations made by the committee may result in drug formulary placement updates. These updates help ensure that the most clinically appropriate, cost-effective formulary drugs remain accessible and that contractual obligations are maintained.

Formulary updates for our commercial, exchange, FAMIS, Medicaid, and Medicare lines of business can be found on our **website**.

Once at the **'Formularies and Drug Lists'** page, choose the appropriate line of business. **The 'Quarterly Pharmacy Changes' document(s) are updated quarterly.** Updates are posted a minimum of 60 days prior to implementation.

Sentara® Health Plans

Important Updates and Reminders

- PRSS
- Register for Our Upcoming Webinars

PRSS

To best serve you and our members, it is important that we have up-to-date information about your practice. Please notify Sentara Health Plans as soon as possible of any changes related to your practice's operations or provider roster.

Providers are required to notify the health plan with a copy of the approval letter via the provider update process (for nondelegates) when they enroll with PRSS.

Update your information on our website.

Register for Our Upcoming Webinars

Mark your calendars to join our upcoming quarterly educational sessions. **Visit our website** to learn more and register. Presentations from previous sessions are also available.

Medical Provider Touchpoint

- February 6, 2024 - 10 a.m.
- February 13, 2024 - 1 p.m.

Let's Talk Behavioral Health

- February 14, 2024 - 1 p.m.

Claims Brush-up Clinics

- March 13, 2024 - 1 p.m.