Q3 2023- SUMMER

providerNEWS

OptimaHealth

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Optima Health News

Optima Health Welcomes Former Virginia Premier Providers

On July 1, 2023, Optima Health Plan assumed the rights and obligations of the Virginia Premier provider agreements, which remain in effect. We will continue to serve former Virginia Premier Medicaid members, now known as "**Optima Health, Group Number: VP**" as well as Virginia Premier Advantage Elite (DSNP) members.

For additional details about this merger, please visit: **optimahealth.com/providers/provider-support/transitioning-providers/transitioning-virginia-premier-providers.**

While we have endeavored to address matters impactful to your business operations, we are here to answer your questions. Please contact your network educator at **1-877-865-9075**, option 2.

We appreciate your assistance in serving our members to meet their healthcare needs and we are excited about this next step in our evolution for both our members and our providers.

Optima Health Appointment Standards

To ensure the best health for our members, Optima Health participating providers should adhere to the following appointment standards:

Service	Medicaid Standard
Emergency Appointments, including Crisis Services	immediately upon the member's request
Urgent Appointments	within 24 hours of the member's request
Routine Primary Care	within 30 calendar days of the member's request. Standard does not apply to appointments for routine physical examinations, regulary scheduled visits to monitor a chronic medical condition if the schedule calls for visits less frequently than once every 30 days, or routine specialty services like dermatology, allergy care, etc.
Maternity Care- First Trimester	within seven calendar days of requests
Maternity Care- Second Trimester	within seven calendar days of requests
Maternity Care- Third Trimester	within three business days of requests
Maternity Care- High-risk Pregnancy	within three business days of high-risk identification, or immediately if emergency arises
Postpartum	within 60 days of delivery
Mental Health Services	as expeditiously as the member's condition requires and within no more than five business days from Optima Health's determination that coverage criteria are met
LTSS	as expeditiously as the member's condition requires and within no more than five business days from Optima Health's determination that coverage criteria are met

Optima Health News

Where To Go for Urgent Care Needs

In recent months, we have noticed an increase in the number of members with low acuity, non-emergent conditions visiting the emergency department. We are finding that members are being advised to return to the emergency department multiple times for follow-up after the initial visit rather than being referred for follow-up with their primary care physician or wait a certain number of days after being seen in the emergency department before they can be seen in their primary care physician's office.

As a result, we have recently reminded Optima Health members to:

- **Call a nurse for free, 24/7** to find out what kind of doctor to see. The number for the Nurse Advice Line can be found on the back of the member's ID card.
- **Contact their PCP first when they start to feel sick** with symptoms such as sore throat or fever, or when they have questions about their medications, to name just a few scenarios.
- Visit the nearest **urgent care center** or take advantage of **telehealth** platforms when seeking care outside normal office hours or after visiting the emergency room.
- **Remain in touch with their primary care physician** when they receive care from other providers.

Pharmacy Travel Essentials

Time spent away from home can increase during the summer months and potentially decrease regular patient trips to the pharmacy. Successful strategies to improve medication adherence during this time include nurturing a relationship with patients. Remind patients of the importance of refilling their medications and reviewing medication instructions. Whether they are taking a three-day or a three-month trip, your patients must take their medicine on time and follow their routine.

With their pharmacy benefits, members can get 90-day supplies of maintenance medications delivered right to their door from Express Scripts® Pharmacy. Ensure they are informed about 90-day supplies and have a reminder mechanism before leaving.

How a patient stores their medication is also essential. It's one thing to pack medication for a trip and another to keep track of it at hotels, inside luggage, and in multiple vehicles. You can recommend different travel medication containers and bags that stand out and are harder to miss when packing up belongings.

Optima Health News

Statin Use in Persons With Diabetes (SUPD)

We're grateful for the steps you take to help your patients avoid complications from diabetes. If you determine a statin medication is appropriate, please send a prescription to the member's preferred pharmacy and request a pickup consultation. To close the SUPD care opportunity, members must use their insurance card to fill their prescriptions in any strength and dose by the end of the measurement year.

- Educate patients on the importance of statin medications for people with diabetes in reducing cardiovascular risk, regardless of cholesterol levels.
- Identify and resolve patient-specific adherence barriers or concerns, such as side effects, cost, and timely refills.
- Communicate that statin use should accompany lifestyle modifications focused on diet and weight loss to improve cholesterol reduction.
- Be aware that medication samples, when given, interfere with pharmacy claims and produce false nonadherence results.
- Encourage the use of pill boxes or medication organizers.

COVID-19 Updates

As of April 18, 2023, the monovalent Moderna and Pfizer-BioNTech COVID-19 vaccines 0001A, 0002A, 0003A, 0004A, 0011A, 0012A, 0013A, 0051A, 0052A, 0053A, 0054A, 0064A, 0071A, 0072A, 0073A, 0074A, 0081A, 0082A, 0083A, 0091A, 0092A, 0093A, 0094A, 0111A, 0112A, 0113A, 91300, 91301, 91305, 91306, 91307, 91308, 91309, 91311 are no longer authorized for use in the United States.

Click here for more information.

Additional resources:

- COVID-19 CPT vaccine and immunization codes | American Medical Association
- COVID-19 Vaccines and Monoclonal Antibodies | CMS
- CPT Assistant guide: Coronavirus (SARS-CoV-2); May 2023 | AMA

As of April 18, 2023, there are six new COVID-19 bivalent codes 0121A, 0141A, 0142A, 0151A, 0171A, 0172A.

For additional information, please visit ama-assn.org/system/files/vaccine-long-descriptors.pdf.

COVID-19 FAQs Updated for Providers

We recently updated our robust list of COVID-19 frequently asked questions (FAQs) document for providers. The Public Health Emergency (PHE) ended on May 11, 2023.

Optima Health News

F/EA Vendor Transition from PPL to CDVA

As of July 13, 2023, Optima Health is transitioning our Fiscal Employer Agent (F/EA) services vendor from Public Partnerships, LLC (PPL) to Consumer Direct Care Network Virginia (CDVA).

CDVA has been providing services in Virginia since 2018.

As an F/EA in Virginia, the CDVA has been providing superior customer service and supporting individuals across the state. They have helped thousands of people all over the country succeed in self-directing their own quality care while remaining in their homes and communities.

Why is Optima Health making this change?

- to provide better member and attendant support with one-call resolution
- to provide leading Electronic Visit Verification (EVV) technology

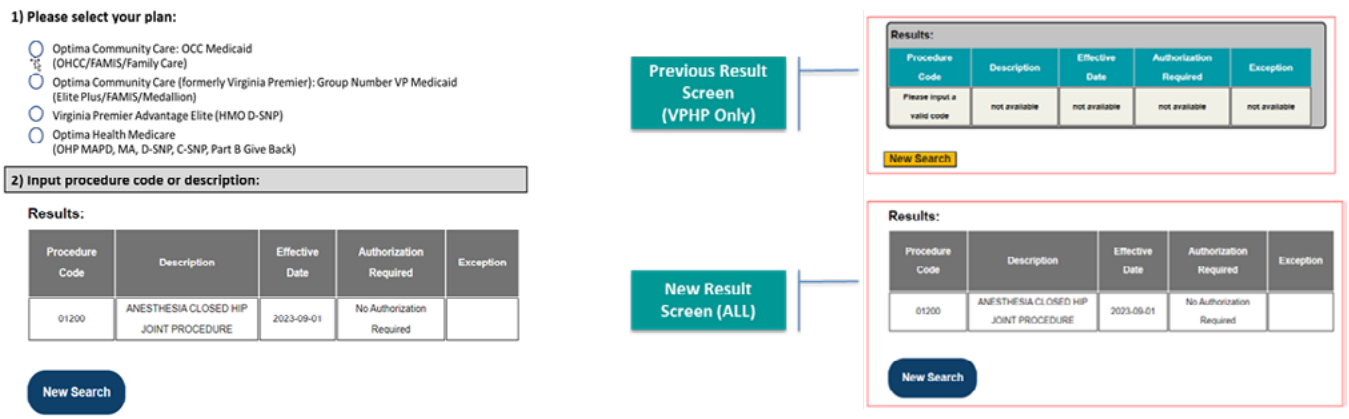
For additional resources and information about Consumer Direct Care Network Virginia, please visit consumerdirectva.com.

Online Prior Authorization List (PAL) Tool Now Available

A new online Prior Authorization List (PAL) tool for identifying authorization requirements is now available on the website. This convenient resource is familiar to former Virginia Premier providers, and we are excited to offer it to Optima Health providers.

The PAL tool is accessible via Provider Connection, our secure portal, and will serve as the source of truth for authorizations. Requirements will be derived from policies and display criteria for each procedure as well as provide determinations for Medicaid or Medicare plans.

Below are images of the tool's design; former Virginia Premier providers will notice a few temporary visual and functional changes



Note: *If the code is managed by a third-party vendor, the results will indicate that you should contact them directly to obtain the authorization.*

DMAS Updates

Transitioning to Cardinal Care

The Department of Medical Assistance Services (DMAS) was notified by the Centers for Medicare & Medicaid Services (CMS) on May 11, 2023, that the Cardinal Care Contract and Technical Manual will be delayed until October 1, 2023. All MCOs will continue business under the Medallion 4.0 and CCC Plus contracts until the Cardinal Care agreement goes live.

The **Optima Medicaid Program Manual** is now available online.

Medicaid Home Health Care Services (HHCS) Electronic Visit Verification (EVV) Project Update

DMAS received a Good Faith Extension from CMS to implement Electronic Visit Verification (EVV) requirements for Home Health Care Services (HHCS) on July 1, 2023.

If you have any questions, please send your inquiry to **EVV@dmas.virginia.gov**.

EVV Requirement for Home Health Care Services

In accordance with the Federal 21st Century Cures Act, Optima Health will require the use of Electronic Visit Verification (EVV) for Home Health Care Services (HHCS), effective **July 1, 2023.**

Providers may choose an EVV system that best meets their needs as long as it meets the requirements outlined by (DMAS).

The following HHCS billing codes must use EVV:

- 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

HHCS claims that did not meet EVV requirements by July 1, 2023, will process with the appropriate EVV error. These soft edits will end on December 1, 2023, and claims with EVV errors will be denied payment.

To learn more, please visit the **DMAS website**.

DMAS Updates

Doula Services

(DMAS) has been made aware that some providers may be charging members for completion of Doula Recommendation and Verification of Pregnancy forms related to access of doula care. DMAS has received complaints from members stating they have been charged by providers to complete forms related to doula services.

It is not permissible to balance bill Medicaid members for covered services. Additionally, providers must reimburse members who have been charged for doula services.

PRSS Enrollment

The Federal 21st Century Cures Act requires all providers, including servicing, ordering, or referring providers, who serve Medicaid members through Managed Care Organization (MCO) networks to enroll directly with (DMAS) through the Medicaid Provider Services Solution (PRSS) Enrollment Portal.

Optima Health is in the process of notifying our impacted members and will assist with aligning members with alternative providers for the continuation of their health needs. Please be advised that per Section 4.04.2 Continuation of Care, of the Agreement, you may be required to provide continuation services until the (i) completion of active treatment, or (ii) Optima Health's orderly transition of members to another provider.

Requests for authorization of member benefits are coordinated by the utilization management department. For more information, please call **1-888-251-3063**.

Instructions to complete this mandatory process are as follows:

1. Find the enrollment application by going to the new PRSS Enrollment Portal: virginia.hppcloud.com/.
2. Click on **"Menu"** in the top left corner, select **"Provider Enrollment,"** and then choose **"New Enrollment."**
3. Submit your application to Gainwell Provider Enrollment through the PRSS Enrollment Portal. You may be asked to provide evidence of your submission, so please retain a copy of your application. For questions, please call the PRSS Provider Enrollment Helpline at **804-270-5105** or **1-888-829-5373** or email vamedicaidproviderenrollment@gainwelltechnologies.com.
4. The provider must then notify Optima Health of their DMAS approval and approval date requesting participation with Optima Health Medicaid by submitting a Provider Update Form located at optimahealth.com/provider.

When the form is received by Optima Health, the provider will be updated to participate for Optima Health Medicaid effective as of the DMAS approval/enrollment date.

Quality Improvement

Satisfaction and Access Survey

This summer, our contracted survey vendor, Press Ganey, will perform several surveys of participating providers that will assist Optima Health in identifying and prioritizing service improvements, allocating resources, and meeting the National Committee for Quality Assurance (NCQA) NCQA and government regulatory requirements.

Appointment Access Survey and After-hours Survey: This required survey determines how well providers meet our appointment access standards and after-hours coverage requirements. Press Ganey will perform the appointment access survey during office hours and the after-hours coverage survey by phone for a random sample of providers. Current appointment standards are listed in the Optima Health provider manual, and after-hours coverage requires that a person or recording be in place to immediately direct patients for emergency care.

Provider Satisfaction Survey: A random sample of provider offices will receive mail, an email, and/or a phone call from our vendor, Press Ganey, asking them to participate in our provider satisfaction survey. This survey asks providers to rate the services Optima Health provides to our providers and is an excellent vehicle to anonymously provide feedback and make suggestions for every area of the health plan.

We appreciate the time you take to assist us with these required surveys. Results will be provided in the newsletter along with action plans created to address areas of concern.

Optima Medicare

Our overall goal is to make Optima Medicare a five-star health plan, which will require the support of all clinical and administrative staff as well as the full engagement of our members. The annual wellness visit (AWV) completion is critical for health discussions, advanced care planning, and care gap closure. Health plan members are receiving notification of open gaps that need to be closed by December 31, 2023.

Please prioritize wellness appointment requests to ensure patients receive closure in care gaps.

Quality Improvement

Annual Wellness Visits (AWV) and Annual Physical Exams (APE)

Scheduling these visits early in the year promotes early and regular intervention with the patient, **leading to improved quality outcomes, greater patient engagement, and improved rapport between the provider and patient.** Additionally, increased patient engagement can lead to positive responses on the Consumer Assessment of Healthcare Providers and Systems **(CAHPS)** and Health Outcomes Survey **(HOS)** surveys and reduced time and payout in hospital and outpatient services.

Sentara Health Plans Medicare plans pay for an AWV and an APE to occur at the same time. Below are some highlighted key points to guide these exams:

"Welcome to Medicare" Preventive Visit (IPPE)	Annual Wellness Visit	Annual Physical Exam
Purpose: Review of medical and social history and preventive services education. **Population:** Patients who are new to Medicare **Coverage:** Only once in a lifetime within 12 months of Part B enrollment **Components:** **1.** Past medical and surgical history **2.** Current medications and supplements **3.** Family history **4.** Diet **5.** Physical activities **6.** History of substance use (alcohol, tobacco, and illegal drug use) **7.** Potential depression risk factors (including current or past) **8.** Assess functional/safety abilities **9.** Exam: height, weight, BMI, and BP, Visual Acuity Screen **10.** End of life planning **11.** Education and reference to preventive services: a once-in-a-lifetime screening ECG/EKG, as appropriate **12.** Review of opiod prescriptions **13.** Screen for potential substance use disorders **Codes:** Preventive Visit= G0402, ECG = G0403, G0404, and G0405	**Purpose:** A visit to develop or update a personalized prevention plan and perform a Health Risk Assesment (HRA) **Population:** New or existing patients **Coverage:** Once every year **Components:** **1.** Perform an HRA (only for the patient's first AWV) **2.** Establish medical family history **3.** Establish list of current providers **4.** Measure BMI and BP **5.** Access cognitive function **6.** Potential depression risk factors **7.** Assess functional/safety abilities **8.** Establish screening schedule for patient **9.** Develop list of patient risk factors **10.** End of life planning **11.** Education and reference to preventive services **12.** Review of opiod prescriptions **13.** Screen for potential substance use disorders **Codes:** G043, G0439	**Purpose:** Exam performed without relationship to treatment or diagnosis for specific illness, symptom, complaint, or injury. **Population:** All **Coverage:** Once every year **Components:** **1.** Vital signs **2.** Exam of heart and lungs **3.** Exam of head, neck, and abdomen **4.** Neurological exam **5.** Skin exam **6.** Lab work **7.** Gender-appropriate exams (breast, genitals, reproductive) **Codes:** (select appropriate code per age of patient) New Patient • 99381–99387 Existing Patient • 99391–99397 **SHP Medicare will pay for the AWV and APE as a supplemental benefit in the same visit.**

Quality Improvement

Focus HEDIS Measures

Colorectal Cancer Screening

Measure:
The percentage of patients 45–75 years of age who had appropriate screening for colorectal cancer

Key Points:
The following screening methods meet criteria:

- fecal occult blood test (iFOBT or gFOBT) annually (measurement year)
- FIT-DNA (e.g., Cologuard) test in the past 3 years (measurement year and 2 years prior).
- flexible sigmoidoscopy in the past 5 years (measurement year and 4 years prior)
- CT colonography (e.g., virtual colonoscopy) in the past 5 years (measurement year and 4 years prior)
- colonoscopy in the past 10 years (measurement year and 9 years prior)

Tips:

- Address patient's fears and anxiety regarding testings.
- Offer FIT testing as an alternative to other screening methods.
- Pre-visit plan for all routine encounters to determine if screening is due and discuss, even if visit is not due to annual check-up.
- Emphasize the importance of this issue with frequent reminders.

Documentation Requirements:
Documentation in the medical record must include a note indicating the date when the colorectal cancer screening was performed.

A pathology report that indicates the type of screening (e.g., colonoscopy, flexible sigmoidoscopy) and the date when the screening was performed meets criteria.

Exlusions: History of colorectal cancer or total colectomy (must be documented annually), hospice, paliative care, aged 66 or older with a diagnosis of frailty and advanced illness.

CPT Codes for Filing Claims:

- FOBT Codes: 82270, 82274
- FIT-DNA Test Recommendation Codes: 81528
- Flexible Sigmoidoscopy Recommended Codes: 45330–45335, 45337, 45338, 45340-45342, 45346, 45347, 45349, 45350
- CT Colonography Recommended Codes: 74261–74263
- Colonoscopy Recommended Codes: 44388–44394. 44397. 44401–44408, 45355, 45378–45393, 45398

Plan All-cause Readmissions

Measure:
The number of acute inpatient and observation stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days

Key Points:

- Inpatient and observation stays where the discharge date from the first setting and the admission date to the second setting are 2 or more calendar days apart must be distinct stays.
- The measure includes acute discharges from any type of facility (including behavorial healthcare facilities).

Tips:

- Reserve appointment times for post-discharge visits and see patients within 7 days.
- Identify, flag, and prioritize patients who are at risk for readmission.
- Utilize an admission, discharge, and transfer (ADT) program to monitor discharges—put a process in place to contact these patients within 24 hours to get them scheduled for a follow-up if they did not already have a visit scheduled prior to discharge.
- Review discharge instructions with the patient to ensure understanding.
- Review medication changes and provide support and encouragement.
- Advise the patient that he or she may qualify for extra benefits, like rewards through the health plan.

Exlusions:

- The patient died during the stay.
- The principle diagnosis is pregnancy.
- The principle diganosis is a condition originating in the perinatal period.
- A planned hospital stay for any of the following:
  - chemotherapy
  - rehabilitation
  - organ transplant
  - planned procedure without an acute diagnosis

Quality Improvement

Medicare Health Outcomes Survey (HOS)

What is the Health Outcomes Survey? HOS is a member experience survey that collects self-reported data from beneficiaries. The results are used to measure certain CMS Medicare Star ratings. HOS is distributed annually from late July–November and involves a two-part survey—to a new baseline cohort and a follow-up two years later to a previous cohort.

How can providers help? Providers can help impact HOS results by starting important conversations and encouraging action during office visits. The survey questions ask beneficiaries about their health status on a topic and **if they've discussed this topic with their provider.**

Outlined below are three HOS measures that are included in the next measurement period and tips for how providers can help.

HOS Measure	How Providers Can Help

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

2. Monitor Physical Activity	• Discuss how to start, increase, or maintain acitivity. • Give patients with limited mobility or walking/balance issues tips on how to learn safe and effective exercises that are right for them.
3. Improving Bladder Control	• Discuss treatments and quality of life options for bladder control issues that may arise from aging, side effects from medications, or health conditions.
4. Reducing Fall Risk	• Discuss balance problems, falls, difficulty walking, and other fall risks. • Suggest a cane or walker. • Check blood pressure with patient standing, sitting, and reclining. • Suggest a vision/hearing test. • Ask about medication side effects that could cause dizziness or other symptoms that could increase risk.

Authorizations, Medical Polices, and Billing

Provider Reminders for Billing and Prescribing

Chronic conditions are the driving force in determining healthcare outcomes and costs in today's value-based world. Consequently, there is much interest in the Hierarchical Condition Category (HCC) coding payment model. HCCs are disease groups organized into body systems or similar disease processes.

CMS HCC Medicare Advantage (MA) is a reimbursement framework specifically designed by CMS as a way of giving weight to chronic conditions to make appropriate and accurate payments for enrollees with differences in expected costs of care. The goal of risk adjustment is to pay Medicare Advantage and prescription drug programs accurately and fairly by adjusting payments for enrollees based on demographics and health status.

Patients with chronic conditions are assigned a risk score based on their overall health status, relative risk that the condition will worsen, and various demographic characteristics. This risk adjustment factor (RAF) is a statistical tool that predicts speculated healthcare cost by reported ICD-10 diagnosis codes that identify future risk. Potential risk could include hospital admissions for a chronic condition exacerbation, costly treatments, or ongoing medications that may require consistent funding.

With the HCC payment model, providers should annually report all chronic conditions and comorbidities to the highest level of specificity. The more chronic conditions a patient has, the more care may be required, so yearly reporting is crucial to ensure quality of care as well as proper funding. If providers do not report all conditions, money funded for a certain patient could be put into a negative balance, creating difficulties for the provider, payer, and patient.

Reminder: Please remember to utilize the Medicaid formulary when prescribing medication.

Primary Coordination of Benefits (COB) for Dual Eligible Members (D-SNP)

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. Going forward with claims DOS 5/1 and later, 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.

Authorizations, Medical Polices, and Billing

Third-party Biller Denied Claim Form (4+ claims)

There is now a third-party biller denied claim form on the Optima Health website found in the provider toolkit.

Note: This form is for medical claims **only**; it cannot be used for behavioral health (BH) claims.

Claims Project Request Template

Please note: When completing the claims project template, the claim number **must** be included. The inclusion of the claim number ensures that the claims project team can work more efficiently to complete your request.

Authorization Updates

Please see the following authorization updates:

HOS Measure	How Providers Can Help
Medical 34 A – Genetic Testing – Cancer Prevention Diagnosis and Treatment	Updated policy to include criteria for coverage: all lines of business. Policy requires prior authorization for codes: 81455, 81449, 81456, 0067U.
Medical 99 – Transplant Rejection Testing	LCD L38568 updated to include TruGraf, OSant, and Viracor TRAC to list of allowable tests for members with Medicare. As a regulatory update, will update policy to include coverage, with criteria, for Medicare lines of business. Policy requires prior authorization codes: 0055U, 0087U, 81479, 81595, 815998. Remains not covered: 0088U.
Medical 172 – Ocular Photoscreening	Coverage policy will archive. Effective January 1, 2023, Medicare no longer covers codes 99174, 99177. Commercial and Medicaid will pay upon request.
Surgical 20 – Cochlear Implants, Bone Attached Hearing Aid Implants, Auditory Brain Stem Implants	NCD Updated. Also updated commercial criteria to expand coverage, which will include bone-anchored hearing aids. Policy requires prior authorization for codes: 69710, 69711, 69714, 69716, 69717, 69719, 69729, 69730, 69930, 92630, 92633, 92640, L8621, L8622, L8623, L8624.

Authorizations, Medical Polices, and Billing

Documenting Clinical Findings for Authorizations

You will notice changes on MCG when documenting clinical findings for authorizations.

Currently, all lines of business are combined in one result. Effective July 1, 2023, each result will display individually for commercial, Medicaid, or Medicare.

Note: If a Medicare policy does not display, you should use the National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs) to determine if certain items or services are covered by Medicare in your area.

Medicaid Authorization Request Forms

For former Virginia Premier providers, Medicaid authorization request forms can be found at optimahealth.com/providers/virginia-premier/documents-and-forms under Medical Management.

MCD/MCR Monitored Anesthesia Care for GI Endoscopic Procedures

Five codes were approved by stakeholders to update prior authorization requirements to **not require authorization**, effective July 1, 2023:

- 00731 Anesthesia Upper GI Endoscopic PX NOS
- 00732 Anesthesia Upper GI Endoscopic PX ERCP
- 00811 Anesthesia Lower INTST Endoscopic PX NOS
- 00812 Anesthesia Lower INTST Endoscopic PX SCR COLSC
- 00813 Anesthesia Combined Upper and Lower GI Endoscopic PX

Note: Code changes and deleted codes are also updated on the formerly Virginia Premier website.

Authorizations, Medical Polices, and Billing

Telecommunication for Home Health (Medicare only)

Effective July 1, 2023, providers will be required to report the use of telecommunications technology in providing Home Health (HH) services on HH payment claims. Please submit the use of telecommunications technology on the HH claim using the following three G-codes:

- G0320: Home health services furnished using synchronous telemedicine rendered via a real-time two-way audio and video telecommunications system
- G0321: Home health services furnished using synchronous telemedicine rendered via telephone or other real-time interactive audio-only telecommunications system
- G0322: The collection of physiologic data digitally stored and/or transmitted by the patient to the home health agency (i.e., remote patient monitoring)

Resource: **MM12805 - Telehealth Home Health Services: New G-Codes**

Positive/Lateral Code Changes

The following changes to prior authorization requirements for dates of service starting July 1, 2023.

- **Optima Health – Medicare**
- **Optima Health – Medicaid**
- **Virginia Premier – Medicare**
- **Virginia Premier – Medicaid**

Prior Authorization Changes

Effective July 1, 2023, Optima Health implemented changes to prior authorization requirements for drugs billed through medical claims. For the most up-to-date authorization requirements, providers should refer to the website: **optimahealth.com/providers/authorizations/prescription-drugs/**.

Important Updates and Reminders

Ensure Your Online Provider Directory Information Is Accurate

Optima Health partners with LexisNexis® to maintain its online provider directory. As a reminder, LexisNexis will contact you via email, fax, and/or phone to complete the directory verification process. The purpose is to help our members select in-network providers, choose health plans, and obtain access to care. Please take a moment to view and verify the accuracy of your profile as unverified provider information cannot be included in our online directory.

Important Member Services Line Update

When calling **1-800-881-2166** for assistance for former Virginia Premier members, please follow the prompt for **"Optima Health Plan formerly known as Virginia Premier"** to reach the correct team.

New Network Management Email Address

All participating providers in need of assistance related to contracting may contact network management at networkmgmt@sentara.com.

Former Virginia Premier providers should note that the networkdevelopment@virginiapremier.com email address has been decommissioned.

Submitting Provider Related Changes

Effective July 1, 2023, you may submit provider- related changes related to Optima Health (formerly Virginia Premier Health Plan) at optimahealth.com/providers/provider-support/update-your-information for the following request types:

- Virginia Premier D-SNP
- Updates to Optima Health data to support claims processing and/or reprocessing efforts for all products prior to July 1, 2023.

If you are a participating provider, and need additional assistance related to provider data updates, please email pustatus@sentara.com.

Important Updates and Reminders

Report Critical Incidents

A critical incident is defined as any actual, or alleged, event or situation that creates significant risk of substantial or serious harm to the member's physical or mental health and the safety or well-being of a member/patient.

Immediately report alleged abuse, neglect, or exploitation-related critical incidents to the appropriate protective services agency:

- Adult Protective Services (APS): **1-888-832-3858**
- Child Protective Services (CPS): **1-800-552-7096**

Within 24 hours:

- email: **optima_critical_incidents@optimahealth.com**
- fax a **critical incident report form** to **1-833-229-8932**
- call Optima Health: **757-252-8400**

PaySpan Registration

Registration with PaySpan is required by September 1, 2023. This was previously communicated as a recommendation, but the following operational changes have transitioned this to a required provider action:

- Medicare claims processing platform changed (effective May 1, 2023).
- All payments will be remitted from Optima Health bank accounts, and Virginia Premier accounts will be closed.
- Remittances will be combined to reflect claims payment decisions.

Providers should contact: providersupport@payspan.com or call **1-877-331-7154**, option 1, for help obtaining the Optima Health registration code and assistance with navigating the website. Provider services specialists are available to assist Monday through Friday from 8 a.m. to 8 p.m.

If a provider is not loaded in our claims platform or is notified by PaySpan that they are a new user with no entry in Payspan system, the provider must submit a claim to Optima Health and can expect to receive a paper check. This check will be mailed with registration information for PaySpan.

Important Updates and Reminders

Register for Our Upcoming 2023 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

- August 1, 2023 - 10 a.m.
- August 9, 2023 - 1 p.m.
- November 1, 2023 - 10 a.m.
- November 7, 2023 - 1 p.m.

Let's Talk Behavioral Health

- August 8, 2023 - 1 p.m.
- November 8, 2023 - 1 p.m.

Claims Brush-up Clinics

- September 12, 2023 - 10 a.m.
- December 6, 2023 - 1 p.m.