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providerNEWS

OptimaHealth

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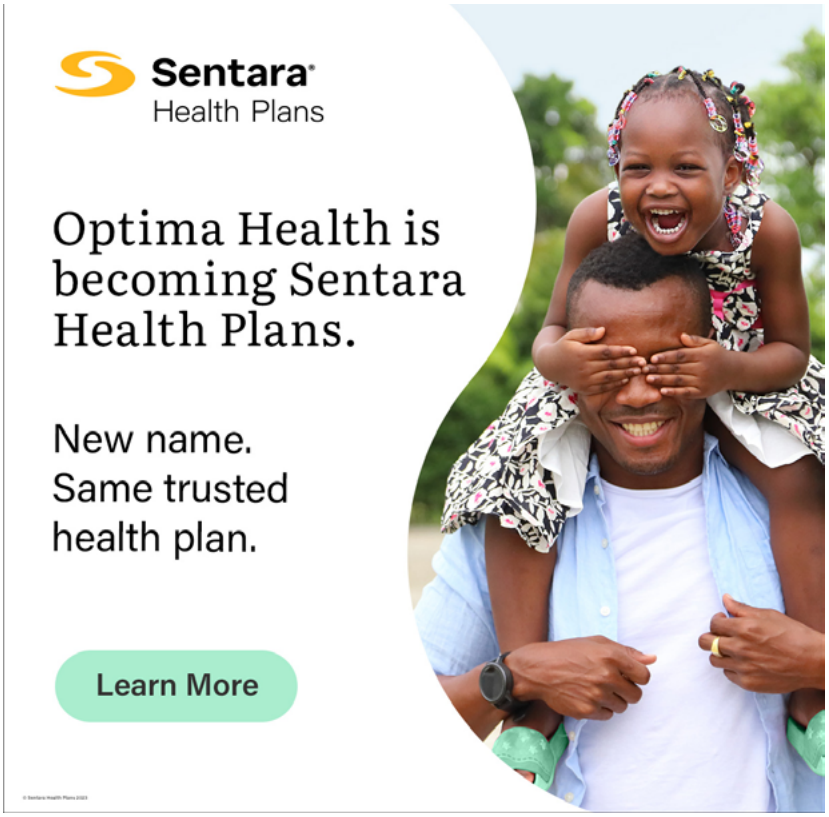
Introducing Sentara Health Plans

We are excited to announce that at the end of this year, the Optima Health and Virginia Premier brands are set to retire and unify under a new name—**Sentara Health Plans**. Effective January 1, 2024, Sentara Health Plans will seamlessly take on all agreements and responsibilities with our esteemed network of providers.

This transition marks a pivotal moment in our journey—one that reflects our growth, resilience, and commitment to pushing the boundaries of innovation in an ever-evolving healthcare landscape.

New membership cards that reflect the updated Sentara Health Plans branding will be issued to our members later this year. We will continue to provide consistent and reliable service throughout the transition.



We enter this new chapter with immense anticipation and dedication to our shared goal: delivering top-quality healthcare that meets the diverse needs of our members. While our name may change, the essence of trust and excellence that you associate with our health plans remains steadfast.

We understand the importance of keeping you, our trusted providers, updated about our progress and initiatives. To stay informed about Sentara Health Plans and access valuable resources, please continue to engage with our provider newsletter and provider email alerts. For further details and insights, visit our website at **optimahealth.com/providers**.

The transformation of our brand does not alter our core mission—**We Improve Health Every Day**—but rather propels us forward with renewed vision and a shared commitment to creating healthier communities. Thank you for your continued support, collaboration, and dedication to advancing healthcare excellence. Together, we will shape a healthier future for all.

Optima Health News

Coming Soon: Sentara Health Plans Partners With Availity

Beginning January 1, 2024, two exciting things will happen: Optima Health Plan officially becomes Sentara Health Plans, and we have chosen Availity as our exclusive Provider Portal. Availity Essentials is a multi-payer portal where providers can check eligibility and benefits, manage claims, and more to streamline their work. Many of you are already using Availity with other payers that you are contracted with and are familiar with its ease of use.

Over the course of 2024, our Provider Portals, including all features, functionality, and resources, will transition to Availity. This is a phased transition, with access to both our Provider Portal and the Availity Portal being available, as features and functionality are deployed on Availity's Portal. We want to encourage you to take action now to register and attend training with Availity.

If a provider is already working in the Availity Essentials portal, the same user ID and password can be used to sign in to the Essentials account for Sentara Health Plans on January 1, 2024. For a refresher, please visit Availity's **Reference Guide for Admins** and **Reference Guide for Users**.

For providers new to Availity Essentials, the **Get Started** page has an abundance of resources, including a recorded webinar. Once an Availity Essentials account has been created, navigate to the "Help and Training" button in the upper right-hand corner of the home screen, then select "Get Trained" for additional training options.

Member Accommodations and Communication Services

Optima Health will use all reasonable means to facilitate healthcare services for members with physical, mental, language, and cultural barriers. To ensure that the needs of members with physical, mental, language, and/or cultural barriers are properly accommodated, members with special needs should be instructed to call member services at the number on the back of their member ID card.

Optima Health provides appropriate auxiliary aids and services, including interpreters and information in alternative formats, to individuals with impaired sensory, manual, or speaking skills where necessary to ensure equal opportunity to benefits. Providers requesting translation services should contact member services to arrange for the member to obtain a hard copy of the material in the primary non-English language or alternative format. The material will be provided on a standing basis, unless otherwise indicated by the member. Providers may also contact Optima Health provider services for assistance coordinating interpreter services. More information can be found in the Optima Health Provider Manual.

Optima Health News

Welcoming Baby Program

Welcoming Baby is the Optima Health incentive-based maternal healthcare program for our Medicaid 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 case manager/care coordinators for care planning and goal setting
- education, community referrals for identified needs
- family planning, LARC, and birth-spacing education
- baby showers (virtual and in person)
- breast pumps
- maternal/child education series (classes)
- referrals to parenting, breastfeeding classes, and lactation services
- hospital tours (virtually and in person)
- OB provider registration program
- timeliness of care incentives

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

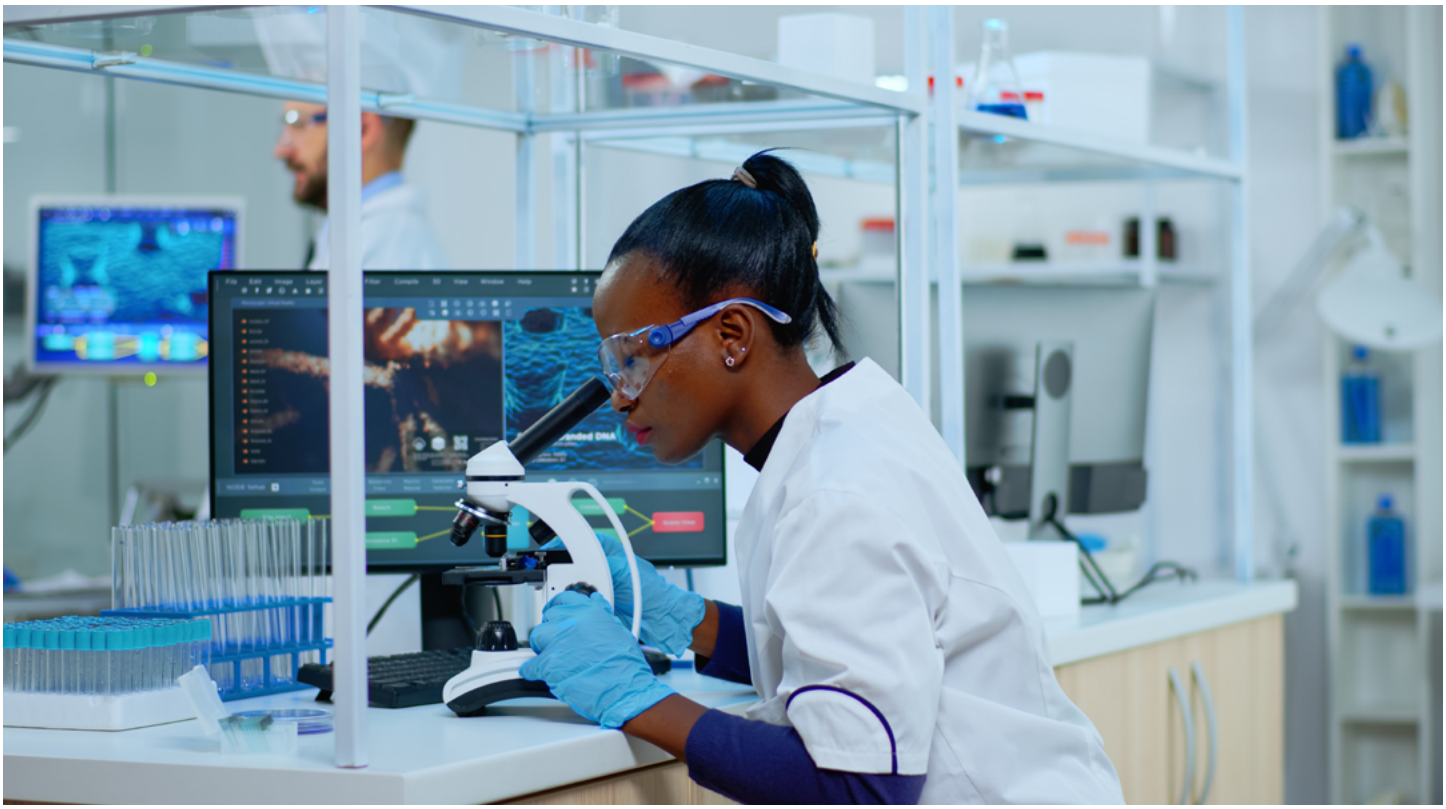
Timeliness of Care:

- Our members are encouraged to seek timely and consistent prenatal and postpartum care with their providers. Through the Welcoming Baby Program, members receive reminders, education, and incentives if they receive their first prenatal visit within 42 days of enrolling with Optima Health (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).

OB Registration Incentive Program:

- Providers are eligible to receive a **$25** incentive for referring pregnant patients to the Welcoming Baby member outreach team upon identification of pregnancy.
- All providers need to do is fill out an OB Registration Form, fax it to outreach at **804-799-5117**, and submit a claim using the code G9001.

Optima Health News



Avalon Laboratory Benefit Management Program

On January 1, 2024, Optima Health will be expanding our partnership with Avalon to implement the current Laboratory Benefit Management (LBM) program to include the formerly known as Virginia Premier membership.

This innovative program includes policies based on the latest science for providers to follow clinically accepted, peer-reviewed guidelines for lab services.

The LBM program provides consistent enforcement of laboratory policies via an automated review of high-volume, low-cost routine laboratory tests performed in-office, hospital outpatient, and independent laboratory locations. Laboratory services, tests, and procedures provided in emergency rooms, hospital observation, and hospital inpatient settings are excluded from this program.

avalon

More information will be provided through our website and network education training offerings.

DMAS Updates

Electronic Visit Verification (EVV)

The Department of Medical Assistance Services (DMAS) has moved the Electronic Visit Verification (EVV) requirements for Home Health Care Services (HHCS) go-live date from October 1, 2023, to December 1, 2023. Soft edits were implemented for noncompliance claims beginning July 1, 2023, in an effort to help prepare and educate providers. Beginning December 1, 2023, claims not compliant with the EVV requirements will be denied. Optima Health 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:

- 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.

Optima Health is offering provider testing until the end of November 2023. If you are interested in testing your HHCS EVV claims with Optima Health or would like additional information on testing, please email **contactmyrep@sentara.com**. For more information on EVV, please visit the **DMAS website**. For technical assistance on EVV claims, please email **editeam@sentara.com**.

OB/GYN Providers - Doula Balance Billing

DMAS notified Optima Health 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.

DMAS Updates

Introduction

- The Quality Management Review (QMR) process is used to assess and evaluate waiver services and their providers.
- Its purpose is to ensure the provider's overall compliance with the administration of home and community-based waiver services in the Commonwealth of Virginia.
- The QMR is not a financial audit and should not be confused with Utilization Reviews.
- The QMR includes a review of waiver services and ensures services are provided per DMAS regulations, policies, and procedures, as per the Commonwealth Coordinated Care Plus Waiver Provider Manual.
- The ultimate goal of the QMR is to ensure the health, safety, and welfare of individuals receiving waiver services.
- Areas of review include but are not limited to provider qualifications, individual eligibility criteria, individualized personal needs, quality of care, and adequate record-keeping.

QMR Overview

- The QMR team will conduct an on-site/desk review of member and employee records.
    - The overall performance of the provider is assessed through the record-review process.
    - The QMR team determines if the provider has deficiencies with DMAS guidelines.
    - After the review, an exit conference is conducted, and the QMR team will communicate findings or deficiencies.
- A formal letter will be sent within two weeks following the exit conference detailing the findings and deficiencies, along with manual citations provided to explain the deficiencies identified.
- A Corrective Action Plan (CAP) template will be sent with the formal letter.
- The provider is given 30 days to submit the CAP addressing findings/deficiencies included in the letter.
- Please refer to Chapter VI, pages 3–8, of the Commonwealth Coordinated Care Plus Wavier Provider Manual for more information regarding the QMR process.

DMAS Updates

What is a Technical Assistance (TA)?

- Technical Assistance (TA) refers to deficiencies that are found during the QMR that do not rise to the level of requiring a CAP.
- TA means there is room for improvement to meet best practices.
- TA does not require any written corrective action on the part of the provider.

What is a CAP?

- A CAP requires action by the provider to correct each deficiency cited.
- A CAP is a plan of action developed to address findings and observations identified by the QMR team during the QMR site review.
- A CAP allows the provider to identify the root causes of the identified findings and to develop a corrective action to address each finding.
- The goal of the CAP is to ensure future compliance with the Commonwealth Coordinated Care Plus Waiver Provider Manual.

Preparing Your CAP

- Review the specific findings/observations noted in the findings letter.
- Determine the root cause of the deficiency and the applicable Commonwealth Coordinated Care Plus Waiver Provider Manual citations.
- Do not include arguments or dispute specific findings.
- Copy and identify each specific review finding addressed in the findings letter.
- Explain the specific plan of correction for each finding addressed in the findings letter.
- Include some type of education (policy reviews, in-services, etc.) with all actions implemented.
- Identify the person(s) responsible for completing and/or implementing each specific plan of correction for each finding identified; person(s) should be appropriate to the specific finding (i.e., a clinical-related finding would not be appropriate for nonclinical personnel to correct).

Examples of specific plans for corrective action include:

- developing/implementing policy and enforcement through monthly internal audits/reviews
- developing/updating training manuals and conducting staff training sessions
- establishing scheduled monitoring (checklists, tracking, etc.)

DMAS Updates

Submitting Your CAP

- Once your specific plan of correction is completed, actions are implemented for each correction, the responsible person(s) is identified, and target dates for implementation for each correction have been completed, submit your CAP as instructed in your findings letter.
- You will be given 30 days to submit your CAP (the actual date can be found in your findings letter).

Expectations

- The QMR team will review the submitted CAP upon receipt.
- The QMR team will determine whether the specific plan for each finding meets the requirements for approval.
- A submitted CAP must be approved by the QMR team and by DMAS.
- The QMR team will provide a letter of CAP approval or denial to the provider based on the submitted CAP.
- The provider is notified in the letter that a CAP follow-up QMR will be done to validate the implementation of the corrective action(s).
- A follow-up review will be done after the provider has had time to implement the CAP.
- The purpose of the follow-up QMR is to ensure the provider has implemented the CAP and is now in compliance with DMAS requirements.
- The follow-up review must show adequate correction of the deficiencies and follow through of the previously approved CAP submitted to the QMR team and DMAS.

CAP may be denied if it:

- fails to address the specific findings
- fails to provide a specific plan for corrective action for each deficiency
- contains argument or refutation of findings
- fails to identify the person(s) responsible for implementation
- fails to identify target dates, including implementation and completion dates

Resources:

- Commonwealth Coordinated Care Plus Waiver Services Provider Manual, Chapters II, IV, and VI
- Code of Federal Regulations, Title 42, Parts 455 and 456

Quality Improvement

Annual Wellness Visits for Closing Care Gaps

Optima Health improves health every day by making it easy for our members, your patients, to get the care they need when they need it. We are asking for your partnership in completing annual wellness visits and annual physical exams to close gaps in care by **December 31, 2023**.

We are encouraging our members to make an appointment with your office. Please make every effort to accommodate these important appointment requests before December 31 to achieve optimal outcomes.

Here is some important information regarding these visits:

1	**The Annual Wellness Visit (AWV) and Annual Physical Exam (APE) can be completed in the same visit for Optima Medicare members.** • Optima Medicare permits billing of both the AWV and APE as a supplemental benefit in the same visit. • The Initial Preventive Physical Exam (IPPE, aka "Welcome to Medicare Visit") billing code is G0402. • The Annual Wellness Visit billing codes are G0438 and G0439. • The Annual Physical Exam billing codes are 99385–99387 and 99395–99397. • Members are eligible for one AWV and one APE each calendar year. • Members are eligible for a $25 reward for completion of the AWV and an additional $25 reward for the completion of the APE.
2	**The AWV and APE are the gateway to building relationships with your patients and improving care.** • Include care gap closure in annual wellness visits and annual physical exams for efficiency. • Include comprehensive coding of clinical conditions with the claim for better documentation. • Start early to avoid the time crunch in Q4; gaps in care must be closed by the end of the year. • Minimize costs of care through early diagnosis and intervention. • Share this resource with your clinical care teams.
3	**Provide limited secure EMR access and submit your supplemental data early.** • Reviewing, faxing, and/or mailing medical records as part of the annual HEDIS process takes time and effort. • Granting limited, secure EMR access to our quality staff allows us to directly retrieve relevant HEDIS medical record information. • Sending medical records can be done using the HEDIS fax number and secure email: 1-844-518-0706 or optima_quality@sentara.com

For more information,
visit optimahealth.com/providers.

Questions? Please call a member of the HEDIS team at **1-844-620-1015.**

Quality Improvement

Annual Wellness Visits

Annual Wellness Visits (AWVs) and Annual Physical Exams (APEs) are essential to timely detection and prevention of health problems. We encourage you to prioritize and schedule these visits in the first six months of the year to promote early and regular intervention with the patient, leading to improved quality outcomes, greater patient engagement, and a better provider-patient rapport. Optima Medicare pays for an AWV and an APE to occur in the same visit. Patients may have received a phone call or mailer from Optima Medicare encouraging them to schedule their appointments. **Below are some key points to guide these exams.**

"Welcome to Medicare" Initial Preventive Physical Exam (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. Physical activities 5. History of substance use (alcohol, tobacco, and illegal drug use) 6. Review of opioid prescriptions 7. Review of potential depression risk factors (including current or past) 8. Functional abilities assessment and level of safety 9. Exam: height, weight, BMI, BP, visual acuity screen 10. End-of-life planning 11. Education and referral for preventive services, as needed 12. A once-in-a-lifetime screening ECG/EKG, as appropriate **Codes:** Preventive Visit= G0402 ECG = G0403, G0404, G0405	**Purpose:** A visit to develop or update a personalized prevention plan and perform a health risk assesment (HRA) **Population:** Patients **new or existing to their health plan** but not new to Medicare (within the last 12 months) **Coverage:** Once every year **Components:** 1. Administration (for the first AWV) or update of the HRA 2. Medical and family history 3. List of current providers and equipment vendors 4. Exam: BMI and BP 5. Cognitive function assessment 6. Review of potential depression risk factors 7. Screening for potential substance use disorders 8. Opioid prescriptions review 9. Functional abilities assessment and level of safety 10. Establishment of screening schedule for next 5–10 years 11. Patient personal risk factors list development 12. End-of-life planning 13. Education and referral for preventive services, as needed **Codes:** G0438, 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. Medical and family history 2. Vital signs 3. Exam of heart and lungs 4. Exam of head, neck, and abdomen 5. Neurological exam 6. Skin exam 7. Gender-appropriate exams (breast, genitals, reproductive) 8. Lab work, as appropriate **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.** **SHP Medicare members can receive a $25 reward for completing the AWV and another $25 reward for completing the APE!**

Quality Improvement

Focus HEDIS Measures

Colorectal Cancer Screening

Measure:
The percentage of patients 50–74 years of age who had a mammogram to screen for breast cancer

Best Practices:

- Order mammograms every two years for patients, starting at age 50, and assist patients in scheduling.
- Encourage screening and educate on the importance of regular mammograms.
- Explain that technology has advanced and mammograms are less uncomfortable and expose the patient to less radiation than in the past.
- Maintain a list of local facilities offering mammograms for patients.

Codes for Filing Claims:
CPT Codes: 77061–77063, 77065–77067

Key Points:

- All types and methods of mammograms (screening, diagnostic, film, digital, or digital breast tomosynthesis) qualify for numerator compliance; MRI, ultrasound, and/or biopsy do not count toward the measure.
- Must be performed any time on or between October 1, two years prior to the measurement year and December 31 of the measurement year.
- SHP reminds patients by phone and/or mail that they may need a mammogram.

Documentation Requirements:

- Document the date of service (month and year at a minimum) of the most recent mammogram in the patient's medical record
- Exclusions: hospice or palliative care; bilateral mastectomy or a unilateral right mastectomy and a unilateral left mastectomy any time during the patient's history through December 31 of the measurement year (document date of service); must be documented annually

Transitions of Care (TRC)

Measure:
The percentage of discharges for patients 18 years of age or older, as of December 31 of the measurement year, who had an acute or nonacute inpatient discharge on or between January 1 and December 1 of the measurement year, who had each of the following:

1. notification of inpatient admission
2. receipt of discharge information
3. patient engagement after inpatient discharge within 30 days
4. medication reconciliation post-discharge

Exclusions:

- received hospice care during the measurement year
- are deceased during measurement year

Best Practices:

- Implement a process (like an admission-discharge-transfer program) to receive auto alerts when a patient is admitted to or discharged from an inpatient facility.
- Create a process (e.g., patient rounding, team huddles) to communicate the patient's discharge progress and plan of action.
- Partner with other involved providers to obtain or create a shareable care plan.
- Reserve appointment times for post-discharge follow-up appointments.
- Schedule patients within seven days of discharge.
- Address member/caretaker barriers to attending the follow-up appointment (e.g., transportation, financial issues, language, etc.).
- Provide reminder calls about upcoming appointments and ask the patient to bring his or her discharge medication list, discharge summary, any other relevant discharge information, and a list of questions for the provider.
- Complete a medication reconciliation during the post-discharge follow-up visit.

Quality Improvement

Component	Criteria
1. Notification of Inpatient Admission and Discharge *(within 72 hours)*	• This can only be met through medical record review. • Documentation in the outpatient medical record must include evidence of receipt of notification of inpatient admission on the day of admission through two days after the admission (three total days) with evidence of the date when the notification was received. • Any documentation of notification that does not include a time frame or date stamp does not meet criteria. **Note:** If the PCP practice is not on the same EMR as the facility, the notification needs to go in the patient's medical record.
2. Receipt of Discharge Information *(within three days of discharge)*	• This can only be met through medical record review. • Documentation in the medical record of receipt of discharge information, on the day of discharge through two days after the discharge (three total days), with evidence of the date when the documentation was received. • Any documentation that does not include a time frame or date stamp does not meet criteria. • At a minimum, the discharge information must include all the following: the practitioner responsible for the patient's care during the inpatient stay, procedures or treatment provided, diagnoses at discharge, current medication list, testing results, or documentation of pending tests or no tests pending, and instructions for patient care post-discharge. Note: If you are not receiving this information in time, please reach out to the facility as soon as possible.
3. Patient Engagement After Inpatient Discharge *(within 30 days)*	• Patient engagement (encounter/visit) is provided within 30 days after discharge. • This includes outpatient visits, home visits, and telehealth/e-visits. • It does not include patient engagement that occurs on the date of discharge.

4. Medication Reconciliation Post-discharge *(within 31 days)*	• Medication reconciliation is completed on the date of discharge through 30 days after discharge (31 total days).
	• It must be conducted by a prescribing practitioner, clinical pharmacist, physician assistant, or registered nurse. Other staff members (MA or LPN) may conduct the medication reconciliation, but it must be signed off by the required provider type.
	• It must be the outpatient medical record, but an outpatient face-to-face visit isn't required.
	• The following meet criteria:
	  ○ documentation of the current medications with a notation that the provider reconciled the current and discharge medications
	  ○ documentation of the current medications with a notation that references the discharge medications
	  ○ documentation of the member's current medications with a notation that the discharge medications were reviewed
	  ○ documentation of a current medication list, a discharge medication list, and notation that both lists were reviewed on the same date of service
	  ○ documentation of the current medications with evidence that the member was seen for post-discharge hospital follow-up with evidence of medication reconciliation or review
	  ○ documentation in the discharge summary that the discharge medications were reconciled with the most recent medication list in the outpatient medical record
	  ○ notation that no medications were prescribed or ordered upon discharge
	• CPT codes 99483, 99495, and 99496 and CPT II code 1111F will close this measure gap.

Quality Improvement

Pharmacy: Medication Therapy Management (MTM)

Optima Health Plan offers a Medication Therapy Management (MTM) program for eligible Medicare members as required by Centers for Medicare & Medicaid Services, then list (CMS). The overall goal is to ensure members achieve the best possible outcomes from their medications. The MTM program promotes collaboration between the pharmacist, member, and prescriber to optimize safe and effective medication use. The program aims to optimize therapeutic outcomes for safety, effectiveness, lower-cost alternatives, and adherence.

CMS guidelines require the following activities:

- completion of a comprehensive medication review (CMR) completed either in person, face-to-face, or via telephone
- CMR completed by a plan-approved pharmacist or provider that has been submitted in the annual requirements to CMS
- documentation of the CMR sent to the member with defined action plans
- quarterly targeted medication reviews for updates and potential adverse interactions (these are not required to be in person with the member unless there is an identified need)

SinfoniaRx is a pharmacy contracted with the Optima Health Plan through the Pharmacy Benefit Manager to conduct the MTM program on our behalf. MTM-eligible members are contacted telephonically by SinfoniaRx to remind them of the importance of the comprehensive medication review. Reminders continue until the member completes a CMR or notifies the plan they do not want to be called again. Members will continue to be contacted throughout the year once they are eligible.

Members must meet each of these criteria to be eligible:

- reach the CMS-designated out-of-pocket spend for the year
- take a minimum of eight chronic or maintenance Part D drugs
- diagnosed with at least three of the following chronic diseases:
    - diabetes
    - chronic heart failure
    - dyslipidemia
    - chronic obstructive pulmonary disease (COPD)
    - osteoporosis

The following elements are part of the CMR:

- assess current medications, create list
- identify any medication problems, adverse events, or therapeutic duplications
- develop a prioritized problem list
- create action plans to the problems in collaboration with the member, caregiver, and/or provider

Quality Improvement

How can our providers help?

- Encourage members to take advantage of the program.
- Remind our members about the Healthy Reward of **$50 upon completion of the CMR**.

Physician offices may be contacted about CMR-identified problems and TMRs, which may be beneficial for the member, so please keep an eye out for those.

Medicare Stars - CAHPS: Annual Flu Vaccine Measure

The Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey is an important tool used to evaluate several Medicare Stars measures. The CAHPS survey collects responses directly from Medicare Advantage beneficiaries on topics related to their experience with plan satisfaction, access to care, and quality of care.

Did you know the CAHPS survey is also used to measure how many beneficiaries get their annual flu vaccine? This self-reported data is collected directly from respondents when answering the question, "Have you received a flu vaccine since July of last year?"

Now that the flu season is upon us, providers can help health plans improve Medicare Stars ratings by encouraging patients to get their annual flu vaccine.

Best Practice Tips:

- Make scheduling a visit as easy as possible, especially if the flu vaccine is their primary or only request.
- Suggest local pharmacies or flu clinics if your patient won't make it in for an office visit.
- Address any hesitations regarding the importance of receiving an annual flu vaccine:
    - Flu vaccines are updated yearly, and getting one every year is recommended.
    - The vaccine does not cause flu and is safe.
    - The flu vaccine is important for all ages, even for Medicare beneficiaries under age 65.

Know about these Important Optima Medicare benefit* highlights that can help:

Transportation to medical appointments: If your patient has trouble driving or getting around town, remind them to use their transportation benefit to get rides to medical appointments.

Papa Pals: If your patient needs a little extra assistance, they may want to use their benefit for in-home support services. Papa Pals can offer a game or a visit, help with light housework or grocery shopping, and even assist with holiday preparations such as gift wrapping or addressing cards. Papa Pals can also drive members to medical appointments or to the pharmacy, helping them get their annual flu vaccine!

**Benefits vary by plan. Members can call member services using the number on the back of their ID card to learn more about using these important benefits and to check their eligibility.*

Authorizations, Medical Polices, and Billing

Authorization Updates

Optima Health would like to notify you of the following authorization updates:

In keeping with the CMS final rule 4201F, Optima Health Plan will be archiving applicable Medicare policies in favor of utilizing the NCD/LCD when appropriate. If the NCD/LCD is more restrictive than the Optima Health policy, providers will be notified.

Policy	Determination/Coverage
Behavioral Health 27 – Sensory-weight Vest	Expanded coverage to include coverage for members diagnosed with sensory processing disorder for commercial, Medicaid, and Medicare. Added member does not have an active DMAS Developmental Disability Waiver to Medicaid policy. Policy requires prior authorization for HCPCS code A9900
Medical 338 – Covid Antibody Testing	For members with Legacy VP Medicaid, updated clinical indications for procedure per DMAS memo dated July 26, 2022. Policy requires prior authorization for CPT codes 0224U, 36415, 86413, 862328, 86769
DME 09 – Electric and Electromagnetic and Ultrasound Bone Growth Stimulation	Added patellar tendinopathy and pathological fractures due to tumor/ malignancy to exceptions for commercial and Medicaid lines of business. Medicare to utilize the NCD. Policy requires prior authorization for CPT codes 20974, 20975, 20979; HCPCS codes E0747, E0748, E0749, E0760
Medical 247 – Accelerated Partial Breast Irradiation	Updated per ASTRO recommendations for commercial and Medicaid. Added clinical indications for procedure. Medicare will utilize the LCD. Policy requires prior authorization for CPT codes 19296, 19297
DME 11 – Continuous Subcutaneous Insulin Infusion	Changed name to external insulin infusion pump. Updated clinical indications for procedure criteria for commercial and Medicaid. Added single-use disposable insulin infusion device (IE: V-Go) to exceptions. Medicare utilizes the NCD. Policy requires prior authorization for HCPCS codes A4224, A4225, A4226, A4230, A4231, A9274, E0784, K0552
DME 10 – Continuous Glucose Monitoring Systems	Updated exceptions and limitations and clinical indications for procedure for commercial. No changes for Medicaid. Utilize NCD for Medicare. Policy requires prior authorization for CPT codes 0446T, 0447T, 0448T; HCPCS codes A4238, A9276, A9277, A9278, A9279, E2102, K0553, K0554
Surgical 55 – Phototherapeutic Keratectomy, Endothelial Keratoplasty, and Corneal Remodeling After Corneal Transplant or Surgery Commercial	Combined policies. Updated exceptions for commercial and Medicaid. Medicare to utilize NCD. Policy requires prior authorization for CPT codes 65756, 65757, 65772, 65775; HCPCS code S0812

Authorizations, Medical Polices, and Billing

Authorization Updates (continued)

Policy	Determination/Coverage
Surgical 92 - Intestinal Transplant With or Without Combined Liver Transplant or Other Visceral Organs	Updated exceptions and clinical indications for procedure for commercial. No change for Medicaid. Medicare to utilize the NCD. Policy requires prior authorization for CPT codes 44132, 44133, 44135, 44136, 44137, 44715, 44720, 44721; HCPCS codes S2053, S2054, S2055
DME 249 – Scalp Cooling During Chemotherapy	For members with Legacy VP Medicaid, updated clinical indications for procedure per DMAS memo dated July 26, 2022. Policy requires prior authorization for CPT codes 0224U, 36415, 86413, 862328, 86769
DME 42 - Transfer Devices and Lifts	Adding clarifications and moving some exceptions to covered in the clinical indications for procedure, for commercial and Medicaid. Medicare will utilize the NCD. Policy requires prior authorization for HCPCS codes E0621, E0625, E0635, E0639, E0640, E1035, E1036, E0247, E0248
DME 53 - Pneumatic Compression of the Chest or Trunk	Utilize NCD for Medicare. Used to pay upon request. NCD requires prior authorization for HCPCS codes E0656, E0657
Medical 293 - Transanal Double Balloon Enteroscopy	Expanding coverage for clinical indications for procedure for commercial, Medicaid, and Medicare. Policy requires prior authorization for CPT code 44799
Medical 342 - New Technology Request for Genicular Artery Embolization (GAE)	Creating coverage policy for commercial and Medicaid. Medicare will utilize the NCD. Policy requires prior authorization for CPT codes 37242, 37244
Medical 328 - Eustachian Tube Balloon Dilation (ETBD) Tuboplasty	Was an NMN policy. Now has clinical indications for procedures for commercial, Medicaid, and Medicare. Policy requires prior authorization for CPT codes 69705, 69706, 69799

Early Intervention (EI) Authorization Requirements

Reminder to providers billing for EI services:

- No authorization required when the four conditions below are met for codes G0151/ G0152/G0153:
  - There is an EI Waiver on file.
  - The member is under three years old.
  - G codes are billed with the appropriate U1 modifier.
  - DMAS limits have not been exceeded.

Note: Code changes and deleted codes have been updated on the **PAL website**.

Authorizations, Medical Polices, and Billing

National Imaging Associates (NIA) Vendor

Virginia Premier Health Plan (VPHP) D-SNP is separate and current until January 1, 2024.

VPHP D-SNP (formerly VPHP Medicaid) utilizes the same codes as Optima Health with the respective effective date of September 18, 2023. A provider notification was sent out on June 29, 2023.

NIA will now manage the authorization for the following procedure codes:

Authorized CPT Code	Description	Allowable Billed Groupings
33225	Cardiac Resynchronization Therapy (CRT)	33221, 33224, 33225, 33231
33249	Implantable Cardioverter Defibrillator (ICD)	33230, 33240, 33249
33208	Pacemaker Insertion	33206, 33207, 33208, 33212, 33213
70336	MRI Temporomandibular Joint	70336
70450	CT Head/Brain	70450, 70460, 70470, +0722T
70480	CT Orbit	70480, 70481, 70482, +0722T
70486	CT Maxillofacial/Sinus	70486, 70487, 70488, 76380, +0722T
70490	CT Soft Tissue Neck	70490, 70491, 70492, +0722T
70496	CT Angiography, Head	70496
70498	CT Angiography, Neck	70498
70540	MRI Orbit, Face, and/or Neck	70540, 70542, 70543, +0698T
70551	MRI Internal Auditory Canal	70551, 70552, 70553, 70540, 70542, 70543, +0698T
70544	MRA Head	70544, 70545, 70546
70547	MRA Neck	70547, 70548, 70549
70551	MRI Brain	70551, 70552, 70553, +0698T
70554	Functional MRI Brain	70554, 70555
71250	CT Chest	71250, 71260, 71270, 71271, +0722T

Authorized CPT Code	Description	Allowable Billed Groupings
71271	Low Dose CT for Lung Cancer Screening	71271
71275	CT Angiography, Chest (noncoronary)	71275
71550	MRI Chest	71550, 71551, 71552, +0698T
71555	MRA Chest (excluding myocardium)	71555
72125	CT Cervical Spine	72125, 72126, 72127, +0722T
72128	CT Thoracic Spine	72128, 72129, 72130, +0722T
72131	CT Lumbar Spine	72131, 72132, 72133, +0722T
72141	MRI Cervical Spine	72141, 72142, 72156, +0698T
72146	MRI Thoracic Spine	72146, 72147, 72157, +0698T
72148	MRI Lumbar Spine	72148, 72149, 72158, +0698T
72159	MRI Orbit, Face and/or Neck	70540, 70542, 70543, +0698T
72159	MRA Spinal Canal	72159
72191	CT Angiography, Pelvis	72191
72192	CT Pelvis	72192, 72193, 72194, +0722T
72196	MRI Pelvis	72195, 72196, 72197, +0698T
72198	MRA Pelvis	72198
73200	CT Upper Extremity	73200, 73201, 73202, +0722T
73206	CT Angiography, Upper Extremity	73206
73220	MRI Upper Extremity, other than Joint	73218, 73219, 73220, +0698T
73221	MRI Upper Extremity Joint	73221, 73222, 73223, +0698T
73225	MRA Upper Extremity	73225
73700	CT Lower Extremity	73700, 73701, 73702, +0722T
73706	CT Angiography, Lower Extremity	73706

Authorized CPT Code	Description	Allowable Billed Groupings
73720	MRI Lower Extremity	73718, 73719, 73720, 73721, 73722, 73723, +0698T
73721	MRI Hip	72195, 72196, 72197, 73721, 73722, 73723, +0698T
73725	MRA Lower Extremity	73725
74150	CT Abdomen	74150, 74160, 74170, +0722T
74174	CT Angiography, Abdomen and Pelvis	74175
74175	CT Angiography, Abdomen	72128, 72129, 72130, +0722T
74176	CT Abdomen and Pelvis Combination	74176, 74177, 74178, +0722T
74181	MRI Abdomen	74181, 74182, 74183, S8037, +0698T, +0724T
74185	MRA Abdomen	74185
74261	Diagnostic CT Colonoscopy (Virtual Colonoscopy, CT Colonoscopy)	74261, 74262, +0722T
74263	Screening CT Colonoscopy (Virtual Colonoscopy CT Colonoscopy)	74263, +0722T
74712	Fetal MRI	74712, +74713
75557	MRI Heart	75557, 75559, 75561, 75563, +75565, +0698T
75571	Coronary Artery Ca Score, Heart Scan, Ultrafast CT Heart, Electron Beam CT	75571, S8092, +0722T
75572	CT Heart	75572, +0722T
75573	CT Heart congenital studies, noncoronary arteries	75573, +0722T
75574	CTA coronary arteries (CCTA)	75574
75635	CT Angiography, Abdominal Arteries	75635
76380	Follow-up, Limited or Localized CT	76380, 70486, 70487, 70488
76390	MR Spectroscopy	76390, +0698T
76497	Unlisted Computed Tomography	76497, +0722T

Authorized CPT Code	Description	Allowable Billed Groupings
76498	Unlisted Magnetic Resonance Procedure	76498, +0698T
77046	MRI Breast	77046, 77047, 77048, 77049, +0698T
77078	CT Bone Density Study	11018
77084	MRI Bone Marrow	77084
78429	Heart PET Scan with CT for Attenuation	78459, 78491, 78492, +78434, 78429, 78430, 78431, 78432, 78433
78451	Myocardial Perfusion Imaging	78451, 78452, 78453, 78454, 78466, 78468, 78469, 78481, 78483 78499, +0742T
78459	Heart PET Scan	78459. 78491 78492, +78434
78472	MUGA Scan	78472, 78473, 78494, +78496
78608	Brain PET Scan	78608, 78609
78813	PET Scan	78811, 78812, 78813, 78814, 78815, 78816
78816	PET Scan with CT for Attenuation	78811, 78812, 78813, 78814, 78815, 78816
93312	Transesophageal Echocardiography (TEE)	93312, 93313, 93314, 93315, +93316, 93317, 93318, +93325
93350	Stress Echocardiography	93350, 93351, 93320, +93321, +93325, +93352, + 93356
93452	Heart Catheterization	93452, 93453, 93454, 93455, 93456, 93457, 93458, 93459, 93460, 93461, +93463, +93464, +93565, +93566, +93567, +93568
G0219	PET imaging whole body, melanoma for noncovered indications	G0219
G0235	PET imaging, any site, not otherwise specified	G0235
G0252	PET imaging, initial diagnosis of breast cancer and/ or surgical planninq for breast cancer	G0252
S8037	MR Cholangiopancreatography	S8037, 74181, 74182, 74183

Authorizations, Medical Polices, and Billing

Brain Injury Services (BIS) Codes

Effective January 1, 2024, Optima Health will offer targeted case management services to individuals 18 years of age and older who have sustained severe traumatic brain injury and meet the medical necessity criteria.

The Brain Injury Services (BIS)/Case Management Program is designed to coordinate services and provide a person-centered plan for members who have suffered a traumatic brain injury. This service will include targeted case management, medical, behavioral health, social, educational, employment, residential, and other supports essential for living in the community while aiming to develop the member's ability to achieve the lifestyle they desire.

The member eligibility requirements are:

- must be age 18 or older and reside in the community must have a physician-documented
- diagnosis of traumatic brain injury (TBI)

This benefit will have two codes (S0280 and S0281), and prior authorization is required.

Please refer to the DMAS manual for additional billing requirements, service limitations, exclusions, and provider criteria. For more information on brain injury services, please refer to the **DMAS website.**

New CPT/HCPCS Codes

New CPT and HCPCS codes for drugs, professional services and procedures, supplies, durable medical equipment, and quality measures went into effect July 1, 2023. Coverage determination and authorization requirements, Medicare and Medicaid, are available via the prior authorization list (PAL) on the website.

- 35 New, 12 Description Change, 9 Deleted CPT codes for quarter 3
    - effective April 18, 2023, six new COVID-19 Codes
    - effective May 3, 2023, one RSV vaccine—limits apply; refer to PAL website for exceptions
- 63 New, 1 Description Change, 9 Deleted HCPS codes for quarter 3

Note: Code changes and deleted codes have been updated on the **PAL website**.

Updated J Code for REBYOTA

CMS has assigned a permanent Healthcare Common Procedure Coding System (HCPCS) Level II code for REBYOTA, **J1440**, effective July 1, 2023. This new code has replaced any previously existing code(s) that may have been in use.

Please note that while the HCPCS unit of measure for reimbursement is 1 mL, you should expect to receive provider claims billed to the actual unit dosage of REBYOTA, which is 150 mL. Providers should take notice of the billing of units to eliminate any billing errors. Rates have been added to the DMAS Fee Schedule.

Note: Code changes and deleted codes have been updated on the **PAL website**.

Important Updates and Reminders

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

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

Let's Talk Behavioral Health

- November 8, 2023 - 1 p.m.

Claims Brush-up Clinics

- December 6, 2023 - 1 p.m.