OptimaHealth

3rd Quarter Medical Provider Touchpoint

August 3rd August 9th, 2022

1

WELCOME

All participants will be placed on mute upon entry into the room

Ask your questions via the chat room OR hold until we have taken everyone off mute

2

Housekeeping Items

Upon entry to the Webinar, you will be placed on mute.

Use headsets vs speakerphones for clear audio connections. Using wired connections will help to minimize wireless connectivity issues.

To ask questions please use the Chat Box on the right of the screen to communicate questions to the

presenter. You may also use the Raise Your Hand icon to ask a questions.

A copy of the Webinar slides will be emailed to the attendees.

3

Network Management Trainer Team

Ashli Morales
NETWORK MANAGEMENT TRAINER

Barbara Stebbins
NETWORK MANAGEMENT TRAINER

The network management trainers help to keep our provider community informed through webinar updates and other forums. We also develop provider education materials and support our internal teammates with timely updates and trainings.

4

Our Mission
We improve health every day.

Our Vision
To be the health plan of choice in the communities we serve.

Our Pledge
Helping you take care of yourself, and your family is our guiding mission. You'll see our commitment to you in the variety of innovative wellness programs we sponsor. Our dedication is also echoed in the concerned, caring manner that characterizes our customer service staff and philosophy. Simply put, it's this: when you're covered by Optima Health, we're passionate about your health.

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Traditional Commercial Plans
Vantage (HMO)
Plus (PPO)
Point of Service (POS)

Integrated Account-based Product Lines
Equity (HSA)
Design (HRA)

Self-funded Options for Large and Small Employer Group Tiered Plans
OptimaDirect℠

Narrow Network Plans
OptimaSelect℠

Individual & Family Plans
OptimaFit®

Medicare Advantage Plans
Optima Medicare HMO

Medicaid/FAMIS Plans
Optima Family Care
(Medicaid XP)

Dual Eligible Special Needs Plan (D-SNP)
Optima Community Complete

Commonwealth Coordinated Care Plus (CCC Plus) Plan
Optima Health Community Care
(Medicaid XP)

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Quarterly Agenda
OptimaHealth
Quarterly Agenda
What's New at Optima Health? – Timely review of new relationships, products, services, or other changes.
Update/Follow-up – Highlight general useful information.
Billing Updates – Billing Information and Updates
Member Experience – Review products, services, and programs useful for our members.
Important Reminders – Review training and regulatory requirements, deadlines, etc.
COVID-19 Update – COVID-19 Review, New Information, Updates
Question and Answers
3rd Quarter Medical Provider Touchpoint 2022
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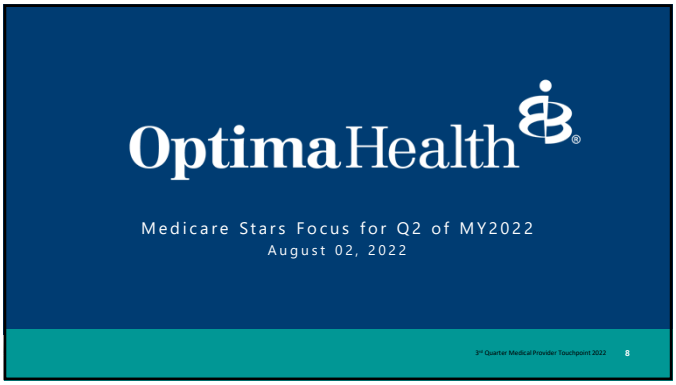
OptimaHealth
Medicare Stars Focus for Q2 of MY2022
August 02, 2022
3rd Quarter Medical Provider Touchpoint 2022
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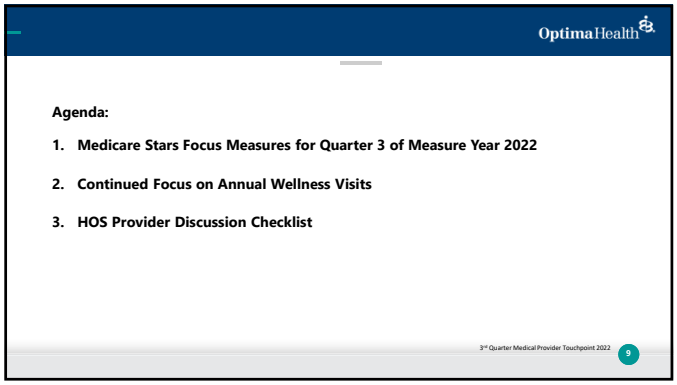
OptimaHealth
Agenda:
1. Medicare Stars Focus Measures for Quarter 3 of Measure Year 2022
2. Continued Focus on Annual Wellness Visits
3. HOS Provider Discussion Checklist
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Medicare Stars Clinical Focus Measures
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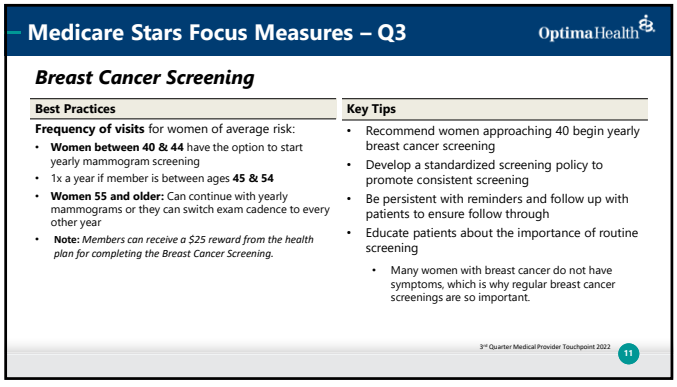
Medicare Stars Focus Measures – Q3
OptimaHealth
Breast Cancer Screening
Best Practices
Frequency of visits for women of average risk:
• Women between 40 & 44 have the option to start yearly mammogram screening
• 1x a year if member is between ages 45 & 54
• Women 55 and older: Can continue with yearly mammograms or they can switch exam cadence to every other year
• Note: Members can receive a $25 reward from the health plan for completing the Breast Cancer Screening.
Key Tips
• Recommend women approaching 40 begin yearly breast cancer screening
• Develop a standardized screening policy to promote consistent screening
• Be persistent with reminders and follow up with patients to ensure follow through
• Educate patients about the importance of routine screening
• Many women with breast cancer do not have symptoms, which is why regular breast cancer screenings are so important.
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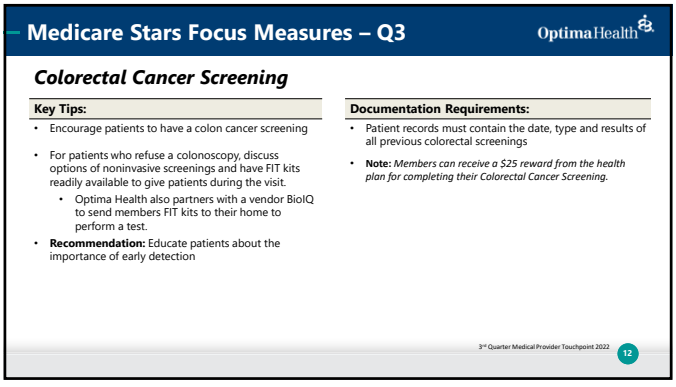
Medicare Stars Focus Measures – Q3
OptimaHealth
Colorectal Cancer Screening
Key Tips:
• Encourage patients to have a colon cancer screening
• For patients who refuse a colonoscopy, discuss options of noninvasive screenings and have FIT kits readily available to give patients during the visit.
• Optima Health also partners with a vendor BioIQ to send members FIT kits to their home to perform a test.
• Recommendation: Educate patients about the importance of early detection
Documentation Requirements:
• Patient records must contain the date, type and results of all previous colorectal screenings
• Note: Members can receive a $25 reward from the health plan for completing their Colorectal Cancer Screening.
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Medicare Stars Focus Measures – Q3

OptimaHealth

Diabetes Care – Eye Exam

Key Tips:

- Refer patients to optometrist or ophthalmologist for dilated retinal eye exam annually and explain why this is different than a screening for glasses or contacts.
- Educate patients about the importance of routine screening and medication compliance.
- Review diabetic services needed at each office visit.
- **Note:** Routine eye exams for glasses, glaucoma or cataracts do not count. Must be a retinal/dilated exam.

Documentation Requirements:

- When receiving a report from an eye care provider: Make sure the date of service, eye exam results, and eye care professional's name with credentials are included for HEDIS compliance.
- Review the report and note if there are any abnormalities. If so, add the abnormalities to the patient's active problem list and indicate the necessary follow-up.
- **Note:** *Members can receive a $10 reward from the health plan for completing their Diabetes Care Eye Exam.*

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Continued Focus on Annual Wellness Visits

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Annual Wellness Visits

OptimaHealth

Key Tips:

- Maximize member encounters – this may be the only visit to address routine health exams and prescriptions. Utilize this time to address other once-a year- screenings (Fall Risk, Improving Bladder Control, Monitoring Physical Activity).
- Schedule a "wellness day" to focus solely on AWVs.
- The yearly "Wellness" visit is not a physical exam the member can complete both with no out-of-pocket expense.
- Be proactive! Evaluate opportunities to close gaps every time the patient is seen rather than only reacting to the gap closure reports.

Note: *Members can receive a $25 reward from the health plan for completing their Annual Wellness Visit.*

Documentation Requirements:

Purpose: A visit to create and update a personalized prevention plan and perform a Health Risk Assessment (HRA).

Population: Patients **new or existing to their health plan**

Coverage: once **every** 12 months. (*Must be 12 months after the IPPE*).

Components:

- Perform an HRA (only for the patients first AWV after IPPE)
- Establish Family Medical History
- Establish list of current providers
- Measure BMI & BP
- Assess Cognitive Function
- Potential depression risk factors
- Assess Functional/Safety Abilities
- Establish Screening Schedule for patient
- Develop list of patient risk factors
- End of Life Planning
- Education & Reference to preventative services
- Review of Opioid prescriptions
- Screen for potential substance use disorders

Codes: G0438, G0439

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Health Outcomes Survey (HOS)

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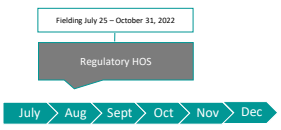
Health Outcomes Survey (HOS) Reminder

OptimaHealth

HOS in flight!

- What is it?
  - The HOS is a member experience survey that affects CMS Medicare Star ratings.
  - Collects **self-reported data** from members and measures the perception of their health status.
- HOS is administered **annually**. The 2022 survey starts now (July 25) and will go through October 31.
- The survey includes two components:
  1. Baseline survey
  2. Follow up survey to the same respondents two years later.



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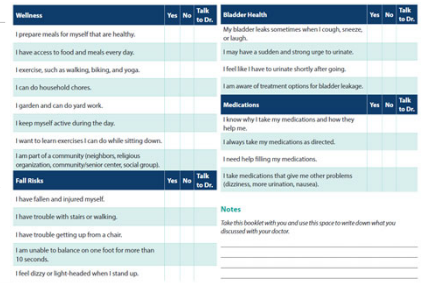
Provider Discussion Checklist

OptimaHealth

Provider Discussion Checklis

- **Goal:**
  - Patients should utilize this checklist to bring questions and potential health issues to the provider's attention.
  - Provide an easy-to-use checklist for patients to help them get the conversation started around uncomfortable topics.
- **Content:**
  - Visit Prep Tips (Med List, Member ID Card, etc.)
  - Discussion Checklist (*as seen on the right*)
  - Wellness Tips: Stay Active, Keep Your Balance, Maintain Your Bladder Health
- Please refer to this document at a member's visit to begin discussions on HOS topics.

Not all members received the checklist mailer.



Wellness	Yes	No	Talk to Dr.
I prepare meals for myself that are healthy.			
I have access to food and meals every day.			
I exercise, such as walking, biking, and yoga.			
I can do household chores.			
I garden and can do yard work.			
I keep myself active during the day.			
I want to learn exercises I can do while sitting down.			
I am part of a community (neighbors, religious organization, community/senior center, social group).			

Fall Risks	Yes	No	Talk to Dr.
I have fallen and injured myself.			
I have trouble with stairs or walking.			
I have trouble getting up from a chair.			
I am unable to balance on one foot for more than 10 seconds.			
I feel dizzy or light-headed when I stand up.			

Bladder Health	Yes	No	Talk to Dr.
My bladder leaks sometimes when I cough, sneeze, or laugh.			
I may have a sudden and strong urge to urinate.			
I feel like I have to urinate shortly after going.			
I am aware of treatment options for bladder leakage.			

Medications	Yes	No	Talk to Dr.
I know why I take my medications and how they help me.			
I always take my medications as directed.			
I need help filling my medications.			
I take medications that give me other problems (dizziness, more urination, nausea).			

Notes

Take this booklet with you and use this space to write down what you discussed with your doctor.

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Thank You

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What's New At Optima Health

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Optima Health Launching Doula Benefit for Pregnant Members

Doula Program is now live, retroactive to 7/1/2022. Optima Health now offers a doula benefit for members covered by Medicaid plans (Medallion and Commonwealth Coordinated Care Plus). Benefits include up to eight prenatal and postpartum visits and support during labor and delivery. Doula support will be offered in addition to existing benefits, including OB/GYN and hospital labor and delivery services.

Pregnant and postpartum members are eligible for:

- eight prenatal or postpartum visits
- one doula attendance at the delivery visit
- Members must choose a community doula who has completed a Virginia Department of Health approved certification program.

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Medicaid Codes No Longer Requiring Authorization Effective 07/15/2022

Medicaid Codes No Longer Requiring Authorization

A5500	A0429	95976	93655
L8030	A0427	95970	93657
L8035	A0425	95972	93462
L8000	A0433	95971	93568
L8440	A0225	95991	93567
L7510	A0430	95801	92971
L7520	A0998	93458	93563
L4370	A0422	93460	93788
L8032	A0420	93451	93566
94016	A0398	93653	93565
94660	A0394	93798	93786
94669	A0392	93459	93790
94762	95806	93656	93260
99177	95800	93650	93292
92072	95977	93654	93050

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Medicaid Long Term Services and Supports Screening in Nursing Facilities, Screening Restoration after COVID-9 Flexibilities

This release shares vital information on a 90-day window (6/14/22 to 9/12/22) for nursing facilities to complete screenings on those residents not possessing a current, valid screening in the system. The most notable language includes:

"...To assure that individuals are held harmless going forward, DMAS will allow 90 days from the date of this bulletin for conducting LTSS Screenings for any individual residing in a nursing facility without a LTSS Screening."
"...During the catchup time period, trained and certified nursing facility LTSS Screeners should complete a LTSS Screening for any individual who is or may be Medicaid eligible who resides in a nursing facility skilled, rehab, or long-term care/intermediate care but does not have a valid, authorizing, LTSS Screening."
"...Going forward, nursing facilities shall follow all laws and regulations regarding Medicaid LTSS Screening and PASRR for MI, ID and RC. All LTSS Screening teams must ensure that required LTSS Screenings are signed and authorized by a physician and entered into the electronic Medicaid LTSS Screening (eMLS) system."

You are encouraged to review this memo in its entirety Medicaid Bulletin-Medicaid Long Term Services and Supports Screening in Nursing Facilities Screening Restoration after COVID-19 Flexibilities-6.14.2022.pdf. Questions and inquiries may also be sent to the DMAS Screening Unit at screeningassistance@dmas.virginia.gov.

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DMAS UPDATES

DMAS: Implementation of new rates from 2022 State Budget Appropriations

DMAS is working on the implementation of new rates, effective July 1, 2022, approved by Governor Youngkin on June 22, 2022. Fee-for-Service (FFS) rates and Capitated rates are currently being developed. All FFS rates will be loaded by July 15, 2022. Capitated rates will be loaded by September 1, 2022. DMAS will distribute additional memos to update providers on the status of rate development and loading.

At this time providers have the option to bill immediately under old rates, and later adjust their claims or delay billing until rates are updated.

- Optima will reprocess all claims retroactively once the rates are loaded
- Optima is targeting to have the impacted claims reprocessed by 8/19/22.

DMAS: Updates to Mental Health Services Manual

DMAS had made changes to Chapter IV, Cover Services and Limitations Chapter and Appendix E, Intensive Community Based Support Appendix of the Mental Health Services Manual, previously known as the Community Mental Health Services (CMHRS) Manual. To familiarize yourself with these changes, please view the July 1, 2022 memo https://vamedicaid.dmas.virginia.gov/memo/updates-mental-health-services-manual

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Partners in Pregnancy Case Management Referral Form

OptimaHealth

To assist the Health Plan with identifying pregnant members, Optima Health has added a Partners in Pregnancy Case Management Referral Form to the website. By following this link https://www.optimahealth.com/providers/provider-support/provider-toolkit you will find a Forms section in which the Partners in Pregnancy Referral Form is located.

You may print the form and fax it to **757-352-2694** OR **833-666-0706**, or for even added convenience, you enter the required fields and hit submit. Your submission will be sent to the Partner in Pregnancy team, who will promptly reach out to the member to assess any case management needs further.

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New Employer Group – Effective October 1, 2022

OptimaHealth

Hampton City School members will be covered by Optima POS

- Effective October 1, 2022
- Approximately 2,800 Hampton City Schools employees and covered members will be transitioning from Cigna to Optima Health.
- Optima is administering both the medical and pharmacy program.

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Provider Connection Self-service Password Reset Now Available

OptimaHealth

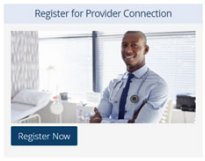
If you are an active Provider Connection user, you can save valuable time by enrolling in the self-service password reset process. Set up is easy and only requires two steps.

- Set up your security questions to activate password reset capabilities.
- Wait 24 hours so our systems can synchronize.

IMPORTANT:

- Login a minimum of once over 90 days to keep your provider portal profile active. If your account expires you may request assistance at Providerconnectionsupport@sentara.com.
- All Provider Connection Registration must complete a two-step login for added security.

NOT REGISTERED for Provider Connection click on this link to get started. https://apps.optimahealth.com/providers/login/login.aspx



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New ID Card Vendor – Effective July 5, 2022

OptimaHealth

Optima Health is transitioning ID card vendors from **HealthLOGIX** to **Clarity** on Tuesday, July 5, 2022, for all lines of business. This new vendor will allow us to provide a better experience to our members and valued physician partners with **improved digital ID cards** that mirror the familiar physical ID cards.

Once the digital integration is complete later this summer, the digital copy of the member ID card will mirror the physical member ID card. The switch to Clarity will be a seamless transition. Questions about this transition, please contact provider customer services at **(800) 229-8822 (medical)** or **(800) 648-8420 (behavioral health).**

clarity®

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Avalon Genetic Testing Implementation Delayed to 2023

OptimaHealth

On March 2, 2022, Optima Health announced that our collaboration with Avalon will expand with the addition of a new laboratory benefit management program in addition to the Routine Testing Management Services launched in October. We have made the decision to delay this implementation until 2023. Additional information will be forthcoming when the new launch date is near.

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New Sleep Testing Services Program – Effective Date Rescheduled to October 1, 2022

OptimaHealth

Our new sleep diagnostic testing program, previously announced to become effective on **August 1st has been rescheduled to October 1, 2022**. This new program is in partnership with CareCentrix® for our Commercial, Medicare, Dual Eligible Special Needs Plans (D-SNP), and Medicaid members. Until **October 1, 2022,** all contracted providers will be able to provide home sleep tests for Optima members. However, for the following two codes, **G0399** and **95806**, you will need to be part of the CareCentrix network to continue providing these services after this date.

If you have questions about Optima Health services, please contact your Network Educator at **1-877-865-9075, option 2.**

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Missing Baby Stats

OptimaHealth

We have identified a recent trend in which we are not receiving baby birth statistics (aka baby stats), to include:

- birth date
- birth weight
- gestational age
- vaginal or c-section birth
- single or multiple births

This is causing denied claims and delays while we obtain the information.

Baby stats are required by DMAS and are needed for HEDIS measures Please include baby stats with the original claim submission to avoid denied claims and other delays.

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OptimaHealth

Updates/Follow up

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Appointment Access Standards

OptimaHealth

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

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

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JIVA: Tips for Requesting an Authorization

OptimaHealth

Since JIVA went live on May 1, we have identified a few helpful tips to make the process of requesting an authorization smoother.
View and print Provider Portal: Tips for Requesting an Authorization (optimahealth.com) this tip sheet is a helpful resource as you acclimate to our new clinical management system.

Also, the JIVA tutorial remains available for viewing. If you have not already done so, complete the easy-to-follow tutorial, JIVA Resources | Providers | Optima Health today to learn how to navigate this new platform.

Important notes:

- You can view real-time decisions via the Optima Health provider portal under **view authorization**.
- Automated faxes have been discontinued.
- Make sure you are selecting clinical criteria as instructed in the tutorial.
- **Call Provider Customer Service for JIVA Portal questions. Give the agent your name, a return call number with area code and extension, and your question or description of the issue. If possible, write down error messages received or capture screenshots.**

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

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Virginia Medicaid Agency Launched New Technology Platform in April 2022

OptimaHealth

The Virginia Medicaid agency launched a new technology platform in April 2022. Providers credentialed in one or more Managed Care Organizations will use the new Provider Services Solution (PRSS) to complete enrollment and maintenance processes. This change is part of the Medicaid Enterprise System (MES) project.

PRSS will be more efficient and make it easier for providers to access information needed as a Medicaid provider. You will be able to update licenses and certifications and submit required attachments through the secure portal. You will also be able to request participation with MCO health plans during the enrollment/revalidation process through the portal.

Providers credentialed in one or more Managed Care Organizations (MCOs) will use the new platform to

- update licenses and certifications
- submit required attachments
- request participation with MCO health plans during the
- enrollment/revalidation process

Enrollment began June 1. To register for PRSS training, visit the MES Website, Provider Training Resources | MES (virginia.gov). The available courses include:
-PRSS-111 Provider Enrollment Application
-PRSS-118 Introduction to Provider and MCO Portal Delegate -Management
-PRSS-120- Introduction to the Provider Portal.

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Third Quarter Provider Edition Coming Soon

OptimaHealth

The second quarter issue of *ProviderNews* is now available on the Optima Health website, Provider News, Spring 2022 (optimahealth.com). Featured articles include the following:

- Let's Talk About Advance Care Planning With Our Patients
- Avalon Genetic Testing Implementation Begins This Summer
- Adhere to Our Appointment Access Standards
- Preparing for CAHPS: Take Steps to Improve Healthcare
- Experiences
- Medicare Stars: Focus Measures for Star Year 2024 (MY 2022)
- HOS Season Is Approaching
- and more...

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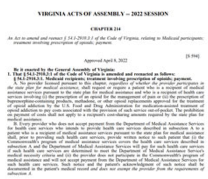
New Legislation Prohibits Accepting Cash for Pain Management

Virginia recently passed legislation that affects providers. Effective July 1, 2022, SB 594 prohibits a prescriber licensed through the Board of Medicine from charging a Medicaid member cash for prescribing an opioid for pain management or medications for treatment of opioid use disorder. Learn more, [legp604.exe (virginia.gov)] about the legislation and how it could affect you.



VIRGINIA ACTS OF ASSEMBLY – 2022 SESSION

CHAPTER 214

An Act to amend and reenact § 54.1-2910.3:1 of the Code of Virginia, relating to Medicaid participants; treatment involving prescription of opioids; payment.

[S 594]

Approved April 8, 2022

Be it enacted by the General Assembly of Virginia:
1. That § 54.1-2910.3:1 of the Code of Virginia is amended and reenacted as follows:
§ 54.1-2910.3:1. Medicaid recipients; treatment involving prescription of opioids; payment.

A. No provider licensed pursuant to this chapter, *regardless of whether the provider participates in the state plan for medical assistance,* shall request or require a patient who is a recipient of medical assistance services pursuant to the state plan for medical assistance and who is a recipient of health care services involving (i) the prescription of an opioid for the management of pain or (ii) the prescription of buprenorphine-containing products, methadone, or other opioid replacements approved for the treatment of opioid addiction by the U.S. Food and Drug Administration for medication-assisted treatment of opioid addiction to pay costs associated with the provision of such service out-of-pocket. The prohibition on payment of costs shall not apply to a recipient's cost-sharing amounts required by the state plan for medical assistance.

B. Every provider who does not accept payment from the Department of Medical Assistance Services for health care services who intends to provide health care services described in subsection A to a patient who is a recipient of medical assistance services pursuant to the state plan for medical assistance shall, prior to providing such health care services, provide written notice to such patient that (i) the Commonwealth's program of medical assistance services covers the health care services described in subsection A and the Department of Medical Assistance Services will pay for such health care services if such health care services are determined to meet the Department of Medical Assistance Service's medical necessity criteria and (ii) the provider does not participate in the Commonwealth's program of medical assistance and will not accept payment from the Department of Medical Assistance Services for such health care services. Such notice and the patient's acknowledgment of such notice shall be documented in the patient's medical record *and does not exempt the provider from the requirements of subsection A.*

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Closing Care Gaps

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At-Home Diabetes Testing Program

- Only members with a gap in A1c testing are included in the annual campaign.
  - Planning to offer KED kits for kidney evaluation in QTR 3 2022
- Members and PCPs receive completed results via mail
- PopCare Team calls members with elevated results
  - If > 9 nurse also calls PCP and refers to case management
- Members can track their results through the online portal: https://optima.bioiq.com
- Info on Diabetes: www.Optimahealth.com/diabetes
- Order a replacement A1c kit here: www.optimahealth.com/dmtest

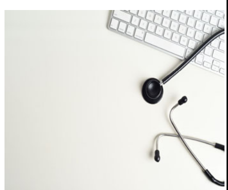
2022 At-Home Diabetes Testing Timeline

A1C Tests PUSH Campaign Timeline:

- **June 2022**
  - Medicare
  - DSNP
  - OHCC (CCCP)
  - OFC (M4)
- **September 2022**
  - Medicare
  - DSNP
  - OHCC (CCCP)
  - OFC (M4)

KED Testing available:

- QTR 3



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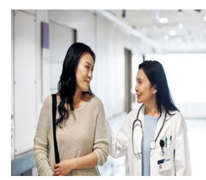
BIOIQ Fit Program

- Only members with a gap in Colorectal Cancer Screening are included in the annual campaign
- Members and PCPs receive completed FIT results via mail
- PopCare Team calls members with Positive and Inconclusive results
- Members can track their results through the online portal: https://optima.bioiq.com
- Info on Colon Cancer: https://www.optimahealth.com/members/health-and-wellness/health-conditions/colorectal-cancer-information-and-prevention

Order a replacement fit kit here: www.optimahealth.com/colonhealth



2022 Annual FIT Campaign Timeline

LOBs included each month:

- **May 2022**
  - Medicare
  - DSNP
  - Exchange
  - Feds
- **June 2022**
  - OHCC (CCCP)
- **July 2022**
  - OFC (M4)
- **August 2022**
  - Commercial SF
- Only groups who agree to the PUSH (automatic mail out)
- Some groups may choose Opt-in only or may choose to be excluded
- September 2021
  - Commercial FF
  - *Each month may also include other LOBs/product lines besides what is listed here due to website requests included in each month's

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Billing Tips and Updates

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DMAS Memo – Coverage of Vaccine Counseling Services for EPSDT – Eligible Members CPT Code 99401

DMAS and All managed care organizations (MCOs)

- Will cover a stand-alone billing code for COVID-19 vaccine counseling services through the last day of the first quarter that begins one year after the last day of the COVID-19 emergency.
- Affirm coverage of non-COVID-19 vaccine counseling via existing well-child and preventive care billing codes for all EPSDT eligible Medicaid members (e.g., full benefit Medicaid members under 21 years of age). This coverage is consistent with Section 9811 of the American Rescue Plan Act of 2021 (ARPA)

NOTE: This procedure code is not dedicated to only COVID Counseling it is used for Nutritional Counseling and other counseling services as well for both Optima Health plan and Virginia Premier Health Plan.

CSC has been configured updating this code so there should not be any issues with paying the provider bills correctly.

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Third Party Biller Denied Claim Form (4+ claims)

There is now a third-party billers denied claim form on the Optima Health website found in the provider toolkit found at this link https://www.optimahealth.com/providers/provider-support/provider-toolkit. You will be able to access the form as well as the content explaining its purpose.

NOTE: This form is for **Denied Medical Claims ONLY**, it cannot be used for BH claims

Provider Customer Service Claims Request:	
Billing Company Name	
Contact Person's Name	
Phone (include area code)	
Fax Number	

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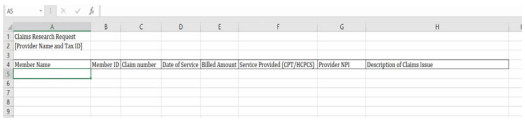
Claims Project Request Template.

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.



	A	B	C	D	E	F	G	H	I
1	Claims Research Request								
2	[Provider Name and Tax ID]								
3									
4	Member Name	Member ID	Claim number	Date of Service	Billed Amount	Service Provided (CPT/HCPCS)	Provider NPI	Description of Claims Issue	
5									
6									
7									
8									
9									

https://www.optimahealth.com/providers/provider-support/provider-toolkit

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Member Experience

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Optima Health partnership with DarioHealth

Optima Health is pleased to announce a new partnership to offer additional support to members with type 2 diabetes. **DarioHealth** helps people with chronic conditions, such as diabetes, to manage their health.

Is there a cost to Dario?

- Dario is covered by Optima Health at no cost to eligible members. In other words, there are no copays or cost-sharing applied to the Dario program for members.

How do members find out about Dario?

- Medicaid and D-SNP members over 18 with type 2 diabetes are identified by claims data and this information is shared with Dario. They will receive an email or letter offering the program with a phone number and website to enroll. We encourage members to enroll. Eligible members may be invited to enroll based on their individual needs; enrollment experiences may vary by eligible member.

What members are eligible to participate in Dario?

- **Optima Health Medicaid and D-SNP members**, who meet the criteria, are eligible:
  - are covered by an Optima Health Medicaid or D-SNP plan
  - Are at least 18 years of age
  - Have been diagnosed with type 2 diabetes
  - Own a smartphone to use the app

Members that may not qualify?

- **Members may not qualify if they are pregnant or have:**
  - liver failure
  - end-stage renal disease
  - had an organ transplant or bone marrow transplant
  - cystic fibrosis
  - other exclusionary conditions

If you have questions about Dario, please reach out to Dario Member Services at 1-833-914-3798(TTY: 711).

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Member assistance transitioning from acute care or requires specific education.

Whether a member needs assistance transitioning from acute care or requires disease specific education, Optima Health has a team of clinicians to assist members in meeting their health goals. Typical referrals to our clinical team include:

- Members with complex medical issues who utilize multiple services
- Members who are non-adherent with treatment plans
- Members who frequently utilize services without consulting PCP or Specialist
- Members who frequently utilize the ER
- Members who could benefit from disease management of heart failure, diabetes, cardiovascular disease, asthma, COPD or obesity
- Neonatal care for premature and medically complex newborns

Medical Provider Relations **Customer Service 1-800-229-8822** available **Monday-Friday 8am-5pm.** Members can call member services from **8 a.m. to 5 p.m. Monday through Friday** at the phone number listed on their Member ID card.

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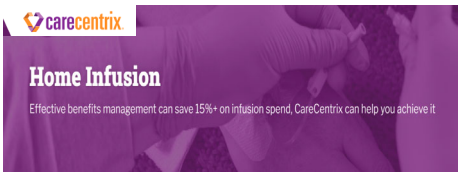
CareCentrix Manages Home Infusion Therapy

Members will receive a notice announcing Optima Health's partnership with CareCentrix to manage the Home Infusion Therapy (HIT) needs of our members who need independent home infusion therapy.



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CDC National Diabetes Prevent Program (DPP)

OptimaHealth

Two participating Health plans Anthem & Optima Health are working in grant-funded collaboration with VDH and DMAS to enroll a total of 200 Medicaid members by June 30, 2022. However, the program currently only has about 60 enrolled members. VDH and DMAS have requested that we continue our efforts to enroll members for another couple of months as well as re-educate our provider groups on the pilot.

NOTES from the 3/22/22 meeting (DPP Program – Provider Help):

- Year-long pilot for Medicaid members. Through June 2023
- Need providers to help identify members to enroll in the program
- Anthem and Optima are the only participating health plans at this time
- Members receive program support for participating
- Goals
  - o Weight loss
  - o Feel better
  - o Reduce risk
- We don't want specific providers targeted, but all providers to be educated and refer any Medicaid members to this program

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OptimaHealth

Important Reminders

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Ensure Your Online Provider Directory Information is Accurate

OptimaHealth

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.

Here is what you need to do:

- Respond quickly
- Register for the Verify Health Care Portal and log in to confirm that all details are correct. If you registered for the portal previously, use your existing credentials to log in.
- Use one of the following browsers: Mozilla Firefox, Microsoft Edge, or Google Chrome.
- Seek help if needed by contacting LexisNexis Risk Solutions Tech Support at healthcare.custhelp.com/app/ask, Ask a Question (custhelp.com)
- The portal is a secure, free website for our Optima Health provider network to confirm directory information. Thank you for assisting us with this process and for your timely response.

Note: Keeping your information up-to-date makes it easy to comply with your Optima Health provider participation agreement and the requirements set by the Centers for Medicare & Medicaid Services(CMS) and the Department of Medical Assistance Services (DMAS).

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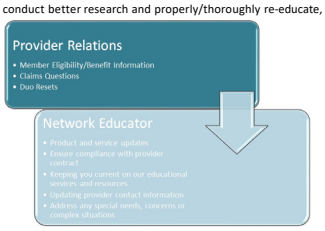
Provider Relations Key Contacts

OptimaHealth

When addressing/escalating concerns with your network educator about Optima Health policies and procedures please note the number dialed, date and time, and the person with whom spoken. Having these details enables us to conduct better research and properly/thoroughly re-educate, whether internally or externally.



Provider Relations
Medical
Phone: 1-800-229-8822
Fax: 757-552-7316
8 a.m. to 5 p.m. M-F

24-Hour Interactive Voice Response
Phone: 757-552-7474 or 1-800-229-8822, option 2

Clinical Care Services Pre-Auth
Government Plans (888) 946-1167 Medical & Drug Questions
Commercial (800) 229-5522 Medical & Drug Questions
Behavioral Health: 1-800-648-8420

Please use the Optimahealth.com/provider website Contact Us option on the top right hand corner of our webpage to get access to the most up to date phone numbers, email addresses and other addresses.

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Reconsiderations

OptimaHealth

A request for reconsideration is a re-billed or corrected claim for same patient, date of service(s) and/or procedure(s)

Electronic Reconsiderations can be done FASTER on www.optimahealth.com to change CPT, Diagnosis, Place of Service, Quantity & Correct Charges (does not apply to behavioral health)
Be sure to reconsider the ENTIRE claim

Paper requests for reconsideration of a claim denial must include the claim or copy of the remit, any supporting documentation, and the "Provider Reconsideration Form or Behavioral Health Reconsideration Form" (found on https://www.optimahealth.com/providers/billing-and-claims/coverage-decisions-and-appeals and mailed to:

Medical Claims PO
Box 5028
Troy, MI 48007-5028

Behavioral Health Claims PO
Box 1440
Troy, MI 48007-5028

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Provider Directory

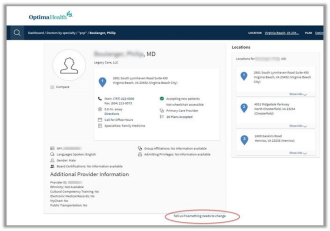
OptimaHealth

Please review the Online Provider Directory
Please review the online provider directory routinely or call provider services for the status of your providers. For SHP providers a written notice to SHP should be provided within 60 days of the occurred change.

Confirm the following for the Online Provider Directory during provider visits:

- Providers who have joined/left the practice
- Service Addresses (Do not list locations where they do not regularly see patients)
- Specific products under contract
- Accepting New Members (Panel Status)
- Public Transportation Availability
- Digital Contact Information (email address or website)

Note: List a provider's subspecialty in the directory only when approved by Credentialing. Notify credentialing if you want to add a subspecialty to a provider that was previously submitted to credentialing without that subspecialty



www.optimahealth.com/providers/provider-support

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Register for Our Upcoming Webinars

We invite providers to join our upcoming webinars. See dates and registration links below:

- **Quarterly Provider Webinar August 3 at 10 AM**
- **Let's Talk Behavioral Health on August 9 at 10 AM**
- **Quarterly Provider Webinar August 10 at 1 PM**
- **Quarterly Provider Webinar November 2, at 10 AM**
- **Quarterly Provider Webinar November 9, at 1 PM**
- **Let's Talk Behavioral Health on November 8, at 10 am**
- **Claims Brush Up September 7 at 10 AM**
- **Claims Brush Up December 7 at 11 AM**

https://www.optimahealth.com/providers/webinars/

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Updating and Certifying Provider Data in NPPES

The National Plan & Provider Enumeration System (NPPES) requires contracted healthcare providers to maintain accurate Provider Data. As you may know, providers are legally required to keep their NPPES data current. The centers for Medicare & Medicaid Services (CMS) is also encouraging Medicare Advantage Organizations to use NPPES as a resource for our online provider directories. By using NPPES, we can decrease the frequency by which we contact you for updated directory information and provide more reliable information to Medicare beneficiaries.

Here's what you need to know:

- When reviewing your provider data in NPPES, please update:
  - any inaccurate information in modifiable fields including provider name
  - mailing address, telephone and fax numbers, and specialty
- Include all addresses where you practice and actively see patients and where a patient can call and make an appointment.
- Do not include addresses where you could see a patient, but do not actively practice.
- Remove any practice locations that are no longer in use.
- Once you update your information, you will need to confirm it is accurate by certifying it in NPPES.
- Remember, NPPES has no bearing on billing Medicare Fee-For-Service.

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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 safety or well-being of a member/patient. It includes, but is not limited to:

- medication errors
- severe injury or fall
- theft
- suspected physical or mental abuse or neglect
- financial exploitation
- death of a member/patient

Reporting critical incidents ensures member/patient safety, helps to avoid repeating errors, addresses areas of concern and complies with regulatory reporting requirements. Immediately report alleged abuse, neglect or exploitation related critical incidents to appropriate protective services agency:

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

Within 24 hours, email or fax all Critical Incidents via the Critical Incident Report Form Critical Incident Form_11092021 (optimahealth.com) located on optimahealth.com/providers:

Email: **Optima_critical_incidents@optimahealth.com**

Critical Incident Fax: (833) 229-8932 **OR** Call Optima Health: (757) 252-8400

We have prepared training materials, Critical Incident Reporting Provider Education (optimahealth.com) and an at a glance resource, Critical Incident Reporting Flyer for Providers (optimahealth.com) which both providing important requirement in greater detail.

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COVID-19 UPDATES

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How to Submit for the One Time COVID-19 Support Payment for Attendant/AIDES

DMAS received federal approval to provide the one-time support payment for aides/attendants who provided agency-directed or consumer-directed personal care (T1019, S5126), respite care (T1005, S5150), or companion care services (S51350, S5136) to Medicaid members during the first quarter of the State Fiscal Year (SFY) 2022 (July 1, 2021 – September 30, 2021). A roster of qualifying aides derived from Medicaid claims from July 1, 2021, through September 30, 2021, has been compiled. The final roster was distributed to providers via email in June 2022. The roster includes the following information which is necessary to receive payment for each aide:

- Member name
- Associated aide
- Payer source as derived from the claim

To receive the one-time payment, agency providers must submit a claim through their standard process utilizing either EDI 3 837P or DDE to the payer source identified on the roster using the HCPCS code G2021.

Very Important:

- **The date of service for the claim is when the aide provided care for the member during the period of July 1, 2021, through September 2021. This can be a range of dates (including dates when services were not provided) or a specific date. Be sure the date of service does not exceed the date the aide last provided service for the member.**
- **The reimbursement amount is $1,117.60. The amount over $1,000 covers the provider's administrative costs, including required payroll taxes.**
- **Providers must not submit claims for members/aides that were not identified on the agency's final roster.**
- **If you have not received a roster, please send a secure email to C19SUPPORT@mslc.com or call the MSLC COVID-19 Support Department at (888) 832-0856.**
- **DMAS is waiving the timely filing requirement for G2021 through October 31, 2022 for claims submitted after twelve months from the service date. For these claims, agencies must attach a Timely Filing Waiver. https://vamedicaid.dmas.virginia.gov/sites/default/files/2022-06/Timely%20Filing%20Attachment_6.9.22_Final.pdf**
- **A G2021 claim submitted with the Timely Filing Waiver that is received after October 31, 2022, will be denied for timely filing.**

Additional billing instructions: https://dmas.virginia.gov/media/4709/billing-instructions-updated-05-18-2022.pdf

FAQs: https://dmas.virginia.gov/media/4708/faq-for-1k-payment.pdf

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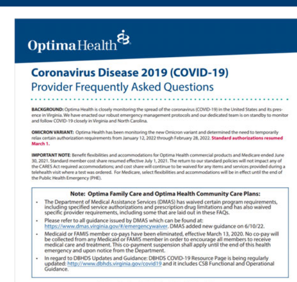
COVID-19 FAQs Updated for Providers

We recently updated our robust list of COVID-19 frequently asked questions (FAQs) document for providers. Certain telehealth flexibilities have been extended to August 31, 2022, and we will notify you of any extensions.

COVID FAQs for Providers (optimahealth.com)


Optima Health
Coronavirus Disease 2019 (COVID-19)
Provider Frequently Asked Questions

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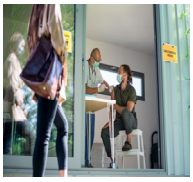
Coverage of COVID-19 Vaccine Boosters and Alternative COVID-19 Vaccine Formulations and Preparations

OptimaHealth

Optima Health will cover the following for all full benefit Medicaid and FAMIS members: 1) a second vaccine booster dose of either the Pfizer-BioNTech or Moderna COVID-19 vaccines for adults, 2) a Pfizer[1]BioNTech COVID-19 vaccine booster for children ages 5-11 years of age, 3) the tris-sucrose formulation of Pfizer-BioNTech COVID-19 vaccine doses for adults, and 4) the new booster preparation of the Moderna COVID-19 vaccine.

Vaccines should be administered according to the latest CDC Guidelines. See DMAS 6/30/22 memorandum for additional details: file:///C:/Users/rwjenki1/AppData/Local/Microsoft/Windows/INetCache/Content.Outlook/N40YD6Y2/Coverage%20of%20COVID-19%20Vaccine%20Boosters%20And%20Alternative%20COVID-19%20Vaccine%20Formulations%20and%20Preparations.pdf



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Questions and Answers

OptimaHealth

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QR SURVEY CODE

OptimaHealth

Scan this QR code to take our quick survey questions

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Thank you For Partnering with Optima Health!

Contact Us

NMTrainers@sentara.com

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