OPTIMA HEALTH MEDICAID PROGRAM
PROVIDER MANUAL

This version of the Optima Health Medicaid Program Provider Manual was last updated on November 1, 2022. This version is available to all providers from our website, optimahealth.com. Updates to the Provider Manual occur as policies are reviewed and updated, new programs are introduced, and contractual/regulatory obligations change.

Please visit *optimahealth.com/providers/provider-support/manuals* for the most current information.

Please note Cardinal Care will be effective July 1, 2023.

INTRODUCTION AND WELCOME

Welcome to the Optima Health Medicaid program. Thank you for your participation with Sentara Health Plan, Inc. (SHP), a division of Sentara Healthcare. As a Participating Provider, you are an integral member of our team. We thank you for making it possible for Sentara Health Plans to promote the maintenance of health and the management of illness and disease by providing access to quality healthcare to the communities we serve.

This Provider Manual is effective January 1, 2023 and covers policies and procedures for providers for Medicaid plans administered by Sentara Health Plans.

Easily find information in this Provider Manual using the following steps:

Select CTRL+F.
Type in the key word.
Press Enter.

The Provider Manual contains important information to assist you with member and product identification, authorizations, claims reimbursement policies/procedures, and provider obligations under your Provider Agreement. You will also find useful information such as contact names, phone numbers, addresses and direct web links to policies and forms. Additional information and tools are available at optimahealth.com.

The Provider Manual was developed to assist you in understanding the administrative requirements associated with managing a member's healthcare. The Provider Manual, including all sources that are referenced by and incorporated herein, via web-link or otherwise; is a binding extension of your Provider Agreement and is amended as our operational policies change. In addition to the Provider Manual being available online, it is also available in paper form, by written request.

If there is a conflict with any state law, federal law or regulatory requirement and this Provider Manual, the law or regulation takes precedence.

Should this Provider Manual conflict with your Provider Agreement, your Provider Agreement takes precedence.

The following terms are used throughout this Provider Manual:

Affiliate means any entity (a) that is owned or controlled, directly or indirectly, through a parent or subsidiary entity, by SHP, or any entity which is controlled by or under common control with SHP, and
(b) which SHP has agreed may access services under the Provider Agreement.

Agreement means the Provider Agreement, attachments, and any amendments, including Exhibits.

Member means any individual, or eligible dependent of such individual, whether referred to as "Insured," "Subscriber," "Member," "Participant," "Enrollee," "Dependent" or otherwise, who is eligible, as determined by a Payor, to receive Covered Services under a Health Benefit Plan. Members specifically include, but are not limited to, individuals enrolled in self-funded employee benefit plans which employ SHP or an Affiliate as a third-party administrator, and individuals enrolled

in fully insured plans with an Affiliate.

Participating Provider means a duly licensed physician or other health and/or mental health care professional, as designated at the sole discretion of SHP, who has entered into a contract with SHP either as an individual or as a member of a Group Practice and who has been approved to provide Covered Services under a Health Benefit Plan(s) in accordance with SHP's credentialing requirements and the requirements of such contract between the provider and SHP at the time such Covered Services are rendered. Participating Providers shall include, but not be limited to, licensed professional counselors, marriage and family counselors, certified behavioral analysts, nurse midwives, nurse practitioners, nurse anesthetists, physician assistants, participating hospitals, and other health and/or mental health care professionals, as may be designated by SHP, in its sole discretion, from time to time.

Sentara Health Plans, Inc. (SHP) is a corporation organized for the purpose of contracting with providers for the provision of health care services pursuant to health insurance benefit plans, as well as for benefit plan administration to provide, insure, arrange for, or administer the provision of healthcare services.

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Methods to Reach the Health Plan

Topic	Website Address	Medicaid Program Phone	Information
Provider Relations & Eligibility Verifications	www.optimahealth.com/providers/contact-us	Phone: 1-844-512-3172	Contact Optima Health Medicaid program Provider Relations for most concerns.
Member Services	www.optimahealth.com/members/	Phone: 1-800-881-2166 (Hearing Impaired/VA Relay: 711)	Members can contact Optima Health for various concerns and questions
Claims	www.optimahealth.com/providers/billing-and-claims/billing-reference-sheets-claims-submission-guidelines	Phone: 1-844-512-3172	Medical Claims P.O. Box 5028 Troy, MI 48007-5028 Behavioral Health Claims P.O. Box 1440 Troy, MI 48099-1440
Claim Overpayment	www.optimahealth.com/documents/forms/general/form-doc-provider-reconsideration-form.pdf	Phone: 1-800-508-0528	Optima Health Provider Refunds P.O. Box 61732 Virginia Beach, VA 23466
Dental (Medicaid Direct: Smiles for Children)	www.dmas.virginia.gov/for-providers/dental/	Provider Relations Phone: 1-888-912-3456	For Dentists Resources, Training Material
Eligibility	login.vamedicaid.dmas.virginia.gov/SecureISS/landingpage	Toll free MediCall Automated System at 1-800-772-9996 or 1-800-884-9730	Phone resource for eligibility review
Electronic Data Interchange Questions and Concerns	www.optimahealth.com/providers/billing-and-claims/edi-transaction-overview-and-eft-set-up	Call Provider Relations for more information.	Electronic claims submission questions, concerns

Interactive Voice Response System	Not Applicable	Main Phone Line 24-Hour Interactive Voice Response: 757-552-8975 or 1-800-881-2166	To verify eligibility, providers should utilize the Optima Health Interactive Voice Response System (IVR).

Topic	**Website Address**	**Medicaid Program Phone**	**Information**
Clinical Care Services Medical Authorizations, Medical Benefit, Drugs for Medicaid Products	Not Applicable	Phone: 1-888-946-1167 Fax numbers for specific services are located on the authorization fax form.	Clinical Care Coordination, Medical Benefit questions and Pharmacy needs
Pre-Authorization	www.optimahealth.com/providers/authorizations/	Phone: 1-888-946-1167 LTSS Authorizations Fax: 1-844-828-0600	The preferred method to obtain prior-authorization is through the Optima Health secure provider portal, Provider Connection.
Behavioral Health	Not Applicable	Phone: 1-888-946-1168	Inpatient Fax: 1-844-348-3719 Outpatient Fax: 1-844-895-3231
Care Coordination	www.optimahealth.com/plans/medicaid/contact-optima-health-medicaid	Phone: 1-866-546-7924	Monday through Friday from 8:00 a.m. to 5:00 p.m. EST After 5:00 p.m. Please contact Member Services at the number on the back of your Member ID Card. Fax: 1-844-552-8398 Medical Reports, etc.

After Hours Program	www.optimahealth.com /plans/medicaid/contact-optima-health-medicaid	Phone: 1-800-394-2237	24-Hour Nurse Advice Line
Telephone for Deaf and Disabled	www.optimahealth.com/plans/medicaid/contact-optima-health-medicaid	Phone: VA Relay 1-800-828-1140 or 711	For Deaf, Hard of Hearing, and Disabled Persons

Topic	**Website Address**	**Medicaid Program Phone**	**Information**
Centipede/HEOPS	www.centipedehealth.com	Phone: 1-855-359-5391	Fax: 1-866-421-4135 Centipede Credentialing: CENTIPEDE Health P.O. Box 291707 Nashville, TN 37229 E- Mail: joincentipede@heops.com
Member Transportation	Transportation benefit can be found at: www.optimahealth.com/providers/provider-support/education/transportation Transportation Benefit Provider Education: www.optimahealth.com/documents/provider-orientation/017- faqs-non-emgergency-transport.pdf	Phone: 1-877-892-3986	Members may schedule using the Member Portal through Verida.
Optima Health Website	www.optimahealth.com	Phone: 1-877 552-7401	Optima Health web access as a resource for provider, member and plan information and updates.
Provider Relations & Eligibility Verification Training & Online Support	www.optimahealth.com /providers	Phone: 1-844-512-3172	

Participation in Medicaid Fee for Service	Virginia Medicaid Provider Enrollment Helpline	Phone: 1-888-829-5373	
Join the Network	www.optimahealth.com/documents/provider-manuals/request-for-participation.pdf		Complete and email the form to: PrvRecruit@sentara.com

Interpreter Services

Providers are to contact Optima Health Provider Services for interpreter services. Interpreter services for Medicaid program members are coordinated and reimbursed by Optima Health as required by the Virginia Department of Medical Assistance Services (DMAS).

SECTION I: MEDICAID PROGRAM OVERVIEW

Effective January 1, 2023, the Virginia Department of Medical Assistance Services (DMAS) has rebranded Medicaid fee-for-service and managed care programs into a single program, Cardinal Care. The previous program names, Commonwealth Coordinated Care Plus (CCC Plus) and Medallion 4.0, are now referred to as Cardinal Care Managed Care. This program alignment will assist individuals as their needs change across the continuum of care.

The Medicaid program is designed to better serve individuals who are receiving Medicaid services in Virginia. The goal of the program is to improve the lives, satisfaction, and health outcomes of participants by providing a seamless, one-stop system of services/supports and assisting with navigating the complex service environment. By integrating medical and social models of care, supporting seamless transitions between service settings and facilitating communication between providers, Optima Health will ensure members receive person-centered care driven by individual choice and rights.

Medicaid Program Members

The Cardinal Care population is comprised of the following population groups:

- former Medallion 4.0 populations, including Low-Income Families and Children Covered Populations and
- former Commonwealth Coordinated Care Plus Populations, including Aged, Blind and Disabled (ABD), Medically Complex MAGI Adults, and LTSS Covered Populations
- managed care eligible populations listed above who have other third-party liability insurance (TPL), except coverage purchased through HIPP and FAMIS Select
- managed care eligible populations listed above who are in the hospital at the time of initial MCO enrollment

Transportation Program

Our Medicaid program provides urgent and emergency transportation. Non-emergency transportation (NEMT) for covered services **requires scheduling**, including air travel and services reimbursed by an out-of-network payer.

Optima Medicaid program member covers non-emergency transportation for eligible members for covered services as well as emergency transportation. If a Medicaid program member has no other means of transportation, transportation will be provided to and from medical appointments. **FAMIS members do not have a nonemergent transportation benefit**.

Optima Health has contracted with Verida (formerly Southeastrans) to administer the transportation program (taxi and wheelchair). The member is expected to call 1-877-892-3986 five days in advance of a scheduled covered service to have transportation arranged. Verida does not cover scheduled ambulance/stretcher transportation. Non-emergency ambulance/stretcher is approved and arranged by Optima Health Medical Care Services. For more information regarding transportation, please call 1-877-892-3986 (toll free).

Where to Begin the Enrollment and Eligibility Process

All members who would like to enroll in Optima Health Medicaid programs must be enrolled in Virginia Medicaid first. Members will either choose or be assigned to an MCO per the DMAS assignment algorithm.

New Member Information

DMAS uses an assignment algorithm to assign Medicaid members to their respective MCOs, often utilizing history of relationships with the providers that have traditionally given the member care. During enrollment, Optima Health members will receive a New Member Handbook, which explains the members' healthcare rights and responsibilities.

To obtain copies of the member Guides, please visit:	www.optimahealth.com/members/manage- plans/member-guides

Medicaid Program Enrollment and Assignment Process

DMAS has sole responsibility for determining the eligibility of an individual for Medicaid funded services.

- Providers can verify Medicaid Enrollment on the DMAS website at login.vamedicaid.dmas.virginia.gov/SecureISS/landingpage or by contacting the toll free MediCall Automated System at 1-800-772-9996 or 1-800-884-9730.

To verify eligibility for Optima Health, providers should utilize the Optima Health Interactive Voice Response System (IVR), the Optima Health secure provider portal (Provider Connection) or call Provider Relations.

- Main Phone Line 24-Hour Interactive Voice Response
  757-552-8975 or 1-800-881-2166

Enrollment Process for Newborns: When a Medicaid program member gives birth during

enrollment, the newborn's related birth and subsequent charges are covered by Optima Health through the Medicaid program. For the newborn to be covered, the mother/parent/guardian must report the birth of the child by calling the Cover Virginia Call Center at 1-855-242-8282 or by contacting the member's local Department of Social Services. Once Medicaid enrolled, the newborn is enrolled in the birth member's MCO, effective with the newborn's date of birth.

Enrollment Process for Foster Care and Adoption Assistance Children: The Optima Health Medicaid program provides services for children enrolled in Foster Care and Adoption Assistance (aid category 076 and 072, respectively). Optima Health and network providers, are required to comply with the following rules:

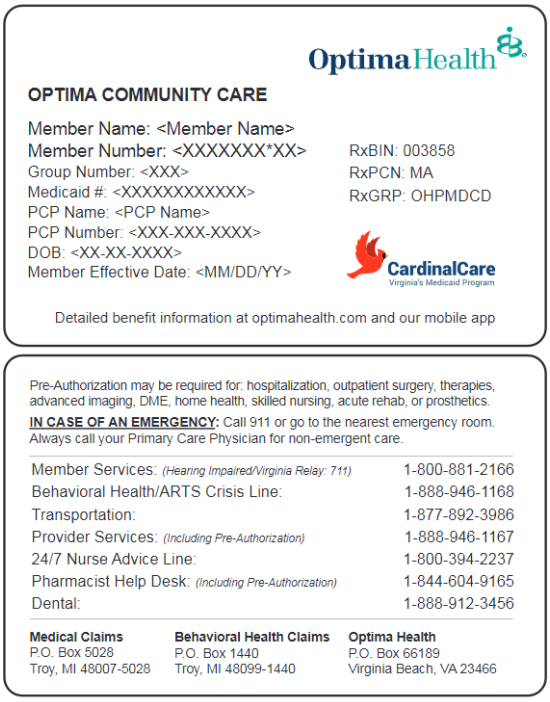
- The social worker is responsible for health plan selection and changes for foster care children.
- The adoptive parent is responsible for health plan selection and changes for adoption assistance children.
- The former foster care or Fostering Futures Members are responsible for their health plan selection and any subsequent health plan changes.
- Members in foster care and adoptions assistance may change their health plan at any time and are not restricted to their health plan selection following the initial 90-day health plan enrollment period.
- Coverage extends to all medically necessary Early and Periodic Screening, Diagnostic and Treatment (EPSDT) or required evaluation and treatment services of the foster care program. Optima Health and network providers work with DMAS in all areas of care coordination. Optima Health provides covered services until DMAS disenrolls the child from the plan. This includes circumstances where a child moves out of our service area.

Newborn Eligibility and Claim Submission for Optima Health Medicaid Program

Any newborn whose mother is enrolled in Optima Health Medicaid program shall also be enrolled from their date of birth up to three months (birth month plus two months). Continued eligibility is determined by DMAS. For the Optima Health Medicaid program, please submit claims for newborns under the child's member ID number if the number is available. Remember that if you file a newborn claim under the subscriber's member ID number, the claim will suspend for assignment of the newborn's name and member ID number. To avoid unnecessary delays in claims payment, please encourage the mother of your patient to call Member Services with the newborn's name as soon as possible so a member ID number may be assigned, and the claims processed. The Optima Health Medicaid program requires the use of the newborn's member ID rather than the subscriber's member ID. Hospitals should submit newborn enrollment via the streamlined online enrollment process through the DMAS web portal at:
login.vamedicaid.dmas.virginia.gov/SecureISS/landingpage

Medicaid Program ID Card Sample

Optima Health Medicaid Program



OptimaHealth

OPTIMA COMMUNITY CARE

Member Name: <Member Name>
Member Number: <XXXXXXX*XX>
Group Number: <XXX>
Medicaid #: <XXXXXXXXXXX>
PCP Name: <PCP Name>
PCP Number: <XXX-XXX-XXXX>
DOB: <XX-XX-XXXX>
Member Effective Date: <MM/DD/YY>

RxBIN: 003858
RxPCN: MA
RxGRP: OHPMDCD

CardinalCare Virginia's Medicaid Program

Detailed benefit information at optimahealth.com and our mobile app

Pre-Authorization may be required for: hospitalization, outpatient surgery, therapies, advanced imaging, DME, home health, skilled nursing, acute rehab, or prosthetics.

IN CASE OF AN EMERGENCY: Call 911 or go to the nearest emergency room. Always call your Primary Care Physician for non-emergent care.

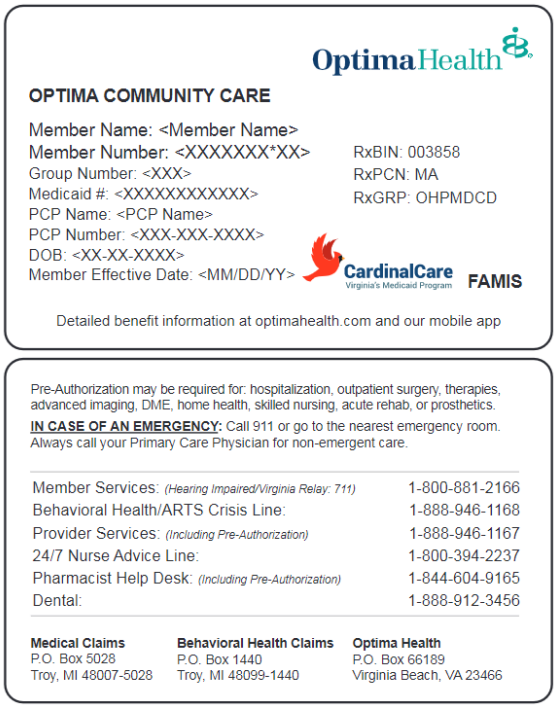
Member Services: *(Hearing Impaired/Virginia Relay: 711)*	1-800-881-2166
Behavioral Health/ARTS Crisis Line:	1-888-946-1168
Transportation:	1-877-892-3986
Provider Services: *(Including Pre-Authorization)*	1-888-946-1167
24/7 Nurse Advice Line:	1-800-394-2237
Pharmacist Help Desk: *(Including Pre-Authorization)*	1-844-604-9165
Dental:	1-888-912-3456

Medical Claims
P.O. Box 5028
Troy, MI 48007-5028

Behavioral Health Claims
P.O. Box 1440
Troy, MI 48099-1440

Optima Health
P.O. Box 66189
Virginia Beach, VA 23466

Optima Health Medicaid FAMIS



OptimaHealth

OPTIMA COMMUNITY CARE

Member Name: <Member Name>
Member Number: <XXXXXXX*XX>
Group Number: <XXX>
Medicaid #: <XXXXXXXXXXX>
PCP Name: <PCP Name>
PCP Number: <XXX-XXX-XXXX>
DOB: <XX-XX-XXXX>
Member Effective Date: <MM/DD/YY>

RxBIN: 003858
RxPCN: MA
RxGRP: OHPMDCD

CardinalCare Virginia's Medicaid Program **FAMIS**

Detailed benefit information at optimahealth.com and our mobile app

Pre-Authorization may be required for: hospitalization, outpatient surgery, therapies, advanced imaging, DME, home health, skilled nursing, acute rehab, or prosthetics.

IN CASE OF AN EMERGENCY: Call 911 or go to the nearest emergency room. Always call your Primary Care Physician for non-emergent care.

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Medical Claims
P.O. Box 5028
Troy, MI 48007-5028

Behavioral Health Claims
P.O. Box 1440
Troy, MI 48099-1440

Optima Health
P.O. Box 66189
Virginia Beach, VA 23466

DMAS Contracted Enrollment Broker

The Virginia Department of Medical Assistance Services (DMAS) and the Managed Care Helpline (DMAS contracted Enrollment Broker) provide enrollment services for Medicaid program members. DMAS contracts with CoverVA to provide enrollment services for Medicaid program enrollees. Eligible recipients interested in enrolling may call Cover Virginia at 1-855-242-8282 or visit the Cover Virginia website at www.coverva.org to request an application.

Applications are also available at local Department of Social Services (DSS) offices.

The Optima Health Network Management Team

The network management department is responsible for keeping our providers up to date on our educational services and resources, including:

- how to get in network and contract with the health plan
- how to update provider demographic information
- directly address any provider special needs, concerns, or complex situations, credentialing, services, and other requirements

Our Network Educators are assigned to specific providers to directly help providers navigate Product and service updates; the Network Education team can be reached at 1-877-865-9075, option 2.

The Web as a Place of Service

Up-to-date contacts, policies and procedures, forms and reference documents are available to Providers through the provider website. Optima Health encourages our Medicaid providers to visit optimahealth.com to research and process information such as**:**

- self-service tools
- medical policies
- newsletters

Provider Connection and Clear Claim

Additional information and operational functions are available anytime for Participating Providers who register for Provider Connection. Provider Connection is a free service for providers but requires secure access registration.

Providers may register for a secure login ID and password to allow secure access to Provider Connection by going to the provider website and completing the online Provider Connection Enrollment Form. Providers can access the registration process at this link: www.optimahealth.com/documents/provider-orientation/001-job-aid-provider-connection-reg-only.pdf

Providers with secure access to Provider Connection are able to perform the following functions 24 hours per day, seven days per week:

- check member eligibility and benefits
- view and print Medicaid ID cards.
- access real-time deductible and out-of-pocket maximum information
- request prior authorization
- create OB notifications
- check authorization status and effective/expiration dates
- view claim detail and status
- view, download and print PCP Membership Reports
- pre-adjudicate medical claims using C3-Clear Claims Connection

- view and download remits and Pended Claim Reports
- submit online reconsiderations for medical claims

Provider Connection will indicate if a member is in the grace period with the dates that claims will be pended. Registered providers may electronically submit reconsiderations through Provider Connection on the provider web portal by selecting "View Medical Claim Status," entering the members Optima Health member ID number, selecting the claim in question, and choosing the "Reconsider Claim" option.

Providers can make changes or corrections online for the following:

- procedure/service coding
- diagnosis
- billed charges
- quantity
- place of service

This option is not available for hospital and ancillary claims that would typically use the UB-04 format. The "View Medical Claim Status" option online will allow you to review the status of your online reconsideration the next day after submission.

Our Provider Relations Team

Contact Optima Health Medicaid program Provider Relations for most needs including:

- member eligibility
- benefits information
- claims questions (limited per Provider Relations guidelines)

Updating Your Information with Optima Health Medicaid Program

To change an address, phone number, add a new provider or other changes concerning your facility's demographics. Please submit a Provider Update Form available online at:	www.optimahealth.com/providers/provider- support/update-your-information Please review the provider credentialing requirements prior to completing your submission.

SECTION II: PROVIDER PROCESSES AND MEMBER BENEFITS

Member Benefits

For information regarding the Optima Health Medicaid program member benefit information please visit the following www.optimahealth.com.

Member PCP Matching

Medicaid members enrolled into the plan are encouraged to select their Primary Care Physician (PCP) provider. The PCP should be enrolled as an Optima Health Medicaid program provider. Providers should have no more than 1,500 members on their Medicaid patient rosters for the Medicaid program. Providers are encouraged to check their panel statuses and sizes by visiting Provider Connection.

The Member Choice for Primary Care Provider

Optima Health Medicaid members have the right to take part in decisions about their healthcare, including their right to choose their providers from the Optima Health Medicaid program network.

Patient-Financial Responsibilities

Per DMAS requirements, members are no longer subject to cost sharing (coinsurance, deductibles, and copayments) effective July 1, 2022. However, members receiving LTSS services may have patient pay obligations. For more information please visit www.dmas.virginia.gov.

After-Hours Nurse Line Nurse Advice Line

When illnesses or injuries occur after hours or when the physician's office is closed, Optima Health plan members can access the 24/7 Nurse Advice Line. Calling the 24/7 Nurse Advice Line gives access to a professional nurse who can assess our members medical situations, advise our members as to where to seek care, and if possible, suggest self-care options until the member can see their physician.

Call the 24/7 Nurse Advice Line:	1–800–394–2237

Please note: the Advice Line nurse will not have access to patient medical records, cannot

diagnose medical conditions, order lab work, write prescriptions, order home health services, or initiate hospital admissions. Any time the Nurse Advice Line is contacted, please have the following information readily available:

- The member ID number of the person who is ill or has been injured. This number is on the front of the member ID card.
- Detailed information regarding the illness or injury.
- Any other relevant medical information about the patient, such as other medical conditions or prescriptions.

The Advice Line nurse will advise our members regarding whether to proceed to the nearest emergency room or urgent care center. The Advice Line nurse may suggest appropriate home treatments. Our members may be advised to see the member's physician on the next business day. If a visit to the emergency room is authorized by the Advice Line nurse, the visit will automatically be covered following Plan guidelines without retrospective review. The primary care physician (PCP) will receive a follow-up report about the call so that medical records can be kept up to date.

Member ID Card

Per DMAS, existing branding and member ID card information will remain in effect until January 1, 2023.

To access sample Identification Cards for Optima Health members, please visit:	www.optimahealth.com/documents/provider- orientation/015-2020-mbrsvcs-samples-all.pdf.

Member Services

Members, providers, their family members, caregivers, or representatives, may contact Member Services through the phone number listed on the back of their member ID card. Member Services Representatives are available to respond to various member concerns, health crises, inquiries (e.g., covered services, provider network), complaints, and questions regarding the Medicaid program. Information for members is also available on the member website.

Continuity of Care for New Members

Optima Health will provide or arrange for all medically necessary services during care transitions for new members to prevent interrupted or discontinued services throughout the transition.

Second Opinion

When requested by the member, Optima Health shall provide coverage for a second opinion for the purpose of diagnosing an illness and/or confirming a treatment pattern of care. Optima Health will provide for a second opinion from a qualified health care professional within the network or, when necessary, arrange for the member to obtain one outside the network, at no cost to the member. Optima Health may require an authorization to receive specialty care for an

appropriate provider; however, Optima Health cannot deny a second opinion request as a non-covered service.

Member Access to Care

Optima Health Medicaid program network adequacy is an important component of quality care and is assessed on an ongoing and recurring basis along several dimensions, including number of providers, mix of providers, hours of operation, accommodations for individuals with physical disabilities (wheelchair access) and barriers to communication (translation services); and geographic proximity to beneficiaries (provider to members or members to provider).

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

Optima Health offers a Medicare Advantage Dual-Eligible Special Needs Plan (D-SNP). Among the most important features of the D-SNP are:

- a team of doctors, specialists, and Care Managers working together for the D-SNP member
- a Model of Care (MOC) that calls for individual care plans for members
- the same member rights available to Medicare and Medicaid recipients

Dual-eligible members enrolled in the Optima Health Medicaid program may receive their Medicare benefits from Optima Health's companion D-SNP, Medicare fee-for-service, or through another Medicare Advantage (MA) Plan. Please reference the Optima Health Dual Eligible Special Needs Plan (D-SNP) Supplement for details regarding this Plan. Optima Community Complete (OCC) is the Medicare Advantage Dual-Eligible Special Needs Plan (MA D-SNP) administered by Optima Health. OCC provides Medicare Part A, B, and D benefits for members who are also eligible for full Medicaid benefits.

More details about the program can be found at:	www.optimahealth.com/documents/provider- manuals/optima-community-complete-provider-manual-supplement.pdf

SECTION III: MEDICAL MANAGEMENT

Hospice

Hospice utilizes a medically directed interdisciplinary team. A hospice program provides care to meet the physical, psychological, social, spiritual, and other special needs, which are experienced during the final stages of illness, and during dying and bereavement.

Individuals receiving hospice at time of enrollment will be excluded from Optima Health Medicaid program participation. Optima Health Medicaid program members who elect hospice will remain enrolled in the program. A member may be in a waiver and be receiving hospice services.

All services associated with the provision of hospice services are covered services. Hospice care must be available twenty-four hours a day, seven days a week.

Utilization Management

The Utilization Management (UM) program reflects the UM standards from the most current NCQA accreditation standards:

- UM decision-making is based only on appropriateness of care and service.
- Optima Health does not compensate practitioners or other individuals conducting utilization review for denials of coverage or service.
- Financial incentives for UM decision-makers do not encourage denials of coverage or service.
- Members have access to all covered services, in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services as provided under FFS Medicaid.

Optima Health has mechanisms in place to detect and correct potential under and over utilization of services, including provider profiles. Processes include:

- analytics reports bases on provider performance and accurate billing
- active committee review of clinical services and cost data
- authorizations based on evidenced-based criteria for clinical services

Providers rendering care to Optima Health Medicaid program members, regardless of network status, are required to complete annual Model of Care training. Training can be accessed at www.optimahealth.com.

Medical Necessity Criteria

Optima Health uses evidence-based national standard(s) in making medical necessity determinations. Coverage decisions are based upon medical necessity and are in accordance with 42 CFR §438.210. The health plan:

- will not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the member
- may place appropriate limits on a service based on medical necessity criteria for the purpose of utilization control, provided that the services furnished can reasonably achieve their purpose
- will ensure that coverage decisions for individuals with ongoing or chronic conditions or who require long-term services and supports are authorized in a manner that fully supports the member's ongoing need for such services and supports and considers the member's functional limitations by providing services and supports to promote independence and enhance the member's ability to live in the community
- will ensure that coverage decisions for family planning services are provided in a manner that protects and enables the member's freedom to choose the method of family planning to be used consistent with 42 CFR §441.20
- will ensure that services are authorized in a manner that supports the:
  - prevention, diagnosis, and treatment of a member's disease, condition, and/or disorder, health impairments, and/or disability
  - ability for a member to achieve age-appropriate growth and development
  - ability for a member to attain, maintain, or regain functional capacity
  - correction, maintenance, or amelioration of a condition (in the case of EPSDT)
  - opportunity for a member receiving long-term services and supports to have access to the benefits of community living, to achieve person-centered goals, and to live and work in the setting of their choice

Women's Health Services

Optima Health covers a full spectrum of women's health services as provided under its contract with DMAS, including those for prevention and treatment to meet the member's health care needs. These services include but are not limited to:

- mammograms
- pap smears
- cervical cancer screening
- genetic testing (BRAC)
- annual physicals and lab tests
- prenatal and postpartum services for all pregnant members
- routine and medically necessary obstetric and gynecologic services
- reconstructive breast surgery
- Certified Nurse-Midwife services

- family planning including sterilizations and hysterectomies
- mental health and substance misuse care
- screening and treatment for sexually transmitted diseases
- counseling services
- smoking cessation and weight management
- immunizations
- lactation services and breast-feeding pump/supplies
- nutritional assessments
- homemaker services
- blood glucose monitors pre and postpartum

Optima Health does not require referrals or authorizations for preventive or obstetrical services.

Optima Health routinely provides members and physicians information about the importance of receiving preventive care including the timeframes for receiving this care. Members receive both written and telephonic information periodically regarding receiving appropriate health screenings and medical services**.**

Gynecological Care

Obstetrician/gynecologists qualify as primary care providers. Any female member of age 13 or older has direct access to a participating obstetrician-gynecologist for annual examinations and routine healthcare services, including pap smears, without service authorization from the primary care physician. Healthcare services means the full scope of medically necessary services provided by the obstetrician-gynecologist in the care of, or related to, the female reproductive system in accordance with the most current published recommendations of the American Congress of Obstetricians and Gynecologists (ACOG).

Obstetrical Services

Prenatal and postpartum services for pregnant members are covered services. Optima Health does not require the member to obtain a referral prior to choosing a provider for family planning services. Members are permitted to select any qualified family planning provider without referral.

Optima Health Medicaid program covers case management services for its high-risk pregnant women. Optima Health provides, to qualified members, expanded prenatal care services, including patient education; nutritional assessment, counseling, and follow-up; homemaker services; and blood glucose meters. Infant programs are covered for enrolled infants. Services are covered for 12 months after pregnancy ends for all eligible members.

In cases in which the mother is discharged earlier than 48 hours after the day of delivery, at least one early discharge follow-up visit indicated by the guidelines developed by the American College of Obstetricians and Gynecologists is covered. The early discharge follow-up visit is provided to all mothers who meet DMAS criteria, and the follow-up visit must be provided within 48 hours of discharge and meet minimum requirements.

Prenatal care and postpartum services do not require pre-authorization, except for the Maternal and Infant Care Coordination Program.

Member may seek the following services at any participating Health Department or Planned Parenthood location:

- obstetrical care

- family planning
- Maternal and Infant Care Coordination Program (including needs assessments, homemaker services and nutritional assessments)

Optima Health reimburses for these services and pays physicians billing for deliveries separately. The fee-for-service reimbursement is based on the contractually determined rates or Optima Health Medicaid program fee schedule.

Providers should promote member receipt of postpartum services as medically necessary throughout the postpartum period and within 60 calendar days of delivery. All pregnant women must be screened for prenatal depression in accordance with the AGOG standards. Women who screen positive must receive referrals and/or treatment as appropriate and follow up monitoring.

Doula Services

Doulas are individuals based in the community who offer a broad set of nonclinical pregnancy-related services centered on continuous support to pregnant women throughout pregnancy and in the postpartum period.

Emotional, physical, and informational support provided by Doulas include:

- childbirth education,
- lactation support, and
- referrals for health or social services.

Like other community health workers, Doulas provide culturally congruent support to pregnant and postpartum women through their grounding within the unique cultures, languages, and value systems of the populations they serve.

To enroll as a Doula with Optima Health, providers must meet DMAS criteria and follow the DMAS Provider Services Solution (PRSS) enrollment process.

Postpartum Coverage

Eligible members can maintain their coverage for 12 months following pregnancy. The 12-month coverage went into effect on July 1, 2022. This extension of benefits will allow new moms to seek additional supportive services such as primary care, dental, and behavioral health services for one year to optimize health and health outcomes. The coverage extension does not include FAMIS Prenatal MOMS.

Medicaid Program Family planning

Optima Health provides Family Planning and Contraceptive Coverage for members for all methods including but not limited to:

- barrier methods
- oral contraceptives
- vaginal rings
- contraceptive patches
- long-acting reversible contraceptives (LARCs)

Sterilization Program

Optima Medicaid program covers these procedures at 100 percent for members over the age of

21. Medicaid program members must sign a state approved waiver 30 days prior to a procedure for sterilization services.

Foster Care and Adoption Assistance

The Optima Medicaid program covers services for managed care enrolled foster care and adoption assistance children. Coverage extends to all medically necessary EPSDT or required evaluation and treatment services of the foster care program. Optima Health works with DSS and the foster parent(s) or adoptive parents in all areas of coordination. Foster care and adoption assistance children are evaluated on a 60-day timeframe. Children should receive a PCP visit if a provider has not been seen within 60 days prior to enrollment.

Immunizations / Vaccines

Providers are required to render immunizations, in accordance with the EPSDT periodicity schedule specified in the most current Advisory Committee on Immunization Practices (ACIP) Recommendations, concurrently with the EPSDT screening and ensure that members are not inappropriately referred to other providers for immunizations. Primary care providers are not permitted to routinely refer members to the local health department to receive vaccines. To the extent possible, and as permitted by Virginia statute and regulations, providers must participate in the statewide immunization registry database.

Medicaid program members, as appropriate to their age, are covered under the Virginia Vaccines for Children (VVFC) program. All PCPs who administer childhood immunizations are encouraged to enroll in the VVFC, administered by the Virginia Department of Health. The VVFC program supplies vaccines to Physicians at no charge. The Optima Medicaid program will reimburse Physicians for administration of the vaccine if the vaccine code is billed. **FAMIS does not participate with VVFC**. Immunizations provided to FAMIS members and eligible Medicaid program subpopulations should be billed using the appropriate CPT code to Optima Health. There is no copayment for immunizations provided to FAMIS members.

For eligible Medicaid program members, vaccines are provided free of charge to members through age 18. Optima Health will reimburse Physicians at the contracted rate for the administration of the vaccine only, and an office visit if billed, based on the provider's submission of the appropriate vaccine code.

Medicaid program members 19 years of age or older are not eligible for the VVFC Program. If vaccines are administered, reimbursement will be at the contracted fee.

The listing of vaccines provided through VVFC is subject to changes by VVFC. Coverage for specific vaccines (e.g., influenza) is subject to VVFC eligibility criteria and special order vaccines require VVFC approval.

The process for VVFC Provider Enrollment is:

- Call the VVFC program at 1-800-568-1929 or 804-864-8055 to receive an Enrollment Packet or go to www.vdh.virginia.gov/immunization/vvfc/vfcenroll/ to print an Enrollment Form
- Complete the VVFC Enrollment Form. Keep a copy and mail the original to the VVFC office
- It will take five business days for VVFC to process your enrollment and assign your practice a VVFC Practice Identification Number (PIN). You will use your PIN to identify your practice when communicating with the VVFC office

- Once your enrollment is processed, a VVFC consultant will contact you and VVFC will schedule an enrollment visit to introduce the program to you

Model of Care

The elements of the Model of Care include:

- specific biopsychosocial approaches for subpopulations
- staff and provider training
- provider networks with specialized expertise and use of clinical practice guidelines and protocols
- comprehensive assessments
- interdisciplinary care teams
- individualized care plans
- care coordination
- transition programs
- member and caregiver education
- gap closure for Healthcare Effectiveness Data and Information Set (HEDIS) and other clinical quality measures

The LTSS program:

- provides for comprehensive care coordination that integrates the medical, behavioral health, and social models of care through a person-centered approach
- promotes member choice and rights
- engages the member and family members throughout the process
- prioritizes continuity of care and seamless transitions, for members and providers, across the full continuum of physical health, behavioral health, and LTSS benefits.

Care Coordination

Care coordination is locally and regionally based. Care coordinators are assigned to individual members to conduct care coordination activities in every region across Virginia and act as advocates for members and providers helping members. The Care Coordinator works closely with the member as a point of contact to identify medical and behavioral health needs, and member strengths and supports. The Care Coordinator also works with the member to develop an understanding of the services they are receiving, ensure appropriate authorizations are in place, and to resolve barriers to care such as transportation issues.

Optima Health and Associating with Our Medicaid Provider Community

Optima Health Care Coordinators are the foundation to the members care delivery. When enrolled, eligible Medicaid program subpopulations will be assigned a Care Coordinator that is encouraged to work with contracted providers within the Medicaid provider network. Pre-Authorization will be required for any requests for services from a provider that is not in network with the health plan.

Person-Centered Care Planning

One of the core areas of focus driving program effectiveness and efficiency is Optima Health's approach to best practices for person-centered care planning and effective care transitions, and for measuring quality improvement to support people living optimally in their preferred setting. Optima Health is committed to delivering efficient, effective, person-centered care that meets people's needs, helps keep people in their preferred setting and aligns with state requirements.

Person-Centered Individualized Care Plan (ICP)

The Care Coordinator works with the member to develop a comprehensive individualized care plan (ICP). Our Medicaid program uses a Health Risk Assessment (HRA) as a tool to develop the member's person-centered ICP. The ICP is tailored to the member's needs and preferences and is based on the results of program's risk stratification analysis. The Health Risk Assessment must be completed and the ICP developed prior to the end of the member's service authorization.

Interdisciplinary Care Team

Optima Health will arrange the operation of an interdisciplinary care team (ICT) for each eligible Medicaid program subpopulation member in a manner that respects the needs and preferences of the member. Each eligible Medicaid program member's care (e.g., medical, behavioral health, substance use, LTSS, early intervention, and social needs) must be integrated and coordinated within the framework of an ICT and each ICT member must have a defined role appropriate to his/her licensure and relationship with the member. The Medicaid program member is encouraged to identify individuals that he/she would like to participate on the ICT. The ICT must be person-centered, built on the member's specific preferences and needs, and deliver services with transparency, individualization, respect, linguistic and cultural competence, and dignity.

An Optima Health care coordinator will lead the ICT. The ICT must include the member and/or their authorized representative(s) and may include the following as appropriate:

- PCP/Specialist
- behavioral health clinician, if indicated
- LTSS provider(s) when the member is receiving LTSS
- targeted case manager (TCM), if applicable (TCM includes ARTS, mental health, developmental disabilities, early intervention, treatment foster care, and high-risk prenatal and infant case management services)
- pharmacist, if indicated
- registered nurse
- specialist clinician
- other professional and support disciplines, including social workers, community health workers, and qualified peers
- family members
- other informal caregivers or supports
- advocates
- state agency or other case managers

Reassessments

The Optima Health Care Coordinator will conduct reassessments to identify any changes in the specialized needs of Medicaid program members. Reassessments will be conducted pursuant to routine timeframes and upon triggering events.

The ICT must be convened subsequent to all routine reassessments, within 30 calendar days and in the following circumstances:

- subsequent to triggering events requiring significant changes to the member's ICP (e.g., initiation of LTSS, BH crisis services, etc.)
- upon readmissions to acute or psychiatric hospitals or nursing facility within 30 calendar days of discharge; and,
- upon member request.

Care Coordination with Transitions of Care

The Optima Health Medicaid program provides transition coordination services to include: the development of a transition plan; the provision of information about services that may be needed, prior to the discharge date, during and after transition; the coordination of community-based services with the care coordinator; linkage to services needed prior to transition such as housing, peer counseling, budget management training, and transportation. Transition support services will be provided to Medicaid program members who are transitioning:

- from a nursing facility to the community
- between levels of care
- children in foster care who are transitioning out the child welfare system
- a child/youth was adopted
- a youth is transitioning to independence

To ensure continuity of care, Optima Health will:

- conduct Risk Stratification to determine if a member may benefit from care management
- observe the continuity of care period for the first 30 calendar days of members enrollment: 60 calendar days for High Intensity Care Management & pregnant members
- allow members to see out-of-network providers
- not change a member's existing provider before end of continuity of care period except in the following circumstances:
    - member requests change
    - provider chooses to discontinue providing services
    - provider or Optima Health identifies performance issues that affect member's health or welfare

Hospital/Ancillary

Inpatient stays in general acute care and rehabilitation hospitals for all Medicaid program members are covered. The Optima Health Medicaid program also covers preventive, diagnostic, therapeutic, rehabilitative, or palliative outpatient services rendered by hospitals, rural health clinics, or federally qualified health centers. Pre-authorization is required for inpatient acute care and rehabilitation hospitals.

Hospital Payment Using Diagnosis Relative Grouping (DRG) Methodology

If Optima Health has a contract with a facility to reimburse the facility for services rendered to its members based on a Diagnosis Relative Grouping (DRG) payment methodology, Optima Health will cover 100% of the full inpatient medical hospitalization from time of admission to discharge. This is effective for any actively enrolled member on the date of admission

regardless of whether the member is disenrolled during the course of the inpatient hospitalization.

Optima Health covers payment of practitioner services rendered during the hospitalization for any dates in which the Optima Health Medicaid member was enrolled with Optima.

Emergency Room

If the service is determined to be emergent and the facility provider is participating, the claim is paid at the contracted rates. If the service is determined to be non-emergent and the facility provider is participating, the claim is paid with a triage fee. If the facility is paid a triage fee, the provider may not balance bill the member. Facilities paid using EAPG methodology will be paid the appropriate EAPG regardless of whether the service is emergent or non-emergent and there is no triage fee to the facility.

SECTION IV: MENTAL HEALTH SERVICES (MHS)

Behavioral health services known as Mental Health Services (MHS), listed in the table below, may be provided in the member's home or in the community.

Mental Health Services	Procedure Code
Mental Health Case Management	H0023
Therapeutic Day Treatment (TDT) School Day for Children	H2016
Therapeutic Day Treatment (TDT) Afterschool, Child	H2016UG
Therapeutic Day Treatment (TDT) Summer Program Child	H2016U7
Crisis Intervention and Stabilization, ended 11/30/2021	H0036
Intensive Community Treatment (ICT)	H0039
Assertive Community Treatment	H0040 Modifiers U1-U5
Mental Health Skill-building Services (MHSS)	H0046 / H0032 U8
Intensive In-Home	H2012 / H0031
Psychosocial Rehab	H2017 / H0032 U6
Crisis Stabilization, ended 11/30/21	H2019
Behavioral Therapy/Assessment, ended 11/30/21	H2033 / H0032 UA
Mental Health Peer Support Services – Individual	H0025
Mental Health Peer Support Services – Group	H0024
MH-Intensive Outpatient (MH-IOP) for Youth and Adults	S9480
Mental Health Partial Hospitalization Program (MH-PHP)	H0035
Effective 12/1/2021	
Mobile Crisis Response	H2011
Community Stabilization	S9482
23-Hour Crisis Stabilization	S9485
Residential Crisis Stabilization Unit	H2018
Multi-systemic Therapy	H2033
Functional Family Therapy	H0036
Applied Behavior Analysis	97151 – 97158, 0362T and 0373T

The following services are encompassed under MHS:

- MHS (Mental Health Services)
- EBH (Enhanced Behavioral Health)
- Mental Health Case Management
- Treatment Foster Care Case Management (carved out)

MHS Provider Training

Optima Health staff will conduct ongoing education via scheduled webinars and direct provider engagement with mental health service providers. Training and technical assistance topics will include model of care elements, person-centered treatment planning, culturally competent care, evidence-based service planning/treatment methods and service provision, effective care coordination in an integrated care service delivery model, effective discharge planning and strengths-based treatment goal selection.

Credentialing

All MHS providers are contracted as an organization (agency) type and all services are billed under the organization's NPI. Except for ABA practitioners, individuals do not complete Credentialing applications for MHS. MHS organizational providers are required to submit the following documents:

- completed OBH MHS application
- a completed W-9
- clinical Staff Roster (must include last name, first name, DOB, NPI – if applicable, and services provided)
- a copy of the DBHDS License and Licensed Services Addendum. Each service/location on the application requires verification by DBHDS
- copies of all other licensure and/or certifications held by the organization
- a copy of their profession liability Certificate of Insurance (face sheet)
- additional Locations Forms
- in addition, Applied Behavioral Analysis services require each ABA practitioner to complete a Behavioral Health Provider Credentialing Packet

Detailed instructions and forms are available on the Optima Health website.

Continuity of Care

Members may maintain their current MHS provider (formerly known as CMHRS) for up to 30 days. Service Authorizations issued prior to Optima Health Medicaid program enrollment will remain for the service authorization or duration of the 30-day continuity of care period, whichever comes first. Authorizations will be extended as necessary to ensure a safe and effective transition to a qualified in-network provider.

Authorizations

All MHS Services require authorizations or registrations. The Optima Health Medicaid program utilizes the DMAS defined medical necessity criteria for MHS. Members must meet service specific medical necessity criteria. Requests are reviewed on an individual basis to determine the length of

treatment and service limits based on the member's most current clinical presentation.

Forms may be submitted on the Optima Health provider website or faxed to the Behavioral Health Authorization Outpatient fax number, 844-348-3719.

The Medicaid program uses the following DMAS Standardized MHS Service Authorization/Registration forms. These forms are specific to the service provided. They are available on the Optima Health provider portal and the DMAS website.

The following chart indicates when a service requires a Registration Form and when the service requires an Authorization Form:

MHS Service	Code	Initial Request	Continued Stay Request
Mental Health Case Management	H0023	Registration	Registration
Mental Health Peer Support Services - Individual	H0025	Registration	Registration
Mental Health Peer Support Services - Group	H0024	Registration	Registration
Crisis Intervention ended on 11/30/21	H0036	Registration	Authorization
Crisis Stabilization ended on 11/30/21	H2019	Registration	Authorization
Assertive Community Treatment (ACT)	H0040	Authorization	Authorization
Intensive In-Home	H2012	Authorization	Authorization
Therapeutic Day Treatment for Children *TDT	H2016U7	Authorization	Authorization
Partial Hospitalization	H0035	Authorization	Authorization
Mental Health Intensive Outpatient for youth and adults.	S9480	Authorization	Authorization
Mental Health Skill-building Services (MHSS)	H0046	Authorization	Authorization
Psychosocial Rehab	H2017	Authorization	Authorization
Mobile Crisis Response	H2011	Registration	N/A
Community Stabilization	S9482	Authorization	Authorization
23-Hour Crisis Stabilization	S9485	Registration	NA
Residential Crisis Stabilization Unit	H2018	Registration	Authorization
Multi-systemic Therapy	H2033	Authorization	Authorization
Functional Family Therapy	H0036	Authorization	Authorization
Applied Behavior Analysis	97153 – 97158 and 0373T	Authorization	Authorization

Billing

All CMHS services may be billed using the CMS-1500 claim form for outpatient services. In addition, Therapeutic Day Treatment (TDT) for Children and Day Treatment /Partial Hospitalization for Adults may also utilize the UB-04 Claim Form for hospitals/facilities as appropriate.

Providers may submit paper or electronic claims. CMHS providers may submit electronic claims through AllScripts/Payer Path or Availity.

Residential Treatment Services

Residential Treatment Services include Psychiatric Residential Treatment Facility Services (Level C) and Therapeutic Group Home Services (TGH) (Levels A & B) and are administered by the DMAS Behavioral FFS Contractor (Magellan of Virginia). Members admitted to a Residential Treatment Facility service will be covered by the fee for service (FFS) contractor, temporarily excluded from the Medicaid program, until they are discharged. Members admitted to a Therapeutic Group Home (TGH) are not excluded from the Medicaid program and any professional medical service rendered to members in a TGH are provided through the Optima Health Medicaid program. The Optima Health Medicaid program works closely with Magellan to coordinate care and provides coverage for transportation and pharmacy services for these carved out services.

Members admitted to a Residential Treatment Center for Substance Use Disorder are not excluded from the Optima Health Medicaid program and all services continue to be provided through the Medicaid program.

Addiction and Recovery Treatment Services (ARTS)

The Addiction and Recovery Treatment Services program (ARTS) is an enhanced and comprehensive benefit package developed by DMAS to cover addiction and recovery treatment services. Optima Health offers a variety of services through ARTS that help individuals struggling with substances, including drugs and alcohol. Services include inpatient, outpatient, residential, and community-based treatment. Medication assisted treatment options are available for members using prescription or non-prescription drugs. Peer services and case management services are also available to members.

The ARTS program improves the benefit and delivery systems for individuals with a substance use disorder. Goals for the ARTS benefit and delivery system include ensuring that a sufficient continuum of care is available to effectively treat individuals with a substance abuse disorder. Optima Health's criteria are consistent with the American Society for Addiction Medicine (ASAM) criteria as well as DMAS criteria for the Addiction and Recovery Treatment Services (ARTS) benefit as defined in 12 VAC 30-130-5000 et al.

More information about ARTS is available in the ARTS Supplement to the Optima Health Provider Manual.

SECTION V: COVERED SERVICES

Covered services include Care Coordination and benefits that are not generally covered through Medicaid fee-for-service including:

- smoking cessation
- assistive devices
- adult vision
- wellness rewards
- home delivered meals after inpatient hospital stay
- weight management
- memory alarms and devices
- free cell phones
- non-medical transportation (up to three round trips every three months)

All enhanced benefits are coordinated through the member's assigned Care Coordinator.

Audiology

Audiology services are provided as inpatient, outpatient hospital services, outpatient rehabilitation agencies, or home health services. Benefits include coverage for acute and non-acute conditions and are limited based upon medical necessity. There are no maximum benefit limits on audiology services. These services are covered regardless of where they are provided.

Behavioral Health Services

Behavioral health services, including inpatient and outpatient individual, family, and group psychotherapy services are covered. Services range from outpatient counseling to hospital care, including day treatment and crisis services.

Chiropractic

Chiropractic services are not covered.

Dental

Dental services should be requested and authorized directly through DMAS.

Medicaid Dental Program	Contact Information

Smiles For Children Medicaid General Dentistry services:	www.dmas.virginia.gov/for-providers/dental/

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)

All EPSDT services for members under age 21 are covered. The health plan complies with EPSDT requirements, including providing coverage for all medically necessary services for children needed to correct, ameliorate, or maintain health status.

Where it is determined that otherwise excluded services/benefits for a child are medically necessary services that will correct, improve, or are needed to maintain the child's medical condition, the health plan will provide coverage through EPSDT for medically necessary benefits for children outside the basic Medicaid benefit package including, but not limited to:

- extended behavioral health benefits
- nursing care (including private duty)
- personal care
- pharmacy services
- treatment of obesity
- neurobehavioral treatment
- other individualized treatments specific to developmental issues

Per EPSDT guidelines, Optima Health covers medical services for children if it is determined that the treatment or item would be effective to address the child's condition. The determination whether a service is experimental will be reasonable and based on the latest scientific information available.

Providers are encouraged to contact care coordinators to explore alternative services, therapies, and resources for members when necessary. No service provided to a child under EPSDT will be denied as "out-of-network" and/or "experimental" or non-covered," unless specifically noted as non- covered or carved out of this program.

Documentation of EPSDT Screenings

EPSDT services are subject to health plan documentation requirements for network provider services and to the following additional documentation requirements:

- The medical record must indicate which age-appropriate screening was provided in accordance with the AAP and Bright Futures periodicity schedule and all EPSDT related services whether provided by the PCP or another provider; and,
- Documentation of a comprehensive screening must, at a minimum, contain a description of the components utilized.
- The medical record must indicate when a developmental delay has been identified by the provider and an appropriate referral has been made.

EPSDT Provider Training

Optima Health staff educates providers on the EPSDT program and goals, required EPSDT screening

components including oral health screening requirements, and qualified EPSDT screening providers. The comprehensive plan ensures that all providers qualified to provide EPSDT services have access to proper education and training regarding the EPSDT benefit.

Early Intervention Services

Early Intervention (EI) services are covered. Children from birth to age 3 who have:

- a 25% developmental delay in one or more areas of development
- atypical development
- a diagnosed physical or mental condition that has a high probability of resulting in a developmental delay is eligible for EI services.
- EI services are designed to address developmental delay in one or more areas (physical, cognitive, communication, social, emotional, or adaptive)

Children are first evaluated by the local lead agency to determine if they meet requirements. If determined eligible, the local lead agency enters the data in the Infant and Toddler Online Tracking System (ITOTS). Based upon ITOTS information, the Department of Behavioral Health and Developmental Services (DBHDS) staff enters the EI level of care (LOC) in the DMAS system.
Once the LOC is entered, the EI services are billable based upon the Physician's order on the Individualized Family Service Plan (IFSP). All EI service providers must be enrolled with Optima Health prior to billing. Service authorization is not required.

EI services are provided in accordance with the child's IFSP, developed by the multidisciplinary team, including the Care Coordinator and EI service team. The multidisciplinary team will address the developmental needs of the child while enhancing the capacity of families to meet the child's developmental needs through family centered treatment. EI services are performed by EI certified providers in the child's natural environment, to the maximum extent appropriate. Natural environments can include the child's home or a community-based setting in which children without disabilities also participate.

The health plan provides coverage for EI services as described in the member's IFSP developed by the local lead agency. Optima Health works collaboratively as part of the member's multidisciplinary team to:

- ensure the member receives the necessary EI services timely and in accordance with Federal and State guidelines
- to coordinate other services needed by the member
- to transition the member to appropriate services

The child's primary care provider (PCP) approves the IFSP. The PCP signature on the IFSP or a letter accompanying the IFSP or an IFSP Summary letter within 30 days of the first visit for the IFSP service is required for reimbursement of those IFSP services. If PCP certification is delayed, services are reimbursed beginning the date of the PCP signature.

When a developmental delay has been identified for children under age 3, Optima Health will collaborate with the provider to ensure appropriate referrals are made to the Infant and Toddler Connection and documented in the member's records. Optima Health will work with DMAS to refer members for further diagnosis and treatment, or follow-up of all abnormalities uncovered or suspected. If the family requests assistance with transportation and scheduling to receive services for early intervention, Optima Health will provide this assistance.

The health plan EI policies and procedures, including credentialing, follow Federal and State EI regulations and coverage and reimbursement rules in the DMAS Early Intervention Services Manual.

Medical Supplies and Medical Nutrition

Medical supplies and equipment are covered to the extent covered by DMAS. Durable medical equipment (DME) benefits are limited based upon medical necessity. There are no maximum benefit limits on DME. Nutritional supplements and supplies are covered benefits. The Optima Health Medicaid program covers specially manufactured DME equipment that was prior authorized per DMAS requirements. Please review the current Summary of Benefits or contact Member Services for prior authorization requirements. Additional information can be found in the Durable Medical Equipment & Supplies Provider Manual available on the DMAS web portal at vamedicaid.dmas.virginia.gov/.

Physical Therapy/Occupational Therapy/ Speech Pathology

Physical therapy (PT), occupational therapy (OT), and speech pathology (SLP) services that are provided as an inpatient, outpatient hospital service, by outpatient rehabilitation agencies, or home health service are covered services. Benefits include coverage for acute and non-acute conditions and are limited based upon medical necessity. There are no maximum benefit limits on PT, OT, and SLP services. These services are covered regardless of where they are provided. Pre-authorization for these services is not required unless they are part of home health services.

All medically necessary, intensive physical rehabilitation services in facilities that are certified as Comprehensive Outpatient Rehabilitation Facilities (CORFs) are also covered. Pre-authorization is required for acute inpatient rehabilitation.

Policies and procedures for speech therapy may vary by enrolled Medicaid program members.

Special Needs Members

Optima Health Medicaid program members that have been identified as hearing impaired, and/or speak limited or no English, and/or require interpreter services, may have these services arranged by the Plan, as directed by the DMAS contract. Provider offices should aid when hand to hand transportation is required for the special needs member. In addition to the provider requirements for special needs members from the DMAS Contract, providers are required to submit physical accessibility information for provider directories to facilitate access for special needs members such as wide entry, wheelchair access, accessible exam rooms, tables, lifts, scales, bathroom stalls, grab bars, or other accessibility equipment.

Preventive Care

The Optima Health Medicaid program encourages and supports the primary care physician (PCP) relationship as the Medicaid member's provider "health home." This strategy will promote one provider having knowledge of the member's healthcare needs, whether disease-specific or preventive care in nature.

PCPs may include pediatricians; family and general practitioners; internists; OB/GYNs, physician assistants, nurse practitioners and specialists who perform primary care functions; and, clinics including, but not limited to, health departments, Federally Qualified Health

Centers (FQHCs), rural health clinics (RHCs), Indian Health Care Providers, and other providers approved by DMAS.

Routine physicals for children up to age twenty-one are covered benefits under EPSDT.

Private Duty Nursing

Medically necessary PDN services for children under age 21 in accordance with DMAS criteria described in the DMAS EPSDT Manual are covered benefits. Individuals who require continuous nursing that cannot be met through home health may qualify for PDN. EPSDT PDN differs from home health nursing, which provides for short-term, intermittent care where the emphasis is on member or caregiver teaching. Under EPSDT PDN, the individual's condition must warrant continuous nursing care, including but not limited to, nursing level assessment, monitoring, and skilled interventions. Pre-authorization is required.

Prosthetic Devices

Prosthetics (arms and legs and their supportive attachments, breasts, eye prostheses) are covered benefits, to the extent that they are covered under Medicaid. Medically necessary orthotics for children under age 21 and for adults and children are covered benefits, when recommended as part of an approved intensive rehabilitation program. Custom or orthotics over $1,000 for a single item requires pre-authorization.

Transplants

Transplants for the Medicaid program are covered according to the contract with DMAS. Necessary procurement/donor services are covered. Children under 21 years of age are covered for transplants per EPSDT guidelines. Pre-authorization is required. Optima Health Medicaid program coverage for transplant varies depending on recipient age and organ. Optima Health uses the Optum Health Care Solutions Centers of Excellence Network and certain local and regional transplant providers for organ transplants. Members will be directed to an appropriate transplant facility for care.

Vision Coverage

Preventive vision services are not reimbursed under the medical plan and should be obtained by members through the Vision Vendor.

Each covered individual may receive an eye exam every 12 or 24 months, depending on the member's vision benefit.

This includes:

- Case History: pertinent health information related to eyes and vision acuity test, unaided and with previous prescription
- Screening Test: (for disease or abnormalities), including glaucoma and cataracts.

Diabetic Dilated Eye Exam Exception: For members with diabetes, regardless of benefit plan, dilated retinal eye exams are covered every 12 months without a referral.

Providers should verify eligibility and coverage by contacting the Vision Vendor. Please use the Member's ID number to obtain eligibility and coverage information.

The following are not covered:

- orthoptic or vision training, subnormal vision aids and any associated supplemental testing
- medical and/or surgical treatment of the eye, eyes or supporting structures (Note: These services are not considered routine services and would not be covered under routine vision vendor coverage, but they are covered by Optima Health when medical necessity criteria is met.)
- corrective eyewear required by an employer as a condition of employment and safety
- eyewear, unless specifically covered under plan
- services provided as a result of any Worker's Compensation law
- and discount is not available on frames where the manufacturer prohibits a discount

Long Term Service and Support Services

Long Term Services and Supports (LTSS) are a variety of services and supports that assist individuals with health or personal needs and activities, activities of daily living, and instrumental activities of daily living over a period. Long term services and supports can be provided at home, in the community, or in various types of facilities, including nursing facilities.

LTSS Service Authorization

All LTSS Services require a Pre-authorization/notification number. The appropriate DMAS form should be attached to the pre-authorization form. Forms are available on the DMAS website and www.optimahealth.com.

Authorizations for LTSS must be resubmitted every six months unless the authorization has been previously updated by the Care Coordinator.

Patient-pay for LTSS

When a Medicaid program member's income exceeds an allowable amount, he/she must contribute toward the cost of his/her LTSS. This contribution is known as the Patient Pay amount. The local DSS will identify Medicaid program members who are required to pay a Patient Pay amount and the amount of the obligation as part of the monthly transition report.

The following are examples of services that qualify for Patient Pay:

- nursing facility
- private duty nursing
- adult day care
- personal care
- respite care

Waivers

Individuals enrolled in the Commonwealth Coordinated Care Plus Waiver receive waiver services furnished by the Optima Health Medicaid program providers as well as medically necessary non-waiver services. Individuals enrolled in the Building Independence (BI), Community Living (CL), and Family and Individual Supports (FIS) waivers are covered only

for their medically necessary non-waiver services:

- acute and primary health care
- behavioral health
- pharmacy
- non-LTSS waiver transportation services

Developmental Disability (DD) Waiver
Individuals enrolled in one of DMAS's Developmental Disability (DD) waivers (the Building Independence (BI), Community Living (CL), and Family and Individual Supports (FIS) waivers) will be enrolled in the Medicaid program for their non-waiver services (e.g., acute, and primary healthcare, behavioral health, pharmacy, and non-LTSS waiver transportation services). DD Waiver services (including when covered under EPSDT), targeted case management and transportation to the waiver services, are paid through Medicaid fee-for-service as "carved-out" services.

Services are based on assessed needs and are included in a person-centered Individual Care Plan (ICP). Individuals receiving home and community-based services through one of these waivers have a variety of choices of both types of services and providers.

The Optima Health Medicaid program manages members that are enrolled in the BI, CL, or FIS waivers, in addition to all individuals with a diagnosis of a developmental disability. Optima Health collaborates with providers to coordinate acute, behavioral health, pharmacy, and non-LTSS waiver transportation services by working with the member's Interdisciplinary Care Team (ICT) and residential provider, as applicable, to support the individual's health and well-being.

Commonwealth Coordinated Care (CCC) Plus Waiver
The CCC Plus Waiver covers a range of community support services for individuals who are aged, who have a disability, or technology-dependent individuals who rely on a device for medical or nutritional support (e.g., ventilators, feeding tube, or tracheostomy). Home and Community Based Services allow members to receive care in their home or community and prevent institutionalization. LTSS are provided through the 1915(c) Home and Community Based Services (HCBS) waiver. Individuals who are technology-dependent, are chronically ill or severely impaired, having experienced loss of a vital body function, and require substantial and ongoing skilled nursing care to avert death or further disability are eligible to receive all CCC Plus Waiver serves as well as private duty nursing services.

To be enrolled in the CCC Plus Waiver, an individual must meet the level of care (LOC) required for a Nursing Facility. Enrollment into the CCC Plus Waiver requires a pre-admission screening (PAS) performed by an approved LTSS Screening team. As part of the PAS, individuals that are technology dependent must also receive an age appropriate DMAS Technology Adult Referral form (DMAS 108) or Technology Pediatric Referral form (DMAS 109). The CCC Plus Waiver is offered to individuals who meet criteria. The individual must choose to receive services through the CCC Plus Waiver in lieu of facility placement. The PAS includes:

- Uniform Assessment Instrument (UAI),
- DMAS-95 MI/DD/RC (and DMAS-95 MI-ID/RC Supplement Form, Level II, if applicable) for individuals who select nursing facility placement

- DMAS-96 (Medicaid Funded Long-Term Care Service Authorization Form)
- DMAS-97 (Individual Choice – Home and Community Based Services or Institutional Care or Waiver Services Form)
- DMAS 108 (Adults) or DMAS 109 (Children) for individuals who are technology dependent and need private duty nursing.

All individuals requesting community based or nursing facility LTSS must receive a screening to determine if they meet the level of care needed for Nursing Facility services. DMAS has contracts with the Virginia Department of Health (VDH), Virginia Department of Social Services (VDSS), hospitals, and nursing facilities to conduct screenings for individuals. In the community, screeners are members of the local health departments (LHD) that may include physicians and nurses along with social workers and family services specialists within the local departments of social services (LDSS). Community screenings for children (up to the age of eighteen [18]) are contracted to a Department designee, currently VDH, through the local health departments in the jurisdiction where the child resides. Acute care hospitals utilize persons designated by the hospital to complete the screening. The Nursing Facility LTSS screening team may complete the LTSS screening for individuals who apply for or request LTSS while receiving skilled nursing services in a setting not covered by Medicaid after discharge from an acute care hospital, when the individual was not a Medicaid enrollee upon admission to the nursing facility Details about the screening process can be found and the criteria for meeting the level of care required for eligibility for LTSS can be found in the Department's Screening Manual for Medicaid-Funded Long-Term Services and Supports (LTSS) on the Virginia Medicaid provider portal.

For members enrolled in the CCC Plus Waiver, Optima Health covers all services that provide members an alternative to institutional placement. This includes:

- adult day health care
- personal care (agency-directed and/or consumer-directed)
- skilled private duty nursing
- personal emergency response systems and medication monitoring
- respite care (agency-directed and/or consumer-directed) or skilled private duty respite care (agency directed)
- assistive technology
- environmental modifications
- transition services (for those members meeting criteria who are transitioning back to the community from a Nursing Facility or long stay hospital)

Waiver services may be agency-directed (AD) or consumer-directed (CD). CD services afford individuals the opportunity to act as the employer in the self-direction of personal care or respite services. This involves hiring, training, supervision, and termination of self-directed personal care assistants. For both AD and CD care, the Member must have a viable back-up plan (e.g. a family member, neighbor or friend willing and available to assist the Member, etc.) in case the personal care aide or CD attendant or nurse is unable to work as expected or terminates employment without prior notice. The identification of a back-up plan is the responsibility of the Member and family and must be identified and documented on the ICP. The back-up plan may be the primary caregiver, when the primary caregiver is not a paid attendant for the Member. Members who do not have viable back-up plans are not eligible for services until viable back-up plans have been developed. For AD care, the provider must make a reasonable attempt to send a substitute personal care aide. If this is not possible, the Member must have someone available to perform the

services needed.

The Medicaid program covers CCC Plus Waiver services when: the member is present; in accordance with an approved person-centered Individualized Care Plan; the services are authorized; and a qualified provider is providing the services to the member. Services rendered to or for the convenience of other individuals in the household (e.g., cleaning rooms, cooking meals, washing dishes, doing laundry, etc. for the family) are not covered.

Adult Day Health Care (ADHC)

The Optima Health Medicaid program covers long-term maintenance or supportive services offered by a community-based day care program providing a variety of health, therapeutic, and social services designed to meet the specialized needs of those waiver individuals who are elderly or who have a disability and who are at risk of placement in a nursing facility. The program must be licensed by the Virginia Department of Social Services (VDSS) as an adult day care center (ADCC).

Personal Care Services

Assistance with Activities of Daily Living (ADL) are: eating, bathing, dressing, transferring, and toileting, including medication monitoring and monitoring of health status and physical condition. This service does not include skilled nursing services except for skilled nursing tasks that may be delegated. When specified in the individual service plan, personal care services may include assistance with Instrumental Activities of Daily Living (IADL), such as dusting, vacuuming, shopping, and meal preparation, but does not include the cost of meals themselves and/or supervision.

The Optima Health Medicaid program provides coverage for personal care services for work-related or school-related personal assistance when medically necessary. This allows the personal care provider to help and support individuals in the workplace and for those individuals attending post-secondary educational institutions. This service is only available to individuals who require personal care services to meet their ADLs. Workplace or school supports through the CCC Plus Waiver are not provided if they are services provided by the Department for Aging and Rehabilitative Services, required under IDEA, or if they are an employer's responsibility under the Americans with Disabilities Act of Section 504 of the Rehabilitation Act.

Individuals are afforded the opportunity to act as the employer in the self-direction of personal care services. This involves hiring, training, supervision, and termination of self-directed personal care assistants. For Consumer Directed services, as defined by the Code of Virginia, “any person performing state or federally funded health care tasks directed by the consumer which are typically self-performed for an individual who lives in a private residence and who, by reason of disability is unable to perform such tasks but who is capable of directing the appropriate performance of such tasks” is exempted from the Nurse Practice Act and nurse delegation requirements.

Personal care hours are limited by medical necessity. The Optima Health Medicaid program manages requests in accordance with criteria listed in 12VAC30-120–927 and contract standards.

Personal care is not a replacement of PDN services and the two must not be provided concurrently. Personal care cannot be used for ADL/IADL tasks expected to be provided during Private Duty Nursing (PDN) hours by the RN/LPN. Trained caregivers must always be present to perform any skilled tasks not delegated.

State and Federal laws and regulations require prospective Personal Care Assistants to pass background checks. Background checks include Virginia State Police Criminal Background checks; Virginia Department of Social Services Child Abuse and Neglect Central Registry checks when the member is under the age of 18; the Federal list of Excluded Individuals and Entities (LEIE) database checks; and employment eligibility checks.

Respite Care Services

Respite care services are provided to members who are unable to care for themselves and are furnished on a short-term basis because of the absence or need for relief of those primary unpaid caregivers who normally provide care. Respite care services may be provided in the member's home or place of residence or children's residential facility. Respite services include skilled nursing respite and unskilled respite.

Individuals may choose to use agency directed (AD), consumer directed (CD), or a combination of these models of service delivery. CD respite is only available to members requiring unskilled respite care services. Unskilled respite is not available to individuals who have 24 hours skilled nursing needs.

Respite care services are limited to 480 hours per household per state fiscal year (July 1 through June 30).

Consumer Direction

Eligible CCC Plus Waiver members may choose the Consumer-Directed model of service delivery for their personal care and respite services. Through Consumer Direction, the member, or someone designated by the member, employs attendants and directs their care. The member will receive financial management support in their role as employer by DMAS's contracted Fiscal/Employer Agent (F/EA).

Services Facilitation (SF)

SF is a function that assists the member (or the member's family or representative, as appropriate) when consumer directed services are chosen. The SF provider serves as the agent of the individual or family and the service is available to assist in identifying immediate and long-term needs, developing options to meet those needs, accessing identified supports and services, and training the member/family to be the employer. Practical skills training is offered to enable families and members to independently direct and manage their waiver services.

Examples of skills training include providing information on recruiting and hiring personal care workers, managing workers, and providing information on effective communication and problem solving. The services include providing information to ensure that members understand the responsibilities involved with directing their services.

Environmental Modifications (EM)

Environmental modifications not covered under Medicaid's State Plan durable medical equipment benefit may be covered under the CCC Plus Waiver. Modifications may be made to a member's primary residence or primary vehicle and must be of a remedial nature or medical benefit to enable the member to function with greater independence. EM may not be used for general maintenance or repairs to a home, or to purchase or repair a vehicle.

EM must be provided in conjunction with at least one other CCC Plus Waiver service. EM is covered up to a

maximum of $5,000 per member per calendar year. Costs for EM cannot be carried over from one calendar year to the next.

Assistive Technology (AT)Assistive technology (AT) provided outside of the Medicaid State Plan durable medical equipment benefit may be covered under the CCC Plus Waiver. Assistive Technology is covered for members who have a demonstrated need for equipment for remedial or direct medical benefit primarily in the member's residence to specifically increase their ability to perform ADLs/IADLs, or to perceive, control or communicate with the environment in which they live.

AT is considered a portable device, control, or appliance, which may be covered up to a maximum of $5,000 per member per calendar year. The costs for AT cannot be carried over from one calendar year to the next. When two or more members live in the same home (congregate living arrangement), the AT must be shared to the extent practicable, consistent with the type of AT.

AT must be provided in conjunction with at least one other CCC Plus Waiver service. All AT requires an independent evaluation by a qualified professional who is knowledgeable of the recommended item before authorization of the device. Individual professional consultants include speech/language therapists, physical therapists, occupational therapists, physicians, certified rehabilitation engineers or rehabilitation specialists.

Personal Electronic Response System (PERS)
PERS is an electronic device that enables members to secure help in an emergency. The system is connected to the person's phone and programmed to signal a response center once a "help" button is activated. PERS services are limited to members who live alone, or who are alone for significant parts of the day and have no regular caregiver for extended periods of time. PERS services are also limited to those individuals ages 14 and older. When medically appropriate, the PERS device can be combined with a medication monitoring system to monitor medication compliance.

Skilled Private Duty Nursing (PDN)
Skilled PDN are nursing services ordered by a physician in the Plan of Care and provided by a licensed Registered Nurse (RN) or by a Licensed Practical Nurse (LPN). This service is provided to individuals in the technology dependent subgroup who have serious medical conditions and complex health care needs. Skilled PDN is used as hands-on member care, training, consultation, and oversight of direct care staff, as appropriate. Examples of members that may qualify for Skilled PDN coverage include, but are not limited to, those with health conditions requiring mechanical ventilation, tracheostomies, prolonged intravenous administration of nutritional substances (TPN/IL) or drugs, peritoneal dialysis, continuous oxygen support, and/or continuous tube feedings.

PDN hours are determined by the scores on the appropriate objective assessment based on the member’s age. The pediatric assessment is utilized for a member less than 21 years of age. PDN hours for adult members are determined by medical necessity.

Transition Services
The Optima Health Medicaid program covers Transition Services, meaning set-up expenses, for Medicaid program members who are transitioning from an institution or licensed or certified provider-operated living arrangement to a living arrangement in a private residence, which may include an adult foster home, where the person is directly responsible for his or her own living expenses. These services could include:

- security deposits
- utility deposits

- essential/basic household furnishings (furniture, appliances, window coverings, bed/bath linens or clothing)
- items necessary for the individual's health, safety, and welfare such as pest eradication and one-time cleaning prior to occupancy
- fees to obtain a copy of a birth certificate or an identification card or driver's license
- other reasonable one-time expenses incurred as part of a transition

Transition Services are furnished only to the extent that they are reasonable and necessary as determined through the transition plan development process, are clearly identified in the transition plan and the person is unable to meet such expense, or when the services cannot be obtained from another source.

Nursing Facility and Long Stay Hospital Services

The Optima Health Medicaid program covers skilled and intermediate nursing facility (NF) care for Medicaid program members including for dual eligible members after the member exhausts their Medicare covered days. Optima Health will pay NFs directly for services rendered.

Optima Health works with NFs to:

- Adopt evidence-based interventions to reduce avoidable hospitalizations, and include management of chronic conditions, medication optimization, prevention of falls and pressure ulcers, and coordination of services
- Ensure that individuals in nursing facilities are assessed for, have access to, and receive medically necessary services for medical and behavioral health conditions

NFs must cooperate with the Optima Health Medicaid program for Optima Health to attend (either in person or via teleconference) all care plan meetings for Medicaid program members who are receiving NF services. Attendance at the care plan meetings will ensure that the NF is current with the care needs of the member and will provide access to Optima Health to discuss service options.

LTSS Provider Credentialing

Optima Health delegates and provides oversight for credentialing and re-credentialing of Medicaid program LTSS providers to HEOPS-Centipede per requirements. Optima Health ensures that HEOPS-Centipede credentials and re-credentials providers per DMAS and Medicaid program requirements and ensures that all providers comply with provisions of the CMS Home and Community-Based Settings Rule.

Providers already contracted and credentialed with Optima Health for provision of medical services, that also provide LTSS services, must also contract with HEOPS-Centipede for provision of LTSS services to Medicaid program members.

Trauma Informed Care

Trauma informed care is an approach to engaging people with histories of trauma that recognizes the presence of trauma symptoms and acknowledges the role that trauma and adverse childhood experiences have played in their lives. This approach builds on member resiliency and strengths to address the physical and emotional well-being of the individual. Optima Health requires

provider education for trauma informed care via a brief provider training that is available on the Optima Health website Education page. The provider directory will indicate providers that have completed this training.

Telehealth

Telemedicine is a service delivery model that uses real time two-way telecommunications to deliver covered physical and behavioral health services for the purposes of diagnosis and treatment of a covered member. Telemedicine must include, at a minimum, the use of interactive audio and video telecommunications equipment (see temporary exception for audio only telecommunications in this section) to link the member to an enrolled provider approved to provide telemedicine services at the distant (remote) site.

Telehealth is the use of telecommunications and information technology to provide access to health assessment, diagnosis, intervention, consultation, supervision, and information across distance.

Telehealth is different from telemedicine because it refers to the broader scope of remote health care services used to inform health assessment, diagnosis, intervention, consultation, supervision, and information across distance. Telehealth includes such technologies such as telephones, facsimile machines, electronic mail systems, remote patient monitoring devices and store-and-forward applications, which are used to collect and transmit patient data for monitoring and interpretation.

Remote patient monitoring (RPM) is defined as the use of digital technologies to collect medical and other forms of health data from patients in one location and electronic transmission of that information securely to health providers in a different location for analysis, interpretation, recommendation, and management of a patient with a chronic or acute health illness or condition. These services include monitoring of clinical patient data such as weight, blood pressure, pulse, pulse oximetry, blood glucose, and other patient physiological data; treatment adherence monitoring; and interactive video conferencing with or without digital image upload.

Optima Health provides coverage for telemedicine and telehealth services as medically necessary, and within at least equal amount, duration, and scope as is available through the Medicaid fee-for-service program. Optima Health provides telemedicine and telehealth services regardless of the originating site and regardless of whether the patient is accompanied by a health care provider at the time such services are provided.

Optima Health cannot require providers to use proprietary technology or applications to be reimbursed for providing telemedicine services.

Optima Health allows the prescribing of controlled substances via telemedicine and requires such scripts to comply with the requirements of § 54.1-3303 and all applicable federal law.

Optima Health also must encourage the use of telemedicine and telehealth to promote community living and improve access to health services.

The Department Medicaid Manuals and Memos on telemedicine specify the types of providers that may provide Medicaid-covered telemedicine and telehealth services. Optima Health may propose additional provider types for the Department to approve for use.

The decision to participate in a telemedicine or telehealth encounter will be at the discretion of

the member and/or their authorized representative(s), for which informed consent must be provided, and all telemedicine and telehealth activities shall be compliant with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Department's program requirements. Covered services include:

1. Synchronous audio-visual telemedicine, including originating site fees;
2. Store-and-Forward Applications: The Contractor shall reimburse for teleretinal screening for diabetic retinopathy. Optima Health is required to provide coverage for teleretinal screening for diabetic retinopathy that is at least equal in amount, duration, and scope as is available through the Medicaid fee-for-service program. Optima Health cannot be more restrictive and cannot require additional fields or photos not required by the Medicaid fee-for-service program. The Contractor may also reimburse for additional store-and-forward Applications, including but not limited to, tele-dermatology and tele-radiology.
3. Remote patient monitoring (RPM)
4. Audio-only services
5. Provider-to-provider consultations
6. Virtual check-ins with patients
7. The ability to cover specialty consultative services (e.g., telepsychiatry) as requested by the member's primary care physician

DMAS publishes additional guidance for coverage for store-and-forward, RPM, audio-only, provider- to-provider consultations, virtual check-ins, and specific CPT Codes in Medicaid Memoranda and Provider Manuals and regulations. Optima Health will be required to provide coverage for store-and-forward, RPM, audio-only, provider-to-provider consultations, and virtual check-ins that is no more restrictive than, and is at least equal in amount, duration, and scope as is available through, the Medicaid fee-for-service program.

All telemedicine and telehealth services shall be provided in a manner that meets the needs of vulnerable and emerging vulnerable subpopulations and consistent with integrated care delivery.

In addition to the above requirements, services delivered via telehealth will be eligible for reimbursement when all of the following conditions are met:

- The provider at the distant site deems that the service being provided is clinically appropriate to be delivered via telehealth.
- The service delivered via telehealth meets the procedural definition and components of the CPT or HCPCS code, as defined by the American Medical Association (AMA).
- The service provided via telehealth meets all state and federal laws regarding confidentiality of healthcare information and a patient's right to his or her medical information; and
- Services delivered via telehealth meet all applicable state laws, regulations, and licensure requirements on the practice of telehealth; and
- DMAS deems the service eligible via telehealth through Medicaid program published fee schedule.

To be reimbursed for services using telehealth that are provided to MCO-enrolled individuals, providers must follow their respective contract with Optima Health.

Additional information about the Medicaid MCO programs can be found at www.dmas.virginia.gov/for-providers/cardinal-care-transition/

Telemedicine Services

The Optima Health Medicaid program provides coverage for telemedicine services for our members. Telemedicine is defined as the real time or near real time two-way transfer of medical data and information using an interactive audio/video connection for the purposes of medical diagnosis and treatment.

Physicians, nurse practitioners, certified nurse midwives, clinical nurse specialists-psychiatric, clinical psychologists, clinical social workers, licensed, and professional counselors are permitted to use medical telemedicine services and one of these types of providers at the main (hub) and satellite (spoke) sites is required for a telemedicine service to be reimbursed. Federal and state laws and regulations apply; including laws that prohibit debarred or suspended providers from participating in the Medicaid program.

The decision to participate in a telemedicine encounter will be at the discretion of the member and/or their authorized representative(s), for which informed consent must be provided, and all telehealth activities must be compliant with Health Insurance Portability and Accountability Act of 1996 (HIPAA) and DMAS's program requirements. All telemedicine services must be provided in a manner that meets the needs of vulnerable and emerging high-risk populations and consistent with integrated care delivery. Telemedicine services can be provided in the home or another location if agreeable with the member.

Carved Out Services

The following services are carved out of the contract between Optima Health and DMAS. These services are reimbursed directly to providers under the DMAS fee-for-service program:

- Dental and related services
- school health services
- Developmental Disabilities (DD) Waiver Services such as Building Independence Waiver, Family and Individual Support Waiver, Community Living Waiver, Targeted Case Management and Transportation to/from DD Waiver Services (non-waiver services are included in the Medicaid program)
- preadmission screening for nursing facilities
- IACCT (Independent Assessment, Certification and Coordination Team)
- Therapeutic Group Home (formerly Level A and B Group Home)
- treatment foster care – case management

SECTION VI: PHARMACY

Prescription Drug Coverage

Optima Health covers Food and Drug Administration (FDA) approved drugs for Optima Health Medicaid program members. Drugs for which Federal Financial Participation is not available are not covered.

Optima Health requires that prescribers have a valid and active National Provider Identifier (NPI). Prescriptions from prescribers who do not have a valid NPI will reject at point of sale.

In most cases, Optima health will pay for prescriptions only if they are filled at the plan's network pharmacies. To find a network pharmacy, visit our website at www.optimahealth.com.

Preferred Drug List (PDL) for the Medicaid Program

The Medicaid program has adopted the DMAS Preferred Drug List (PDL) for all members. Note that the PDL does not apply to dual eligible members who have a pharmacy benefit covered by a Medicare Part D plan. The DMAS PDL is not an all-inclusive list of drugs. The Medicaid program will cover all medically necessary, clinically appropriate, and cost-effective drugs that are federally reimbursable.

Drugs not listed on the PDL may reject at the pharmacy unless Optima Health has approved a Medical Necessity request and an override is put into the system. Optima's Medical Necessity Form is available on the provider website or by contacting Pharmacy Authorizations by phone at 1-844-672-2307, Monday through Friday 8am to 6pm. Medical Necessity Request Forms should be faxed to the pharmacy department at 1-800-750-9692.

Over the counter (OTC) medications that are covered on the DMAS Preferred Drug List will require a prescription to process at the pharmacy.

Drugs on the PDL may be subject to edits such as Prior Authorizations, Step-Edits, and Quantity limits. These drugs may reject at the pharmacy without a Prior Authorization in the system. Prior Authorization forms are available on the provider website or by contacting Pharmacy Authorizations by phone at 1-844-672-2307, Monday through Friday 8am to 6pm. Prior-authorization Request Forms should be faxed to the Pharmacy Department at 1-800-750-9692.

All members enrolled in the FAMIS program will utilize a closed formulary pharmacy benefit. There is a mandatory generic prescription requirement for FAMIS members.

For a complete list of covered drugs, please access:

Provider website:	www.optimahealth.com/providers/authorizations/prescription-drugs/medicaid-drug-authorization-forms

Medicaid section of the Optima Health Formularies at:	www.optimahealth.com/providers/authorizations/prescription-drugs/

Day Supply Dispensing Limitations

Medicaid program members may receive up to a 34-day supply of a prescription drug at a retail or specialty pharmacy. A 34-day supply shall be interpreted as a consecutive 34-day supply. Members may receive a ninety (90) day supply per prescription of select maintenance drugs identified on the "DMAS 90-day Medication Maintenance List." In order to be eligible for a 90-day supply, members must first receive two 34-day or shorter duration fills. The list of covered dugs for DMAS 90-day Medication list can be located at:

www.virginiamedicaidpharmacyservices.com/provider/documents/

Members may receive up to a 12-month supply of contraceptives including all oral tablets, patches, vaginal rings, and injections that are used on a routine basis when dispensed from a pharmacy.

Prior Authorization Process

In the event a drug has restrictions, and no substitution can be made, a prior authorization process will need to be requested.

Optima Health accepts telephonic, facsimile, or electronic submissions of service authorization requests that are delivered from e-prescribing systems, electronic health records, and health information exchange platforms that utilize the National Council for Prescription Drug Program's SCRIPT standards for service authorization requests.

Coverage decisions are made on a case-by-case basis based upon the specifics of the member's situation and in conjunction with the terms and conditions of his or her benefit plan. Please note that approved pharmacy service authorizations will not exceed one year in duration.

All requests will be processed, and a response provided within 24 hours of receipt of the complete request. A response will be provided by telephone or other telecommunication device within 24 hours of a request for prior authorization.

If the decision results in a denial, a Notice of Action will be issued within 24 hours of the denial to the prescriber and the member. The Notice of Action includes appeal rights and instructions for submitting an appeal in accordance with the requirements described in the Grievances/Complaints and Appeals section of the Medicaid program contract.

Emergency Supply

Members will be eligible for a 72-hour emergency supply of a prescribed medication in an instance where the medication requires a service authorization, or the prescribing physician cannot readily provide an authorization. This process provides a short-term supply of the prescribed medication to provide time for the provider to submit an authorization request for the prescribed medication. Requests for an emergency supply will be evaluated on a case-by-case basis, to ensure continuity of care. To request an emergency supply, a provider or member can contact Pharmacy Services where a pharmacist is on-call 24 hours a day to resolve pharmacy related issues or concerns.

Benefit Exclusions

Medicaid program excludes coverage for the following:

- drugs used for anorexia or weight gain
- drugs used to promote fertility
- agents whose primary purpose is cosmetic, including but not limited to hair growth (agents used in the treatment of covered Gender Dysphoria services are not primarily cosmetic)
- agents used for the treatment of sexual or erectile dysfunction, unless such agents are used to treat a condition other than sexual or erectile dysfunction, for which the agents have been approved by the FDA
- All DESI (Drug Efficacy Study Implementation) drugs as defined by the FDA to be less than effective. Compound prescriptions, which include a DESI drug, are not covered
- drugs which have been recalled
- experimental drugs or non-FDA-approved drugs, except for children and youth covered by EPSDT
- any legend drugs marketed by a manufacturer who does not participate in the Medicaid Drug Rebate program

Long-Acting Reversible Contraception (LARC)

Medicaid program provides coverage for members for all methods of family planning including, but not limited to:

- barrier methods
- oral contraceptives
- vaginal rings
- contraceptive patches
- long-acting reversible contraceptives (LARCs)

Members are free to choose the method of family planning.

Patient Utilization Management and Safety Program

The purpose of the Optima Health Pharmacy Utilization Management (PUMS) program is to develop, implement, monitor, evaluate, and refine a comprehensive integrated process to reduce the inappropriate use of controlled substances.

To ensure the delivery of high-quality, cost-effective health care in a manner consistent with ethical and fiscal responsibility, Pharmacy Care Services and Clinical Care Services (CCS) collaborate to assure that each member accesses care in an appropriate manner and consistent with his/her Individualized Care Plan (ICP). The PUMS accomplishes this by limiting the opportunity for members to continue to misuse or abuse multiple medical resources and by referring members to care/services appropriate to the member's unique situation.

PUMS restricts members, whose utilization of medical services is documented as being excessive or potentially unsafe, to access prescription refills and certain clinical services to limited sites chosen by or for the member.

In addition to focusing on misuse or abuse of the Medicaid prescription benefit, the PUMS program also focuses on patient safety and further ascribes limits regarding sites of care that can be reimbursed for members in the program.

PUMS is designed to ensure medical and pharmacy benefits are received at an appropriate frequency and are medically necessary. PUMS is also used to assist providers in monitoring potential abuse or inappropriate utilization of controlled prescription medications by Optima Health members.

If a member is chosen for PUMS, they may be restricted to or locked into only using one pharmacy or one provider to get certain types of medicines.

Members who are enrolled in PUMS will receive a letter from Optima Health that provides additional information on PUMS including:

- a brief explanation of the PUMS program
- a statement explaining the reason for placement in the PUMS program
- information on how to appeal to Optima Health if placed in the PUMS program
- information regarding how to request a State Fair Hearing after first exhausting the Optima Health appeals process
- information on any special rules to follow for obtaining services, includingfor emergency or after-hours services
- information on how to choose a PUMS provider

Member Services or the member's Care Coordinator should be contacted with any questions about the PUMS program.

Prescription Monitoring Program

The Prescription Monitoring Program (PMP) is an electronic system to monitor the dispensing of Schedule II, III, IV, and V controlled substance prescription drugs. It is established, maintained, and administered by the Department of Health Professions. More information on the Virginia PMP is available on the Department of Health Professions website at www.dhp.virginia.gov.

The PMP may be accessed to determine information about specific members when completing prior authorization forms and to manage care of members participating in the PUMS program.

Opioid Treatment Management

Opioid treatment (including individual, group counseling and family therapy and medication administration) is a covered benefit. For additional details regarding opioid treatment, please refer to the ARTS Supplement to the Provider Manual located at the hyperlink below:

ARTS Supplement to the Provider Manual located at:	www.optimahealth.com/documents/provider- manuals/optima-health-addiction-and- recovery-treatment-program-provider-manual-supplement-en.pdf.

Specialty Drugs

Specialty drugs have unique uses and are generally prescribed for people with complex or ongoing medical conditions. Specialty drugs typically require special dosing, administration, and additional education and support from a healthcare professional.

Specialty drugs may include:

- medications that treat certain patient populations including those with rare diseases
- medications that require close medical and pharmacy management and monitoring
- medications that require special handling and/or storage
- medications derived from biotechnology and/or blood-derived drugs or small molecules
- medications that can be delivered via injection, infusion, inhalation, or oral administration

For more information on how to obtain specialty drugs for your patients, please call Pharmacy Services at 1-844-672-2307, Monday through Friday 8am to 6pm.

SECTION VII: QUALITY IMPROVEMENT

Optima Health, through its commitment to excellence, has developed a comprehensive program directed toward improving the quality of care, safety, and appropriate utilization of services for our members. The Quality Improvement (QI) program is designed to implement, monitor, evaluate, and improve processes within the scope of our health plan on a continual basis to improve the health of our members every day**.**

Clinical Practice Guidelines Update

These medical and behavioral health guidelines are based on published national guidelines, literature review, and the expert consensus of clinical practitioners. They reflect current recommendations for screening, diagnostic testing, and treatment. These guidelines are published by Sentara Health Plans, Inc. (SHP) as recommendations for the clinical management of specific conditions. Clinical data in a particular case may necessitate or permit deviation from these guidelines. The SHP guidelines are institutionally endorsed recommendations and are not intended as a substitute for clinical judgment. Copies of clinical guidelines are available via mail, email, fax, or online. Please contact the quality improvement department at 757-252-8400 or toll free at 1-844-620-1015.

Optima Health QI Program

Each year, Optima Health develops a QI Program and work plan that outlines our efforts to improve clinical care and service to our members. Providers may request a copy of the current QI Program and Work Plan by calling the Network Management Department. Information related to QI initiatives is also available on the provider website and in our provider newsletters.

The Optima Health QI program is a comprehensive document or a set of documents that serves our culturally diverse membership. It describes, in plain language, the QI program’s governance, scope, goals, measurable objectives, structure, responsibilities, annual work plan and annual evaluation.

The QI Program includes:

- the QI program's functional areas and responsibilities
- description of how the QI and Population Health Management (PHM) programs are related in regard to operations oversight
- reporting relationships of QI department staff and the QI Committee
- resources and analytical support
- delegated QI activities, if the organization delegates QI activities
- collaborative QI activities
- outlines Optima Health's efforts to monitor and improve behavioral healthcare and the role of

designated behavioral healthcare practitioners in the QI Program
- the role of a designated physician in the QI program, which includes participating in or advising the QI Committee or a subcommittee that reports to the QI Committee
- defines the role, function and reporting relationships of the QI Committee and subcommittees, including committees associated with oversight of delegated activities (e.g., clinical subcommittees, ad hoc task forces, or multidisciplinary work groups or subcommittees)
- describes practitioner participation in QI committee and how participating practitioners are representative of the specialties in the organization's network. Including those involved in the QI subcommittees such as the Physician Advisory Committee (PAC) and the Medical Care Review Committee (MCRC)
- outlines the organization's approach to address the cultural and linguistic needs of its membership
- QI program description might include objectives the organization deems appropriate
- what and how to report member critical incidents (inclusive of quality of care and sentinel events)
- training for providers and organization employees on cultural competency, bias, or inclusion
- organization may use practitioner performance data for quality improvement activities

Goals of Quality Improvement Program

The QI program's functional areas and their responsibilities:

- to reduce health care disparities in clinical areas
- to improve cultural competency in materials and communications
- to improve network adequacy to meet the needs of underserved groups
- to improve other areas of needs the organization deems appropriate
- include a dynamic work plan that reflects ongoing progress on QI activities throughout the year
- yearly planned QI activities and objectives for improving quality and safety of clinical care, quality of service, and member experience
- time frame for each activity's completion
- staff members responsible for each activity
- monitoring of previously identified issues
- annual evaluation of the QI program's effectiveness by comparing the performance measure outcomes

For hard copies or information about QI at Optima Health, please contact the quality improvement department at 757-252-8400 or toll-free 1-844-620-1015.

NCQA's website www.ncqa.org contains information to help consumers, employers, and others make more informed health.

DMAS Performance Withhold Program (PWP)

The PWP is a value-based program developed by DMAS for the purposes of aligning provider quality incentive payments in exchange for addressing gaps in care that will improve the quality of life and achieve population health management for eligible Medicaid program members. Primary Care Providers will be afforded financial incentives for successful participation

in the program as it is designed by DMAS and administered by the health plan. Participation in this program requires additional contracting commitments- if interested in more information, please reach out to Network Management.

Critical Incident Reporting

Critical incidents include, but not limited to, the following incidents: medication errors, severe injury or fall, theft, suspected physical or mental abuse or neglect, financial exploitation, and death of a member. Optima Health requires its staff and contracted Optima Health providers to report, respond to, and document critical incidents to Optima Health.

The incident must be reported to Optima Health within 24 hours. Providers should call the Optima Health care coordination department, fill out the Critical Incident Reporting Form on the Optima Health website at www.optimahealth.com/documents/forms/general/provider-critical-incident-report-form.pdf and fax the form to Optima Health using the fax number listed on the form.

SECTION VIII: CLAIMS AND COORDINATION OF BENEFITS

Coordination of Benefits (COB)

Optima Health Medicaid program members who are covered by employer sponsored health plans may be enrolled in a Medicaid managed care plan. It is also important that if an Optima Medicaid program member is identified as having a commercial product, that initial claim should be sent to the commercial plan for payment. Medicaid is always the payer of last resort. Optima Health will coordinate benefits.

For children with commercial insurance coverage, providers must bill the Commercial insurance plan first for covered early intervention services except for the following services that are federally required to be provided at public expense:

- assessment/EI evaluation,
- development or review of the Individual Family Service Plan (IFSP); and,
- targeted case management/service coordination,
- developmental services; and,
- any covered early intervention services where the family has declined access to their private health/medical insurance.

Under these circumstances, and in following with federal regulations, the Optima Health Medicaid program requires the Early Intervention provider to complete the Notification to the Department of Medical Assistance Services: Family Declining to Bill Private Insurance form (https://infantva.org/documents/ovw-st-taskf-mtg-20090520form-decliningpriv_ins.pdf) and submit it with the bill to the Optima Health Medicaid program.

Filing Claims Electronically

Providers that submit electronic claims to Optima Health enjoy a number of benefits: documentation of claims transmission, faster reimbursement, reduced claim suspensions, and lower administrative costs.

- Claims can be submitted through AllScripts/PayerPath or Availity, or any clearinghouse that can connect through AllScripts/PayerPath, or Availity. Electronic claims may also be submitted directly to Optima Health by a provider or vendor via data files in a HIPAA compliant format.

- The Optima Health Payor ID Number is 54154 for medical providers and 5415M for behavioral health providers. The ID for institutional providers is 00453.

- Providers who can receive data files in the HIPAA compliant ANSI 835 format may elect to receive EFT/ERA directly from Optima Health. The 835 transaction contains the remittance information as well as the Electronic Funds Transfer. Inquiries about direct claims submission or EFT/ERA transactions may be submitted by e-mail to EFT_ERA_Inquiry@sentara.com .

- All claims must be submitted within the Timely Filing Policy provisions stated in your Provider Agreement or as dictated by Optima Health policy.
- Claims submitted electronically will be accepted when billed under the member's Optima Health Member ID or the member's Medicaid number. Providers should first review their Clearinghouse requirements for submission of Member Identification to confirm that their clearinghouse will accept claims using their chosen option for submission.

- Claims submitted must have charge amounts. Claims for zero (0) charge amounts will be rejected.

- Claims submitted electronically will be received within 24 hours for processing.

Electronic Funds Transfer (EFT)

EFT is safe, secure, efficient, and less expensive than paper check payments. Funds are typically deposited 24 hours after payments are processed. Clean claims are processed and paid by Optima Health within an average of seven days when submitted electronically and when payment is made through EFT.

Providers are encouraged to enroll for EFT by completing the Electronic Payment/Remittance Authorization Agreement at optimahealth.com.

Ineligible Members

Optima Health may retract provider payments made during a period when the member was not eligible. Providers will be instructed to invoice DMAS for payment. Reimbursement by DMAS for services rendered during a retroactive period is contingent upon the member meeting DMAS eligibility and coverage criteria requirements. Optima Health will not deny payment due to enrollment processing errors or because payment was not reflected on the DMAS 820 Payment Report.

Payment Coordination with Medicare

In accordance with 42 CFR §438.3(t), Optima Health Medicaid program has entered a Coordination of Benefits Agreement (COBA) with Medicare and participates in the automated claims crossover process for claims processing for its members who are dually eligible for Medicaid and Medicare.

Nursing Facility, LTSS, ARTS, Community Behavioral Health and Early Intervention Claim Payments

Clean claims from Nursing Facilities, LTSS (including when LTSS services are covered under

ESPDT), Community Behavioral Health, ARTS and Early Intervention providers are processed within 14 calendar days of receipt as an exception to payment within 30 calendar days of receipt for other services. If the service is covered under Medicare other than by Optima Health, the 14-day time period starts post adjudication of the Medicare claim by the other payer.

Specific claim payment information is detailed in Provider Connection on the Optima Health provider website or by calling Provider Services.

NDC Number

Optima Health requires a National Drug Code (NDC) number, drug Quantity and Unit of Measure (UOM) on claims that include a billed amount for drugs. The NDC number is required in addition to the appropriate HCPC code. This requirement applies to both UB and HCFA claims. The most current NDC numbers are available from the FDA's NDC Directory or from the RJ Health Systems listing.

NDC Number

- the NDC Number field - 11 digits are required for this field
- the NDC number cannot be inactive
- the NDC number must be valid for any specific drug HCPCS, or CPT code billed
- the NDC number must be a valid NDC number if a miscellaneous/unlisted drug code is billed
- the most current NDC numbers are available from the FDA's NDC Directory

Quantity

- the quantity is the "metric decimal units/measurement" (dosage) administered to the member
- the smallest NDC Quantity that the MMIS can accept is .0005
- the "metric decimal units/measurement" is NOT the same quantity found in field 46 on the UB04 or field 24G on the CMS 1500 form

Unit of Measurement: There are 4 valid qualifiers for the Unit of Measurement (UOM) field

- F2: International units
- ML: Milliliter
- ME: Milligram
- GR: Gram
- UN: Unit

Electronic Visit Verification for Home Health Providers

To comply with the 21st Century Cures Act and the Virginia Appropriations Act; EVV is required for certain home health service codes. These services include personal care, respite, and companion services.

More information regarding Optima Health and its Electronic Visit Verification program please visit:	www.dmas.virginia.gov/for-providers/long-term-care/programs-and- initiatives/electronic-visit-verification/.

National Provider Identification Number

All Medicaid program providers are required to register and attain their National Provider Identification number before conducting business with the health plan.

EDI General Overview

All Optima Health Companion Guides are to be used with the HIPAA-AS Implementation Guide. The HIPAA Implementation guides provide comprehensive information needed to create each ANSI transaction set. The Optima Health Companion Guide is used in conjunction with the HIPAA Implementation Guide; it is intended to clarify issues where the HIPAA Implementation Guide provides options or choices to be made. The HIPAA Implementation Guide is available from the Washington Publishing Company.

EDI Business Use

Each EDI vendor will have to sign a Trading Partner Agreement, which includes the Network Access Agreement and the Business Associate Agreement:

- Each transaction set will be used to expedite the execution of electronic information and accelerate the processing and payment of a claim or encounter.
- The 837 transactions may be sent daily, with a disposition report available the next business day. The disposition report replaces the 997 Acknowledgement File.
- The 835-transaction file consists of a separate remittance file (ERA) and a separate electronic funds file (EFT).

Optima Health providers may elect to receive an EFT/ERA from Optima Health directly if they can receive data files in the HIPAA compliant ANSI 835 format.

340B Registered Entities

A UD modifier must be billed by providers enrolled as 340B providers for all 340B-eligible drugs to identify them as 340B purchased drugs and prevent duplicate discounts from the manufacturer. NDC numbers and quantities are still required.

Dispute Resolution

Any dispute between the Parties arising out of or relating in any manner to the Provider Agreement, whether sounding in tort, contract, or under statute (a “Dispute”) shall first be addressed by exhausting all Policies and Procedures applicable to the Dispute, including but not limited to claims payments, credentialing, utilization management, adverse benefit determinations, or other programs, including applicable appeals procedures, before either Party may seek to resolve the Dispute in any other forum or manner. If the dispute is not resolved by the Parties via the Policies and Procedures or is of a type not subject to the Policies and Procedures, the Parties shall engage in good faith negotiations between their designated representatives (such representatives shall be authorized to resolve the dispute). The negotiations may be initiated by either Party upon written request to the other (the “Meeting Request Notice”), provided such Meeting Request Notice is delivered in accordance with the notice requirements of the Provider Agreement within 60 days of the date on

which the requesting party first had, or reasonably should have had, knowledge of the event(s) giving rise to the Dispute. The negotiations shall occur within 30 calendar days following the day the receiving Party receives the Meeting Request Notice, and neither Party may seek to resolve the Dispute in any other forum or manner unless the Dispute is not resolved within 60 days after the Meeting Request Notice.

The deadline for initiating any recovery efforts (including applicable regulatory timeframes and or statute of limitations) shall be tolled by the applicable dispute resolution procedures and appeal process(es) set forth in the Policies and Procedures and herein.

Any and all dispute resolution procedures shall be conducted only between the Parties and shall not include any member unless involvement of a member is necessary to the resolution of the dispute, which determination shall be made in the sole discretion of SHP or Payor.

SECTION IX: MEMBER RIGHTS AND RESPONSIBILITIES

Privacy Regulations

As affiliates of Sentara Healthcare, Optima Health entities follow the Sentara Healthcare Notice of Privacy.

Practices available at:	www.optimahealth.com/policies/Pages/SentaraHealthcareNoticeofPrivacyPractices.aspx.

Optima Health maintains compliance with the Privacy Rule and Security Rule under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Health Information Technology for Economic and Clinical Health (HITECH) Act, and American Recovery and Reinvestment Act (ARRA).

To ensure the protection of confidential information and patient health information, Optima Health has implemented privacy and security policies and procedures, has developed required forms, has established safeguards to protect patient health information, and conducts HIPAA awareness training

Optima Health Medicaid Program Member Rights and Responsibilities

Member rights	Member responsibilities
Receive timely access to care and services	Present their Medicaid program membership card whenever they seek medical care
Take part in decisions about their health care, including their right to choose their providers from the Optima Health Medicaid program network and their right to refuse treatment	Provide complete and accurate information to the best of their ability on their health and medical history
Confidentiality and privacy about their medical records and when they get treatment	Participate in their care team meetings, develop an understanding of their health condition, and provide input in developing mutually agreed upon treatment goals to the best of their ability
Receive information and to discuss available treatment options and alternatives presented in a manner and language they understand	Keep their appointments, and if they must cancel, call as soon as they can

Get information in a language they understand - they can get oral translation services free of charge	Receive all their covered services from the Medicaid program network
Receive reasonable accommodations to ensure they can effectively access and communicate with providers, including auxiliary aids, interpreters, flexible scheduling, and physically accessible buildings and services	Obtain authorization from the Optima Health Medicaid program prior to receiving services that require pre- authorization
Receive information necessary for them to give informed consent before the start of treatment	Call Optima Health Medicaid whenever they have a question regarding their membership or if they need assistance, toll-free at one of the numbers on their ID card

Be treated with respect and dignity	Tell the Optima Health Medicaid program when they plan to be out of town so Optima Health can help arrange their services
Get a copy of their medical records and ask that the records be amended or corrected	Use the emergency room only for real emergencies
Be free from restraint or seclusion unless ordered by a physician when there is an imminent risk of bodily harm to themselves or others or when there is a specific medical necessity. Seclusion and restraint will never be used as a means of coercion, discipline, retaliation, or Convenience.	Call their PCP when they need medical care, even if it is after hours
Get care without regard to disability, gender, race, health status, color, age, national origin, sexual orientation, marital status, or religion	Tell the Optima Health Medicaid program when they believe there is a need to change their plan of care
Be informed of where, when, and how to obtain the services they need from the Optima Health Medicaid program, including how they can receive benefits from out-of-network providers if the services are not available in the the Optima Medicaid program networks	Tell the Optima Health Medicaid program if they have problems with any health care staff. Members should call Member Services at one of the numbers listed on their ID card
Complain about the Optima Health Medicaid program to the State. Members can call the Helpline at 1-800-643-2273 to make a complaint about the Optima Health Medicaid program.	Call Member Services at one of the phone numbers listed on their ID card about any of the following:
Appoint someone to speak for them about their care and treatment and to represent them in an Appeal	• Changes to their name, their address, or their phone number. Members should also report these to their case worker at their local Department of Social Services • If they have any changes in any other health insurance coverage, such as from their employer, their spouse's employer, or workers' compensation
Make advance directives and plans about their care in the instance that they are not able to make their own health care decisions	
Change their health plan once a year for any reason during open enrollment or change their Managed Care Organization after open enrollment for an approved reason	

Appeal any adverse benefit determination (decision) by the Optima Health Medicaid program that they disagree with that relates to coverage or payment of services	• If they have any liability claims, such as claims from an automobile accident • If they are admitted to a nursing facility or hospital • If they get care in an out-of-area or out-of- network hospital or emergency room
File a complaint about any concerns they have with Optima Health customer service, the services they have received, or the care and treatment they have received from an Optima Health Medicaid program network provider	
To receive information from the Optima Health Medicaid program about their plan, covered services, providers in the Optima Health Medicaid program Networks, and about their rights and responsibilities	
To make recommendations regarding the Optima Health Medicaid program member rights and responsibility policy, for example, by joining the Optima Health Medicaid program Member Advisory Committee.	• If their caregiver or anyone responsible for them changes • If they are part of a clinical research study

Member Grievances/Complaints and Appeals

Medicaid Program Member Appeal Procedure

The member appeal process for Medicaid program members is as follows:

Medicaid program members must contact Member Services by telephone or in writing within 60 calendar days of the original notification of a reduced, terminated, or denied claim or request for service, unless good cause is indicated for a delay. Members may continue to receive services that were denied during the review process if an appeal is submitted within 10 days of the denial or the change in services or by the date the change in services is scheduled to occur. Medicaid program Members may have to pay for continued benefits if the appeal results in another denial.

Medicaid program members will be informed that they may appeal in writing directly and immediately to the Department of Medical Assistance Services (DMAS) for a State Fair hearing after appealing to Optima Health.

Members will receive written notice of receipt of their appeal. Clinical appeals will be reviewed by qualified health professionals with appropriate clinical expertise who were not involved in the initial decision. Member and authorized representatives may obtain and review the case file prior to and during the appeal and provide information for the appeal decision in person or in writing. Standard appeals will receive a decision within 30 calendar days.

FAMIS Member Appeal Procedure

FAMIS members must contact Member Services by telephone or in writing within 60 days of the original notification or a reduced, terminated, or denied claim or request for service, unless good cause is indicated for the delay.

Appeals from FAMIS members must be submitted first to the Optima Health Appeals Department for resolution through the Optima Health Appeals Process.

If the FAMIS member is not in agreement with the Optima Health resolution, the member may file an appeal within 60 days of receipt of the Optima Health final appeal decision.

An external review will be conducted by an independent external quality review organization. External review requests from FAMIS members should be sent to:

FAMIS External Review c/o
KePro 2810 N. Parham Road
Suite #305
Henrico, VA 23294,
Phone Number: 804-622-8900
Website: dmas.kepro.com/

The decision of the External Quality Review Organization is final and can no longer be appealed.

Medicaid Program Expedited Appeals

The member or his/her physician may request an expedited appeal verbally by telephone or in writing by fax or letter and must explicitly state "expedited appeal" in the request to initiate the expedited process. For expedited requests, providers may be contacted to confirm that the member's health condition requires an expedited review. Expedited appeals will be resolved within 72 hours from the initial receipt of the appeal. If additional information is required, the member will be notified within two days. The review timeframe may be extended by up to 14 calendar days. If Optima Health extends an expedited appeal timeframe or refuses a request for an expedited appeal, the member will be notified in writing or orally within 24 hours of Optima Health receiving the request. Members may also request additional time for the decision. If Optima Health determines that the request does not qualify as an expedited appeal, the routine standard process will apply. A written notice will be sent to the member and provider if the request was denied or approved in an amount less than requested.

To appeal to DMAS, the member should contact DMAS Appeals Department at 804-371-8488 or send a written request within 120 calendar days of receipt of a notice of adverse action/denial to:

Department of Medical Assistance Services Appeals Division
600 East Broad
Street Richmond,
VA 23219
Fax: 804-452-5454
Phone: 804-371-8488 (Standard and Expedited Appeals)

There are a few ways to ask for an appeal with DMAS. The deadline to ask for an appeal with DMAS is 120 calendar days from when Optima Health issues the final MCO internal appeal decision.

1. Electronically. Online at dmas.virginia.gov/appeals/ or email to appeals@dmas.virginia.gov
2. By fax. Fax appeal request to DMAS at 1-804-452-5454
3. By mail or in person. Send or bring appeal request to Appeals Division, Department of Medical Assistance Services, 600 E. Broad Street, Richmond, VA 23219
4. By phone. Call DMAS at 804-371-8488 (TTY: 1-800-828-1120)

A decision to uphold or reverse the decision will be issued within 30 days for Medicaid program

members. If the Medicaid program member is not in agreement with the resolution by DMAS, they may appeal such a decision to the Circuit Court.

For provider appeals where Optima Health does not reverse its decision, the written notice of Optima Health's final decision will also include a reference to the specific plan provision on which Optima Health based its determination. Notification of the provider's right to request a DMAS Informal or Formal hearing and how to do so will be provided.

Continuation of Benefits: The member may be able to continue the services that are scheduled to end or be reduced if they ask for an appeal within 10 days from being told that the request is denied, or care is changing or by the date the change in services is scheduled to occur. If the appeal results in another denial, the member may have to pay for the cost of any continued benefits that they received if the services were previously solely because of the requirement.

Medicaid Program Grievances/Complaints

Disputes may involve Optima Health Medicaid program benefits, the delivery of services or Optima Health's operation. This procedure includes both medical and non-medical (dissatisfaction with the plan of care, quality of Member Services, appointment availability, or other concerns not directly related to a denial based on medical necessity) issues. A complaint, by phone or in writing, can usually be resolved by contacting Member Services.

The grievance/complaint procedure is available to all providers; timely resolution will be executed as soon as possible and will not exceed 72 hours from initiation of the complaint for urgent cases and 90 days for all other issues.

A Medicaid program member or the member's authorized representative (provider, family member, etc.) acting on behalf of the member, may file a grievance/complaint either orally or in writing at any time.

Medicaid Program Member Grievance/Complaint Procedure

Medicaid program members have the right to express a complaint about service or clinical issues at any time. Members may register an internal complaint by calling Member Services during business hours or by submitting a complaint in writing to:

Optima Health Appeals Department
P.O. Box 62876 Virginia
Beach, VA 23466-2876

Optima Health shall resolve a grievance/complaint and provide notice as expeditiously as the member's health condition requires, within state established timeframes not to exceed 90 calendar days from the date Optima Health receives the grievance/complaint. Optima Health may extend this timeframe by up to an additional 14 calendar days if the member requests the extension or if Optima Health provides evidence satisfactory to DMAS that there is need for additional information and that a delay in rendering the decision is in the member's interest.

Members may also register a complaint externally to the:

DMAS Helpline:	<1-844-374-9159> TDD <1-800-817-6608>
US Department of Health and Human Services Office for Civil Rights:	www.hhs.gov/ocr

Office of the State Long-Term Care Ombudsman:	www.elderrightsva.org

Providers must respond to requests from Optima Health for information regarding a member's complaint within five business days. Optima Health will notify the member within two days if additional information is needed. If a complaint is deemed clinically urgent, the complaint will be addressed no later than 72 hours (working days) from receipt of the request.

State Fair Hearing

If the member disagrees with the Appeal decision, they may appeal directly to DMAS by submitting a request for a State Fair Hearing. The Appeals process above must be exhausted before a member or their Authorized Representative may submit a request for a State Fair Hearing. DMAS will resolve a standard request within 90 days and an expedited request within 72 hours. The State Fair Hearing Request may be submitted by internet, mail, fax, email, telephone, in person, or other electronic means. It must be submitted no more than 120 calendar days from the final appeals decision. Members may write a letter or submit a Virginia Medicaid Appeal Request Form and send it to:

Appeals Division
Department of Medical Assistance Services
MLTSS External Review Request Health Care Division
600 Broad Street
Richmond, VA 23219
Fax: 804-452-5454
804-371-8488

DMAS will notify the member of the date, time, and location of the scheduled hearing. Most hearings will occur by telephone.

A decision to uphold or reverse the decision will be issued within 90 days for a standard appeal and within 72 hours of receiving a letter from the provider for an expedited appeal.

Members may continue to receive services that were denied during the State Fair Hearing process. Members may have to pay for continued benefits if the appeal results in another denial.

If the State Fair Hearing decision is to reverse the denial, the Optima Health Medicaid program will authorize or provide the services as quickly as the condition requires but no later than 72 hours from receipt of notice from the State reversing the denial. If services were denied during the appeal, the Optima Health Medicaid program will pay for those services.

If the Medicaid program member is not in agreement with the resolution by DMAS, they may appeal such a decision to the Circuit Court.

Processes related to reversal of our initial decision

If the State Fair Hearing reverses a decision to deny, limit, or delay services not provided while the appeal was pending, Optima Health will authorize or provide the disputed services as quickly as the member's health condition requires. If the decision reverses denied authorization of services and the disputed services were received pending appeal, Optima Health pays for those services as specified in policy and/or regulation.

SECTION X: PROVIDER PRINCIPLES

Common Provider Responsibilities

Notice of Non-Discrimination and the Civil Rights Act

Optima Health providers will not differentiate or discriminate in the treatment of any member because of age, sex, marital status, sexual orientation, gender identity, race, color, religion, ancestry, national origin, disability, handicap, health status or need for health services, source of healthcare coverage/payment, utilization of medical or mental health services or supplies, or other unlawful basis including, without limitation, the filing by any member of any complaint, grievance or legal action against provider or the applicable Health Benefit Plan.

Immediate Termination for Cause of care following termination of your participation

Optima Health may immediately terminate this Agreement at any time for the following reasons:

- insolvency
- dissolution
- failure to comply with review programs
- termination of provider's insurance
- loss of provider license
- conviction of a crime
- material breach
- harm to member
- exclusions
- false statements and omissions
- provider representations
- failure to provide notice
- termination for merger or acquisition
- termination for breach
- termination with notice
- termination of individual practice providers
- notice to members

Provider Services Solution (PRSS)

On April 4, 2022, DMAS launched the Medicaid Enterprise System (MES). This new technology platform includes the Provider Services Solution (PRSS), a module to support both fee-for-service and managed care network providers. Fee-for-service (FFS) providers and those dually enrolled in fee-for-service and managed care networks are already using PRSS to manage enrollment and maintenance processes.

PRSS will simplify provider enrollment tasks, such as updates to licenses, certifications, and submission of documents through the secure portal. All Medicaid managed care network providers must enroll through PRSS to satisfy and comply with federal requirements in the 21st Century Cures Act. Network providers that are currently enrolled as FFS in Medicaid do not have to re-enroll in PRSS. However, all new MCO-only providers must first enroll with PRSS prior to requesting credentialing with Optima Health.

For a list of common questions and answers for providers on the PRSS portal, please visit the MES website vamedicaid.dmas.virginia.gov/provider/faq.

Making Sure Providers Appear in the Directory

The health plan serves members of all socio-economic and cultural backgrounds. Optima Health Medicaid program members rely on the health plan and the providers to deliver complete and accurate information in our directories at all times.

Changing an existing TIN or adding a health care provider

If your practice/organization (tax ID) is out of network and is interested in participating with Optima Health, please complete the “Request for Participation Form” at:
www.optimahealth.com/providers/provider-support/join-our-network

Update Your Information

To best serve you and our members, it is important that we have up to date information about your practice. Please notify Optima Health as soon as possible, but at least 60 days before any changes related to your practice’s operations or provider roster. Optima Health offers electronic submission for your provider update requests.

The Provider Update form is intended for providers who are currently contracted with Optima Health or are in the contracting process:	www.optimahealth.com/providers/provider-support/update-your-information.

Fraud, Waste, and Abuse

Optima Health is responsible for detecting and preventing fraud, waste, and abuse (FWA) in accordance with the Deficit Reduction Act and the False Claims Act. Optima Health, through the Program Integrity Unit (PIU), has implemented policies and procedures to detect, prevent and recover dollars from all forms of insurance fraud, including fraud involving employees, providers, employer groups, and contractors or agents of Optima Health.

Optima Health is required to refer suspected fraud, waste, and abuse to law enforcement and regulatory agencies. We also cooperate with law enforcement and regulatory agencies to fight against fraud, waste, and abuse. Optima Health has a fiduciary responsibility to protect the integrity of the company, its employees, members, providers, government programs, and the public.

Optima Health understands that health plans are at risk for fraud, waste, and abuse. Optima Health use risk analysis to focus our efforts on the needs of our programs. The Program Integrity Unit conducts reviews and audits to help ensure compliance with state and federal laws and regulations. Providers are contractually obligated to cooperate with the company and government entities.

Claim reviews and/or audits are conducted either on a prepayment or post payment basis. Claim reviews/audits are conducted in order to confirm that healthcare services and supplies were delivered in compliance with the member's plan of treatment and/or to confirm that charges were accurately reported in compliance with Optima Health's policies and procedures as well as general industry standard guidelines and State and Federal regulations.

In order to conduct reviews and audits, Optima Health and its designees will request documentation, mostly in the form of patient medical records. Optima Health will accept other documentation in addition to the medical record from the provider or facility that substantiates the treatment or service. The documentation may be the provider's or facility's established internal policies, professional licensure standards that reference standards of care, or business practices justifying the service. The provider or facility must review, approve and document all such internal policies and procedures as required by applicable accreditation bodies.

Upon request from Optima Health or its designee, facilities are required to submit additional documentation for claims identified for pre-payment review or post payment review/audit. Applicable types of claims include, but are not limited to:

- Claims being reviewed to validate the correct diagnosis related group (DRG) assignment/payment (DRG validation audits)
- Claims being reviewed to validate items and services billed are documented in the medical record for hospital bill audits (also known as hospital charge audits)
- Claims with unlisted or miscellaneous codes
- Claims for services requiring clinical review
- Claims for services found to possibly conflict with covered benefits
- Claims for services found to possibly conflict with medical necessity
- Claims being reviewed for potential fraud, waste, and/or abuse or demonstrated patterns of billing/coding inconsistencies
- Other documentation required by other entities such as the Centers for Medicare and Medicaid Services (CMS), and state or federal regulation
- Documentation for such services as the provision of durable medical equipment, prosthetics, orthotics, and supplies, rehabilitation services, and home health care

Optima Health or its designee will use the following guidelines for records requests and the adjudication of claims identified for prepayment review or post payment review/audit:

1. Upon confirmation of provider's or facility's address, an original letter of request for supporting documentation will be sent.
2. When a response is not received within 30 days of the date of the initial request, a second request letter will be sent.
3. When a response is not received within 15 days of the date of the final request (45 days total):

a. Optima Health or its designee will initiate claims denials for claims identified as pre-payment review claims as provider or facility failed to submit the required documentation. The member shall be held harmless for such payment denials. Or

b. Optima Health or its designee will initiate claim retractions for claims identified as post payment audit claims as provider or facility failed to submit the required documentation. The member shall be held harmless for such payment retractions.

The Deficit Reduction Act (DRA) has provisions reforming Medicaid and Medicare, and reducing fraud, waste, and abuse within the federal health care programs. All entities receiving at least $5 million in annual Medicaid payments must have written policies for their employees and contractors. The policies must provide detailed information about the false claims, false statements and whistleblower protections. As a contracted provider with Optima Health, you and your staff are subject to these laws and regulations.

Code of Conduct

Optima Health requires employees and affiliates to conduct business and personal activities in a manner that is ethically and legally responsible. The Code of Conduct outlines this commitment.

- Treat members with respect and dignity
- Deal openly and honestly with fellow employees, members, providers, representatives, agents, governmental entities, and others
- Adhere to federal and state laws, regulations and Optima Health policies in procedures in all business and personal dealings whether at work or outside of work
- Exercise discretion in the processing of claims regardless of provider, practitioner, and vendor source
- Notify and return overpayments to the health plan immediately upon receipt of such payments
- Notify Optima Health's Compliance Officer of any instances of non-compliance and cooperate with all investigational efforts by Optima Health and other state and federal agencies
- Use supplies and services in an efficient manner to reduce cost to the health plan
- Do not misuse Optima Health resources nor influence in such a way as to discredit the reputation of Optima Health
- Maintain high standards of business and ethical conduct in accordance with regulatory and accredited agencies to include standards of business to address fraud, waste, and abuse
- Practice good faith in transactions occurring during the course of business
- Conduct business dealings in a manner that the organization shall be the beneficiary of such dealings
- Preserve patient confidentiality, unless there is written permission to divulge information, except as required by law

- Refuse any illegal offers, solicitations, payment or other enumeration to induce referrals of the members we serve for an item of service reimbursable by a third party
- Disclose financial interest/affiliations with outside entities to Optima Health as required by the Conflict of Interest Statement
- Hold all contracted parties to the same Standards of Professional Conduct as part of their dealings with Optima Health
- Notify Optima Health's Compliance Officer of any instances of non-Compliance and cooperate with all investigation efforts by Optima Health and other state and federal agencies
- Providers providing services to CCC Plus waiver members shall comply with the provider requirements as established in the DMAS provider manuals available at https://vamedicaid.dmas.virginia.gov/provider/faq and the following regulations: 12 VAC 30-120-900 through 12 VAC 30-120-995
- Providers of CCC Plus waiver services (including Adult Day Health Care) shall maintain compliance with the provisions of the CMS Home and Community Based Settings Rule as detailed in 42 CFR §441.301(c)(4) and (5)

HIPAA Privacy Statement

Optima Health maintains compliance with the Privacy Rule and Security Rule under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Health Information Technology for Economic and Clinical Health (HITECH) Act, and American Recovery and Reinvestment Act (ARRA). To ensure the protection of confidential information and patient health information, Optima Health has implemented privacy and security policies and procedures, has developed required forms, has established safeguards to protect patient health information, and conducts HIPAA awareness training. As affiliates of Sentara Healthcare, Optima Health entities follow:

Sentara Healthcare Notice of Privacy Practices available at	www.optimahealth.com/policies/Pages/SentaraHealthcareNoticeofPrivacyPractices.aspx

Medicaid Program Provider Availability: Access and After-Hours Standards

Participating providers must comply with the following access standards for Optima Health members:

Appointment Standards

Service	Optima Health Medicaid Standard

Emergency appointments, including Crisis Services	Emergency appointments and services, including crisis services, must be made available immediately upon the Member's request
Urgent appointments	Within 24 hours of the member's request
Routine Primary Care	Routine, primary care service appointments must be made within 30 calendar days of the member's request. Standard does not apply to appointments for routine physical examinations, for 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.)
Maternity Care – First Trimester	Within 7 calendar days of request
Maternity Care – Second Trimester	Within 7 calendar days of request
Maternity Care – Third Trimester	Within 3 business days of requests
Maternity Care – High Risk Pregnancy	Within 3 business days of high-risk identification, or immediately emergency exits
Postpartum	Within 60 days of delivery
Mental Health Services	As expeditiously as the member's condition requires and within no more than 5 business days from Optima Health's determination that coverage criteria is met
LTSS	As expeditiously as the member's condition requires and within no more than 5 business days from Optima Health's determination that coverage criteria is met

Providers must offer hours of operation that are no less than the hours of operation offered to Medicaid fee-for-service (if the provider serves only Medicaid members).

Cultural Competency

Optima Health Medicaid program promotes the delivery of services in a culturally competent manner to all members including those with limited English proficiency and diverse cultural, gender identity, and ethnic backgrounds. Culturally competent care allows healthcare providers to appropriately care for and address healthcare concerns, to include belief and value systems, of patients with diverse cultural and linguistic needs. Providers are encouraged to:

- build rapport by providing respectful care
- determine if the member needs an interpreter or translation services
- remember that some cultures have specific beliefs surrounding health and wellness
- ensure that the member understands diagnosis, procedures, and follow-up requirements
- offer health education materials in languages that are common to your patient population
- be aware of the tendency to unknowingly stereotype certain cultures
- ensure staff is receiving continued education in providing culturally competent care

The Optima Health Medicaid program requires providers demonstrate cultural competency in all forms of communication and ensure that cultural differences between providers and members

do not impede access and quality health care.

All providers must attest to completion of cultural competency training by either completing the Optima Health Cultural Diversity Training or The U.S. Department of Health & Human Services “Think Cultural Health” training at https://cccm.thinkculturalhealth.hhs.gov/ or by visiting the Education page of the Optima Health website where Cultural Awareness Training and attestation is available. The provider directory will indicate providers that have completed this training.

Provider Satisfaction Surveys

Optima Health may conduct provider surveys to monitor and measure provider satisfaction with Optima Health services and identify areas for improvement. Participation in these surveys is highly encouraged; provider feedback is very important. Optima Health informs providers of the results and plans for improvement through provider bulletins, newsletters, meetings or training sessions.

SECTION XI: MEDICAL RECORDS

Optima Health will collaborate with our providers to inspect, audit, review, and make copies of medical and patient records, maintained by our provider community and those that relate to covered services rendered to members under this Agreement.

Optima Health may at times request to obtain patient information from providers for the purpose of making benefit determinations and payment decisions. Provider agrees to provide Optima Health with such patient information electronically if provider maintains an electronic health recording system.

Listed below are the current medical record standards:

- Current active problem list must be maintained for each member.
- Should be legible and updated as appropriate.
- Significant illnesses and chronic medical conditions must be documented on the problem list.
- If there are no identified significant problems, there must be some notation in the progress notes stating that this is a well-child/adult visit.
- Allergies and adverse reactions must be prominently displayed.
- If the member has no known allergies or history of adverse reactions, this is appropriately noted in the record.
- A sticker or stamp noting allergies/NKA on the cover of the medical record is acceptable.
- Past medical history (for patients seen three or more times) must be easily identified and includes family history, serious accidents, operations, and illnesses.
- For children and adolescents (18 years and younger), past medical history relates to prenatal care, birth, operations, immunizations, and childhood illnesses.
- Prescribed medications, including dosages and dates of initial or refill prescriptions, are recorded.
- Each page of the medical record contains patient name or ID number. All entries are dated. Working diagnoses and treatment plans are consistent with medical findings.
- All requested consults must have return reports from the requested consultant or a phone call follow-up must be noted by the PCP in the progress note.
- Any further follow-up needed or altered treatment plans, should be noted in progress notes. Consults filed in the chart must be initialed by the PCP to signify review.
- Consults submitted electronically need to show representation of PCP review.
- Continuity and coordination of care among all providers involved in an episode of care, including PCP and specialty physicians, hospitals, home health, skilled nursing facilities, and

free-standing surgical centers, etc. must be documented when applicable.

- There should be documentation present in the records of all adult patients (emancipated minors included) that advance care planning/advance directives have been discussed. If the patient does have an advance directive, it should be noted in the medical record. A copy of the advance directive should be present in the record.
- Confidentiality of clinical information relevant to the patient under review is contained in the record or in a secure computer system, stored and accessible in a non-public area, and available upon identification by an approved person. All office staff must comply with HIPAA privacy practices.
- An assessment of smoking, alcohol, or substance abuse should be documented in the record for patients 12 years old and older. Referrals to a Behavioral Health Specialist should be documented as appropriate
- Records should indicate that preventive screening services are offered in accordance with Optima Health's Preventive Health Guidelines. This should be documented in the progress notes for adults 21 years and older.

Monitoring the Quality Care

Optima Health will oversee and review the quality of care administered to members. Providers are encouraged to maintain best practices when documenting in a members' medical records.

This includes cooperating with reviews of the care administered to members as such reviews are conducted by the medical director for Optima Health, or the Medical Director's designee.

Confidentiality**:** Provider agrees that all medical records, Protected Health Information (as defined by Health Insurance Portability and Accountability Act of 1996 ("HIPAA")), and any other personal information about a member received by provider from Optima Health (together the "Information") shall be maintained within the United States of America and shall be treated as confidential.

Charging for Copies of Records

Providers **may not** charge the Plan or plan members for copies of medical records or for the completion of forms.

Failure to Comply with Review Programs

Failure to comply with Utilization Management and Quality Improvement Programs could be grounds for corrective action. The failure of provider to follow the policies and procedures of our credential verification, quality assurance, risk, or Utilization Management programs regulations can lead to exclusion from federal funding including payments from Medicare and Medicaid as well as criminal and civil liability.

Office Site Reviews

Site visit assessments may be conducted, as the result of one or more of the following quality concerns:

- member grievances/complaints
- quality of Care (QOC) indicators
- sentinel events

- practice-specific member surveys
- reports from Optima Health employees
- credentialing department ongoing monitoring process
- other quality-related initiatives

The purpose of the review is to ensure practitioners meet our, regulatory and accreditation site standards for quality, safety, and accessibility. Optima Health will assess the following during an office site visit:

- facility accessibility, appearance, and adequacy
- safety
- adequacy of medical supplies and practices
- medical record-keeping practices
- availability of appointments

Practitioners who do not meet our site visit assessment performance threshold will be expected to document and implement a corrective action plan within a specified time frame. At least every six months after the initial review, each deficiency will be monitored for progress and/or until the performance standards are met. If deficiencies are not resolved within a six-month time frame, they will be presented to the Chief Medical Officer and/or credentialing to begin a review process with the practitioner.

Waiver Audit Site Visits

Waiver audit site visits will be conducted to assess operational and medical management aspects for organizations delivering interventions to members receiving waivered services. Audits focus on the following domains as issued by the Department of Medical Assistance Services:

- level of care
- service plans
- qualified providers
- health and welfare
- financial accountability
- administrative authority

SECTION XII: PROVIDER COMMUNICATIONS

The Optimahealth.com/providers website assists with delivering up-to-date information to Medicaid program providers. The website gives providers access to items such as:

- pre-authorization forms
- provider manuals
- clinical practice guidelines
- Provider Connection
- electronic data interchange Information
- quality and utilization Information
- educational materials such as newsletters and bulletins
- provider service updates

Providers may be notified of updates or changes to policies via email or website notices.
We notify providers of news, updates, or changes to our policies via our quarterly provider newsletter, with an email notification when the newsletter is available on the Optima Health website.

Network Bulletin: Policy and protocol updates

Optima Health notifies providers of any planned policy changes 60 days before going into effect. Any pertinent changes to policy and protocols are communicated with an online provider notice posting.

Medical Policy Update Bulletin

Any pertinent changes to medical policies are communicated via email and an online provider notice posting. For more information, providers can go to the following website:
www.optimahealth.com/providers/clinical-reference/clinical-guidelines

Targeted Email Campaigns

Throughout the year, Optima Health may inform providers of efforts focused on patient education, improved health outcomes, or other health plan campaigns via email.

Communications

Health and Preventive Services participates with the Optima Health Physician Advisory Committee to obtain essential feedback about preventive health practices and recommendations for innovations or revisions in existing services to better meet the needs of health plan members.

Health and Preventive Services contributes news and current preventive health initiatives to the Optima Health provider newsletter, and other Optima Health and Sentara publications.

Notice of changes, amendments, and updates to this Provider Manual and any sources that are referenced by and incorporated herein, are communicated to you via the Optima Health website and by email (for providers that have notified Optima Health of their email address) 60 days before the changes become effective. For these reasons, keep us updated of changes to your mailing and email addresses, and make sure to check your emails and the provider web portal often.

Provider Quarterly Webinars

Online educational webinars are held quarterly and allow providers to ask questions, share Optima Health updates, and offer refreshers on how to successfully do business with Optima Health. Providers must register on the Optima Health provider website by the day before each event. The events are announced on the www.optimahealth.com/providers/ education page and in the provider newsletter, along with other educational opportunities.

Provider Trainings

Providers can access required and supplemental trainings at Optimahealth.com on the Providers tab under Provider Support. Model of Care Training is required annually for providers participating in Medicare. Providers are encouraged to take Fraud, Waste, and Abuse, Trauma Informed Care and Cultural Competency trainings at both onboarding and ongoing training.

Optima Health also provides technical assistance to providers including:

1. Supporting the performance of Member needs assessments;
2. In-person and virtual trainings (e.g., billing, credentialing, service authorizations, etc.);
3. Direct one-on-one support/assistance; and,
4. Facilitating sharing of best practices.

Telephone

Medical and Behavioral Health providers may contact Provider Relations by phone. In the event an issue or a dispute under the Provider Agreement cannot be satisfactorily resolved by Provider Relations, providers should contact their assigned Network Educator.

A complete directory of phone and fax numbers for Optima Health departments (including contacts for after hours) may be found online on the provider website under “Contact Us”. A listing is also provided in the “Methods to Reach the Health Plan” section in the front of this Provider Manual.