Optima Health

providerNEWS
Fall 2022

Optima Health News 2

- COVID-19 Coverage Extension Update
- Coverage of COVID-19 Boosters and Novavax Vaccine
- Optima Health to Implement New PBM
- Jiva GoLive Mailbox Transition
- Flu Vaccine Reminder
- New Vision Partner Selected for Routine Eye Exams
- Provider Connection Self-Service Password Reset
- Optima Medicare Advantage and Optima D-SNP Updates
- Optima EAP Improvements – Electronic Claim Submission
- Ensure Your Online Provider Directory Information is Accurate
- New Medicaid Provider Manual Available Soon
- Other Optima Health Updates

DMAS Updates 10

- Immediate Action Needed: Enroll in PRSS Today
- Cardinal Care Information
- Virginia Medicaid Policy Updates – Cardinal Care
- DD Waiver Services and HCBS Rate Updates
- Rate Update for Developmental Disability (DD) Waiver Services
- Reimbursement for a Telemedicine Originating Site Fee
- Updated Coverage of Screening for Lung Cancer with LDCT

Quality Improvement 19

- Annual Wellness Visits: Help Us Close Care Gaps
- Low Acuity, Non-Emergency ER Visits on the Rise
- Use of Imaging Studies for Low Back Pain (LBP)
- Provider Alert: 2022 Healthy Rewards Program
- Newborn Birth Statistics: Remember to Report to Meet DMAS Requirements
- Optima Medicare Star Rating

Authorizations and Medical Policies 30

- Authorization Updates
- Authorization Required for Outpatient Services

Important Phone Numbers 33

- Keep Your Practice Information Up to Date

Any policy changes communicated in this newsletter are considered official and effective immediately unless otherwise indicated, and will be reflected in the next edition of the Optima Health Provider Manual.

We have attempted to identify each policy change by placing a red push pin to the left of the corresponding language.

COVID-19 Coverage Extension Update

Optima Health has updated our robust list of COVID-19 provider frequently asked questions (FAQs). Flexibilities for telehealth services have also been extended until January 11, 2023. We will notify you of any extensions.

In addition, we updated our COVID-19 Vaccine Guidance to add details about boosters and additional doses for the immunocompromised.

Coverage of COVID-19 Boosters and Novavax Vaccine

DMAS fee-for-service and all managed care organizations (MCOs) will cover the following for all full benefit Medicaid and FAMIS members:

- Moderna bivalent COVID-19 vaccines as booster doses for members 18 years of age and older
- Pfizer-BioNTech bivalent COVID-19 vaccines as booster doses for members 12 years of age and older
- Novavax vaccine for members 12 years of age and older

Corresponding COVID-19 vaccines will also be covered for age-appropriate Plan First members until the last day of the first calendar quarter that begins one year after the last day of the federally declared Public Health Emergency (PHE). The Department of Medical Assistance Services (DMAS) will no longer cover monovalent boosters for Moderna and Pfizer-BioNTech vaccines for members 12 years of age and older. Expanded coverage of the Novavax vaccine builds on coverage previously authorized for adults at least 18 years of age via a July 27, 2022 bulletin.

For further information, please visit the Memo/Bulletin Library on the DMAS website and look for the DMAS Medicaid Bulletin.

Optima Health News

Optima Health To Implement New PBM

Effective January 1, 2023, Optima Health will change our pharmacy benefit manager (PBM) from OptumRx® to Express Scripts® for commercial, Medicare, and Medicaid plans.

Here is what you need to know:

- Members should experience a seamless transition; all active pre-authorizations will automatically transfer to the new vendor.
- Prior to January 1, 2023, we will issue new Optima Health member ID cards to members with our pharmacy benefit to reflect the new pharmacy vendor information.
- If applicable, members will receive a notification letter in advance of any formulary or network changes. As always, members should refer to their benefits for information regarding medication tiers and costs.
- We will continue to use Proprium Pharmacy for specialty and tier 4 medications.
- Optima Medicare Providers: Beginning January 1, coverage determinations and appeals and grievances will be managed by Express Scripts. Currently, those functions are managed by OptumRx.

If you have questions, please contact your Network Educator at 1-877-865-9075, option 2.

Jiva GoLive Mailbox Transition

The Jiva GoLive mailbox was disconnected on Saturday, October 1, 2022. Below are the new Internal User Mailboxes. Providers who are receiving errors in their authorization processing should contact Provider Customer Service.

Providers who cannot access the Provider Connection portal or new uers to the system should email PROVIDERCONNECTIONSUPPORT@sentara.com. Jiva resources with a step-by-step guide can be found on the Optima Health website on the Jiva Resources page.

Please note: This is a two-step submission process; if you are trying to attach documents prior to the first submission, it will not work. Providers must put in contact information and then submit to get actions/review.

Flu Vaccine Reminder

The Centers for Disease Control and Prevention (CDC) says people who can avoid the flu will help reduce the burden on the U.S. healthcare system already overwhelmed by COVID-19. Flu vaccines have been updated by the CDC for the 2022-2023 season.

Here are a few things you can do to help:

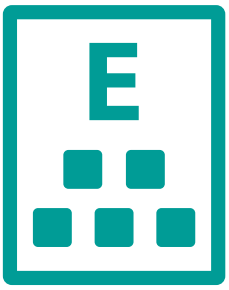
- Share with members the difference between Influenza and COVID-19.
- Remind members they can earn a $10 Healthy Reward if they receive their annual flu vaccine in 2022.
- Talk with members about the importance of receiving the flu vaccination and the health risk related to influenza.

Procedure Codes for Filing Claims:

G2163, G8482, 90630, 90653, 90654, 90655, 90656, 90657, 90658, 90660, 90662, 90672, 90673, 90674, 90682, 90685, 90686, 90687, 90688, 90689, 90694, 90756, Q2034, Q2035, Q2036, Q2037, Q2038, Q2039, G0008

Optima Health News

New Vision Partner Selected for Routine Eye Exams



Optima Health is pleased to announce the selection of VSP® Vision Care to manage routine eye exams and materials benefits for commercial, Medicare, and Medicaid product lines, beginning **January 1, 2023**.

Benefit offerings will remain consistent. We anticipate increased opportunities to close gaps in care through programs designed to remind members with diabetes to get their eye exams, as an example. In addition, simplified plan configuration will allow for easier maintenance and improved accuracy.

Coverage information will be available in the Virginia Medicaid Manual. Log in to eyefinity.com, go to VSP Online and select Manuals, then select Medicaid.

If you have benefit related questions, please contact VSP at providernetworkdevelopment@vsp.com or 1-800-742-6907.

Note: Community Eye Care (CEC), a subsidiary of VSP, will service all Medicare members. For any CEC benefit related questions, contact provider services at 1-888-254-4290.

Provider Connection Self-Service Password Reset Now Available

Providers can now save valuable time by enrolling in the self-service password reset process. Set up is easy and only requires two steps:

1. Set up their security questions to activate password reset capabilities.
2. Wait 24 hours so our systems can synchronize.

That's all there is to it! We have created guides to assist providers through the steps. Important: Providers must login a minimum of once over 90 days to keep their provider portal profile active.

If their account expires, request assistance at Providerconnectionsupport@sentara.com. All Provider Connection registratrants must complete a two-step login for added security.

Optima Health Credentialing Process Updates for Crisis Services – Effective September 1, 2022

The Optima Health Credentialing process for crisis services has been updated as well as the Comprehensive Crisis Services (Appendix G) in the Mental Health Services Manual.

Optima Medicare Advantage and Optima D-SNP Updates

Effective January 1, 2023, Optima Health will be processing any claims received on or after this date of service through our new claims platform.

What this means for our providers:

The new claims system platform will be utilizing Optum Claims Edit System® (CES) to administer reimbursement policy and claim edit rules for professional and institutional claims. Please be aware that claims submitted prior to this date will be processed based on the current editing system and will not be affected by this transition.

CES uses the following sources for its edits:

- National Correct Coding Initiative (NCCI) edits, including Medically Unlikely Edits (MUEs)
- Federal Register (the Daily Journal of the US Government that contains agency rules, proposed rules and public notices)
- Medicare publications
- Local and National Coverage Determinations (LCDs/NCDs)
- Outpatient Code Editor (OCE)
- Medicare Code Editor (MCE)

What do you need to do?

Because many other carriers with whom you work already use Optum's CES, we do not anticipate this transition will disrupt how you work with Optima Health. CES will replace our legacy edits and automatically review and catch errors, omissions and questionable coding. The end result will be streamlined claims, reduced reimbursement errors and improved payment integrity.

The transition to this editing system will enable Optima Health to manage cost effective health care and delivery and reimbursement by identifying potentially incorrect coding relationships on submitted claims.

The benefits to you as the health care provider are as follows:

- Equitable reimbursement
- Efficient reimbursement
- Accurate and consistent claims processing and reimbursement

Electronic Funds Transfer (EFT) and Electronic Remittance Advices (ERA):

All EFT and ERA will be issued through PaySpan. This change will require the provider to create an account, if you do not already have one. For providers that access PaySpan currently, updates will be required.

Optima Health News

Optima Medicare Advantage and Optima D-SNP Updates (continued)

New PaySpan users — How to register:

Providers can contact providersupport@payspan.com or 1-877-331-7154, option 1, for help obtaining registration codes and assistance with navigating the website. Provider Services Specialists are available to assist Monday through Friday from 8 am to 8 pm.

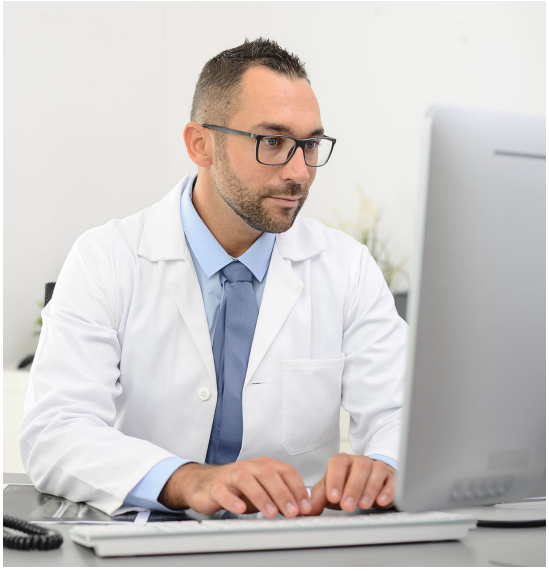
If a provider is not loaded in the new Optima Health claims platform, or receives feedback from PaySpan that they are a new user with no provider entry in PaySpan system, the provider will need to submit a claim to Optima Health and receive a paper check. This check will include registration information for PaySpan.

For current PaySpan users:

If providers already have an account, there will be a single registration code that is tied to the pay to entry. If there are multiple pay to entries in Optima Health claims platforms, providers will have multiple registration codes. To obtain code, providers can contact PaySpan and provide TIN/NPI.

If there are any questions please contact a PaySpan Provider Service Representative at 1-877-331-7154. Please view this video to learn more about PaySpan.

Optima EAP Improvements – Electronic Claim Submission



Optima EAP has recently undergone some changes that will improve the reimbursement process for your services. In the past, claims have been processed via the paper HICFA 1500 Form. We are proud to announce we have fully converted over to electronic claims processing. **Effective December 1, 2022**, we will no longer accept the paper HICFA 1500 forms. Moving forward, you will need to submit your claims through your EMR/EHR/Billing System using the following information:

1. Submit the clients Optima EAP member number. The ID number will always begin with the letter O followed by seven numeric digits and then alpha E * 01. Optima EAP will ensure you have this as a part of the authorization form.
2. The only billable code is 99404 with Modifier HJ. All other billed codes will be denied.

As a part of these changes, we ask that you allow 30 days for claims processing. Also, if you have questions regarding payment status or denials, please contact Optima Behavioral Health Provider Relations at 1-800-229-8822.

Our goal is to make this process as seamless as possible. If you have any questions about the new transition, please feel free to contact Optima EAP at 757-363-6777, and one of our representatives will assist you.

Ensure Your Online Provider Directory Information is Accurate

Optima Health partners with LexisNexis. Unverified provider information cannot be included in our online directory.

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

Here is what you need to do:

1. Respond quickly
2. Register for the Verify Health Care Portal and log in to confirm that all details are correct. If you registered for the portal previously, use your existing credentials to log in.
3. Use one of the following browsers: Mozilla Firefox, Microsoft Edge, or Google Chrome
4. Seek help if needed by contacting LexisNexis Risk Solutions Tech Support at healthcare.custhelp.com/app/ask.

The portal is a secure, free website for our Optima Health provider network to confirm directory information. Thank you for assisting us with this process and for your timely response.

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

New Medicaid Provider Manual Available Soon

A new Medicaid Provider Manual will be released on November 1, 2022. The manual will be effective **January 1, 2023**. Updates include a new Pharmacy Benefit Manager that will be effective January 1, 2023, the PRSS system, Doula and Postpartum benefits, EPSDT, and Provider Trainings. Providers can review the new manual at optimahealth.com.

Optima Health News

Register for Our Upcoming Webinars

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

- Medical Provider Touchpoint: November 2 at 10 am
- Medical Provider Touchpoint: November 9 at 1 pm
- Let's Talk Behavioral Health: November 8 at 10 am
- Claims Brush Up: December 7 at 11 am

Supporting Medicare Members with Chronic Conditions

The Optima Medicare Chronic Special Needs Plan (C-SNP) provides an extra level of support to members with one or more chronic conditions, including diabetes, congestive heart failure, and cardiovascular disease. This plan will be available January 1, 2023, to all people with Medicare who have been diagnosed with the above health conditions.

As part of the enrollment process, Optima Health will need provider verification of the member's diagnosis. If one of your patients applies for C-SNP, we will reach out to your office directly. Following a phone call, we will fax a condition verification form. We ask that you return the signed form via fax within three business days.

We appreciate your efforts to provide the best care for our members. If you have any questions, please contact the CSNP Case Management team at 1-888-204-3381.

New Employer Group – Effective October 1, 2022

Hampton City Schools: Effective October 1, 2022, approximately 2,800 Hampton City Schools employees and covered members will be transitioning from Cigna to Optima Health. Optima Health is administering both the medical and pharmacy program, and Hampton City School members will be covered by Optima POS plans.

AIM Specialty Health Becomes Carelon Specialty Health – Effective March 2023

In March 2023, AIM Specialty Health will change its name to Carelon Specialty Health. At that time, any operational assets that mention AIM Specialty Health, such as determination letters, will begin adopting the new Carelon Specialty Health name. There will be no process changes. Your account management team will remain in place and will be reaching out with additional details.

Southeastrans, Inc. to Become Verida, Inc. Effective January 1

Southeastrans, Inc. is transitioning to Verida, Inc. effective January 1, 2023. Member facing material will not change until January 1, 2023.

Immediate Action Needed: Enroll in PRSS Today

In April 2022, the Virginia Department of Medical Assistance Services (DMAS) launched a new portal to manage provider enrollment — the Provider Services Solution (PRSS). Medicaid providers will use the PRSS portal, located on the Medicaid Enterprise System (MES) website, to complete enrollment and maintenance processes. This platform will be more efficient and make it easier for you to access the information you need as a Medicaid provider. All Medicaid managed care network providers must enroll through PRSS to satisfy and comply with federal requirements in the 21st Century Cures Act. Those network providers that are currently enrolled as FFS in Medicaid do not have to re-enroll in PRSS.

As an Optima Health participating provider, you must take immediate action to initiate enrollment through the new PRSS enrollment wizard. All provider types, including hospitals, nursing facilities, residential treatment facilities, and pharmacies must enroll as soon as possible.

Here is what you need to know:

- To enroll, go to "Enroll as a new provider, or check your enrollment status."
- Only one enrollment application is necessary in PRSS, even if you participate with more than one MCO. The application process allows for selection of one or more MCO plans.
- Once approved, providers will need to create a PRSS portal online account in order to revalidate their enrollment, make changes to personal or business information, and check member eligibility. You may be asked to provide evidence of your submission.
- All new MCO-only providers must first enroll with PRSS prior to requesting credentialing with one or more of the managed care health plans.
- Per the 120-day rule (exceptions for emergency enrollment), MCOs may execute a provider agreement for up to 120 days pending the outcome of the enrollment process. The MCO must terminate a network provider immediately if the 120-day window expires without enrollment and screening of the provider in PRSS.
- You can find helpful training resources on the MES website.

Questions? Contact the PRSS Provider Enrollment Helpline at 804-270-5105 or 1-888-829-5373 or email vamedicaidproviderenrollment@gainwelltechnologies.com.

Cardinal Care Information

Optima Health is following the Department of Medical Assistance Services (DMAS) protocol for the release of Cardinal Care information and has developed a communication plan that will be timely and ongoing throughout the phased-in implementation.

Once we have received DMAS approval, we will proceed with Cardinal Care implementation, which will include appropriate provider education. We will keep you abreast of key implementation milestones through our website and emailed Provider Alerts.

Virginia Medicaid Policy Updates – Cardinal Care

Virginia Medicaid Regulatory Updates to Provider Agreements

The Virginia Department of Medical Assistance Services ("DMAS") has announced a policy change, the consolidation of the Medallion 4.0 and Commonwealth Coordinated Care Plus (CCC Plus) managed care programs into a single program, "Cardinal Care".

Pursuant to the Provider Agreement, if any state or federal laws, regulations or policies change or affect any provisions of the Provider Agreement, the Provider Agreement shall be deemed to be automatically amended to conform with such changes in the laws, regulations or policies effective as of the date on which such laws, regulations or policies become effective.

In order to assist with the transition to Cardinal Care and to clarify the automatic amendment to the Provider Agreement triggered by the announced change in state policy, the following changes shall be effective January 1, 2023:

1. The following terms in the Provider Agreement and related documents shall be deemed automatically updated as follows:
   - "Medicaid Contract" shall mean "a contract entered into between any SHP Affiliate and any state Medicaid agency, such as Virginia Department of Medical Assistance Services ("DMAS") for the provision of Covered Services to Members receiving coverage through any Medicaid program."
   - "Family Access to Medical Insurance Security Program", "FAMIS", "Commonwealth Coordinated Care Plus Program", "CCC Plus", or "Medallion", whether individually or collectively, shall be deemed to refer instead to the defined term "Medicaid Contract".
   - "Optima Family Care", "Optima Health Community Care", "Optima Community Complete" or any other specific Medicaid product offered by Plan, individually or collectively, shall be deemed instead to refer to generally the Medicaid products offered by SHP.
2. All Performance Management Bonus (PMB), Patient Management and Alignment Fees, or other incentive-based payments associated with prior Medicaid programs such as Medallion 4.0 are not part of the Cardinal Care Program and shall cease being paid on December 31, 2022.
3. The Medicaid Addendum attached to and made a part of the Provider Agreement shall be automatically replaced with the updated Medicaid Addendum below

Virginia Medicaid Policy Updates - Cardinal Care (continued)

UPDATED MEDICAID REGULATORY ADDENDUM

Effective January 1, 2023

SHP and Provider, agree to abide by all applicable provisions of any Medicaid Contract. For purposes of this Medicaid Addendum: (a) the term "Medicaid Contract" shall include any Medicaid contract between Optima Health Plan and the Virginia Department of Medical Assistance Services; and (b) the term "Medicaid Member" shall include any Member who is entitled to receive coverage for certain health care services under the terms of any such Medicaid Contract. Sentara Health Plans, Inc. and Optima Health Plan shall be referred to collectively herein as "SHP." Provider compliance with a Medicaid Contract specifically includes, but is not limited to, the following requirements (to the extent applicable to Provider):

1. No terms of this Agreement are valid which terminate legal liability of SHP in any Medicaid Contract.
2. Provider shall meet SHP's standards for licensure, certification, and credentialing as described in the underlying Agreement and/or Provider Manual.
3. Provider agrees to participate in and contribute required data to SHP's quality improvement and other assurance programs as required in the Medicaid Contract.
4. Provider agrees to abide by the terms of the Medicaid Contract for the timely provision of emergency and urgent care. Where applicable, Provider agrees to follow those procedures for handling urgent and emergency care cases stipulated in any required hospital/emergency department Memorandums of Understanding ("Hospital/ Emergency MOUs") signed by SHP in accordance with the Medicaid Contract.
5. Any conflict in the interpretation of SHP's policies and the Agreement shall be resolved in accordance with federal and Virginia laws and regulations, including the State Plan for Medical Assistance Services and DMAS memos, notices and provider manuals. Provider shall comply with federal contracting requirements described in 42 CFR Part 438.3, including identification of/non-payment of provider-preventable conditions, conflict of interest safeguards, inspection and audit of records requirements, physician incentive plans, recordkeeping requirements, etc Changed the term "emergent" to "urgent" throughout the document to broaden the service definitions to increase access to care.
6. Consolidated service limitation lists with the "Non-Reimbursable Activities for all Mental Health Services" in Chapter IV.
7. Provider agrees to submit SHP utilization data in the format specified by SHP, so SHP can meet the DMAS specifications required by the Medicaid Contract.
8. Provider agrees to comply with corrective action plans initiated by SHP.
9. Provider agrees to comply with all non-discrimination requirements in the Medicaid Contract, including, but not limited to, the requirement to provide services to Medicaid Members in the same manner as all non-Medicaid members.
10. Provider agrees to comply with all record retention requirements and, where applicable, the special reporting requirements on sterilizations and hysterectomies stipulated in the Medicaid Contract.

Virginia Medicaid Policy Updates - Cardinal Care (continued)

11. Where applicable, Provider agrees to make every reasonable effort to screen pregnant women (or refer pregnant to an appropriate Participating Provider to screen) for maternal mental health concerns in accordance with the American College of Obstetricians and Gynecologists (ACOG) or American Academy of Pediatrics (AAP) standards. Provider shall follow SHP's referral process to refer to appropriate services including, but not limited to, follow-up screening, monitoring, evaluation, and treatment for pregnant Medicaid Members who screen positive for mental health concerns.
12. Provider agrees to provide representatives of SHP, as well as duly authorized agents or representatives of DMAS, the U.S. Department of Health and Human Services, and the Virginia State Medicaid Fraud Unit access to its premises and its contracts and/or medical records in accordance with the Medicaid Contract. Provider agrees otherwise to preserve the full confidentiality of medical records in accordance with the Medicaid Contract.
13. Provider acknowledges that DMAS reserves the right to audit, formally and/or informally, for compliance with any term(s) of the Medicaid Contract and regulations of the Federal Government and the Commonwealth of Virginia, and for compliance in the implementation of any term(s) of this Agreement. Provider further acknowledges that if DMAS, CMS, or the DHHS Inspector General determine that there is reasonable possibility of fraud or similar risk, each may inspect, evaluate, and audit Provider at any time. Such right to audit will exist through ten (10) years after the final date of the contract period or from the date of completion of any audit, whichever is later.
14. Provider agrees to disclose the required information, at the time of application, credentialing, and/or recredentialing, and/or upon request, in accordance with 42 C.F.R. § 455 Subpart B, as related to ownership and control, business transactions, and criminal conviction for offenses against Medicare, Medicaid, CHIP and/or other federal health care programs. See 42 C.F.R. § 455, Parts 101 through 106 for definitions, percentage calculations, and requirements for disclosure of ownership, business transactions, and information on persons convicted of crimes related to any federal health care programs. Provider shall perform, at a minimum, a monthly comparison of its owners and managing employees against the LEIE database to ensure compliance with these Federal regulations.
15. Provider agrees to the requirements for maintenance and transfer of medical records stipulated in the Medicaid Contract. Provider shall make medical records available, or provide a copy of a Medicaid Member's medical records, to Medicaid Members and their authorized representatives within ten (10) business days of the record request. Provider shall ensure that each Medicaid Member's medical record(s) include(s), as appropriate, the required elements pursuant to 42 C.F.R. §§ 456.111 and 456.211, including but not limited to: beneficiary ID, physician name, admission dates, and dates of application for and authorization of Medicaid benefits if application is made after admission, plan of care as required under 42 C.F.R. §§ 456.80 and 456.180, initial and subsequent continued stay review dates as required by 42 C.F.R. §§ 456.128, 456.133, 456.233, and 456.234 date of operating room (if applicable), justification of emergency admission (if applicable), reasons and plan for continued stay (if Provider believes continued stay is necessary), and other supporting material as necessary and appropriate.
16. Provider agrees to ensure confidentiality of family planning services in accordance with the Medicaid Contract, except to the extent required by law, including, but not limited to, the Virginia Freedom of Information Act.

Virginia Medicaid Policy Updates - Cardinal Care (continued)

17. Provider agrees not to create barriers to access to care by imposing requirements on Medicaid Members that are inconsistent with the provision of Medically Necessary and Medicaid Covered Services.
18. Provider agrees to clearly specify referral approval requirements to its Practice Providers and in any sub-contracts. Additionally, Provider agrees to hold Medicaid Members harmless for charges for any Medicaid Covered Service. This includes those circumstances where Provider fails to obtain necessary referrals, preauthorization, or fails to perform other required administrative functions.
19. Provider agrees not to bill Medicaid Members for Medically Necessary services covered under the Medicaid Contract and provided during a Medicaid Member's period of SHP enrollment. This provision shall continue to be in effect even if SHP becomes insolvent. However, if a Medicaid Member agrees in advance of receiving the service and in writing to pay for a non-Medicaid Covered Service, then Provider can bill such non-Medicaid Covered Service.
20. Provider shall forward to SHP medical records, within ten (10) business days of SHP's request.
21. Provider shall promptly provide or arrange for the provision of all services required under the Agreement. This provision shall continue to be in effect for subcontract periods for which payment has been made even if Provider becomes insolvent until such time as the Medicaid Members are withdrawn from assignment to the Provider.
22. Except in the case of death or illness, Provider agrees to notify SHP at least thirty (30) days in advance of disenrollment and agrees to continue care for his or her panel Medicaid Members for up to thirty (30) day after such notification, until another Participating Provider is chosen or assigned. 22. If Provider is a primary care physician, Provider agrees to act as a PCP for a predetermined number of Medicaid Members, not to exceed the panel size limits set forth in the Medicaid Contract.
23. SHP shall follow prior authorization procedures pursuant to Virginia Code § 38.2-3407.15:2 and incorporate the requirements into its provider contracts. SHP must accept telephonic, facsimile, or electronic submissions of prior 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 Programs' SCRIPT standards for prior authorization requests.
24. Notwithstanding any other provision to the contrary, the obligations of the Commonwealth of Virginia shall be limited to annual appropriations by its governing body for the purposes of the Agreement
25. This Agreement is an agreement for the services of Provider and may not be subcontracted by Provider without prior written approval of SHP.
26. To the extent that any terms or provisions contained in this Exhibit C are inconsistent with or in conflict with the terms and provisions set forth in the Agreement, the terms and provisions set forth in this Exhibit shall control with respect to the subject matter contained herein. All other terms and provisions of the Agreement shall continue to apply.
27. Provider shall have a NPI.

Virginia Medicaid Policy Updates - Cardinal Care (continued)

28. Provider shall comply with all applicable Federal and State laws and regulations including Title VI of the Civil Rights Act of 1964; Title IX of the Education Amendments of 1972 (regarding education programs and activities); the Age Discrimination Act of 1975; the Rehabilitation Act of 1973; the Americans with Disabilities Act of 1990 as amended; Health Insurance Portability and Accountability Act of 1996 (HIPAA) security and privacy standards, section 1557 of the Patient Protection and Affordable Care Act and the Deficit Reduction Act of 2005 (DRA) requiring that emergency services be paid in accordance with the DRA provisions [Pub. L. No. 109-171, Section 6085], and as explained in CMS State Medicaid Director Letter SMDL # 06-010.
29. Unless a longer time period is required by applicable statutes, regulations or the Agreement, Provider shall maintain records, including all medical, financial and administrative records related to Medicaid Covered Services, for the longer of: (a) ten (10) years from the termination of the Agreement; or (b) with regard to minors, at least six (6) years after a minor has reached 21 years of age.
30. Provider shall screen employees and contractors initially and on an ongoing monthly basis to determine whether any such employees or contractors has been excluded from participation in Medicare, Medicaid, SCHIP, any Federal health care programs (as defined in Section 1128B(f) of the Social Security Act), or from certain procurement and non-procurement activities, and not employ or contract with an individual or entity that has been excluded or debarred. Provider further understands that SHP is prohibited from contracting with providers who have been terminated from the Medicaid program by DMAS for fraud, waste, and abuse. Provider shall immediately report to SHP any exclusion information discovered, including its own termination from the Medicaid program for fraud, waste, and abuse. Provider acknowledges that civil monetary penalties may be imposed against any Participating Provider that employs or enters into contracts with excluded individuals or entities to provide items or services to Medicaid Members.
31. As a condition of payment, Provider shall identify to SHP any provider-preventable conditions or health care-acquired conditions that are associated with claims for Medicaid payment or with courses of treatment furnished to Medicaid Members for which Medicaid payment would otherwise be available. Provider further acknowledges that no payment will be made by SHP to Provider for provider-preventable conditions, as identified in the State plan and that under 42 CFR § 434.6(a)12(i), SHP is prohibited from making a payment to Provider for provider-preventable conditions outlined in 42 CFR § 447.26(b). SHP will comply with 42 C.F.R. § 438.3(g) requirements mandating provider identification of provider-preventable conditions as a condition to payment, as well as the prohibition against payment for provider-preventable conditions as set forth in 42 C.F.R. § 434.6(a)(12) and § 447.26. No reduction in payment for a provider-preventable condition shall be imposed on the Provider when the condition defined as a provider-preventable condition or that meets the definition of a health care-acquired condition for a particular Medicaid Member that existed prior to the initiation of treatment for that Medicaid Member by the Provider.

Virginia Medicaid Policy Updates - Cardinal Care (continued)

32. To the extent applicable, Provider shall comply with the CMS Home and Community-Based Services Settings Rule detailed at 42 C.F.R. § 441.301.
33. Provider shall comply with all applicable Affordable Care Act SHP policies and procedures, including but not limited to, reporting overpayments pursuant to state or federal law.
34. Provider shall accept SHP payment as payment in full except for patient pay amounts and shall not bill or balance bill a Medicaid Member for Medicaid Covered Services provided during a Medicaid Member's period of SHP enrollment. The collection or receipt of any money, gift, donation or other consideration from or on behalf of a Medicaid Member for any Medicaid Covered Service provided is expressly prohibited. This includes those circumstances where the Provider fails to obtain necessary referrals, service authorization or fails to perform other required administrative functions. Should an audit by SHP or an authorized state or federal official result in disallowance of amounts previously paid to Provider, Provider will reimburse SHP upon demand and shall not bill the Medicaid Member.
35. SHP shall pay nursing facilities, community Long Term Services and Supports (LTSS) providers, LTSS services when covered under the Early and Periodic Screening, Diagnosis, and Treatment Services (ESPDT) program, Community Mental Health Rehabilitation Services (CMHRS) and Behavioral Therapy, and Addiction and Recovery Treatment Services (ARTS) Participating Providers within fourteen (14) calendar days of receipt of a Clean Claim. Such claims shall be paid at no less than the current Medicaid FFS rate in effect on the date of service. For such services, Provider shall use the DMAS established billing codes. SHP shall pay all other Participating Providers within thirty (30) days of the receipt of a Clean Claim for Medicaid Covered Services rendered to a Medicaid Member.
36. Provider has the right to appeal adverse actions taken by SHP for services that have been rendered. However, Provider shall exhaust SHP's reconsideration process prior to filing an appeal with the DMAS Appeals Division.
37. SHP shall have the right to modify this Exhibit C from time to time, without the consent of Provider, to reflect changes to Medicaid Contracts, applicable law, and/or any requests or requirements of DMAS or any other Medicaid agency.

DD Waiver Services and HCBS Rate Updates—Effective July 1, 2022

As stated in the June 28, 2022 bulletin on "Implementation of new rates from 2022 State Budget Appropriations," the Department of Medical Assistance Services (DMAS) is diligently working on the implementation of new rates set forth in the 2022 Appropriation Act approved by Governor Youngkin on June 22, 2022. The new fiscal year 2023 Fee-for-Service rates have been posted.

Rate Update for Developmental Disability (DD) Waiver Services

In accordance with the 2022 Appropriation Act Item 304.KKKK(2), the Department of Medical Assistance Services (DMAS) will update the Developmental Disability (DD) Waiver services using the most recent data to be consistent with efficiency, economy, quality, and sufficiency of care.

Rate increases shall be made for the following services: Group Homes, Sponsored Residential, Supported Living, Independent Living Supports, In-home Supports, Community Engagement, Community Coaching, Therapeutic Consultation, Private Duty and Skilled Nursing, Group Day Support, Group Supported Employment, Workplace Assistance, Community Guide, and DD Case Management and Benefits Planning. DD Waiver rate updates can be found on the DMAS website under "Developmental Disability Waiver Rates."

Reimbursement for a Telemedicine Originating Site Fee for Emergency Ambulance Transport Providers

The Department of Medical Assistance Services (DMAS) will reimburse an originating site fee for facilitating a telemedicine consultation between a Medicaid member and a Medicaid-enrolled provider for the purposes of identifying whether the Medicaid member is in need of emergency ambulance transportation.

Specifically, emergency ambulance transportation providers may submit a claim for providing a telemedicine "originating site fee" service (CPT Q3014) under the following conditions:

- The Emergency Ambulance Transport provider is licensed as a Virginia Emergency Medical Services (EMS) ambulance provider.
- The Emergency Ambulance Transport provider must be enrolled as such with DMAS.
- The Medicaid member is in a physical location where telemedicine services can be received per requirements set forth in the Telehealth Supplement.
- The member and provider of telemedicine services are not in the same physical location during the consultation.
- The Emergency Ambulance Transport provider assists with initiation of the visit, but the presence of the Emergency Ambulance Transportation provider in the actual visit shall be determined by a balance of clinical need and member preference or desire for confidentiality.

Emergency Ambulance Transport providers should submit a claim for providing an originating site fee service in one of two ways:

1. If the member receives emergency ambulance transportation subsequent to and based on the facilitated telemedicine consultation, submit two claims: one claim for Q3014 on a CMS-1500 and a separate claim for emergency transportation services.
2. If the member does not receive emergency ambulance transportation subsequent to and based on the facilitated telemedicine consultation, submit one claim for Q3014 on a CMS-1500.

For further information, please see the DMAS Bulletin dated September 7, 2022.

Updated Coverage of Screening for Lung Cancer with LDCT

The Department of Medical Assistance Services (DMAS) Fee-For-Service (FFS) and all managed care organizations (MCOs) will cover screening for lung cancer with low-dose computed tomography (LDCT) and associated counseling, consistent with recently revised United States Preventive Services Task Force (USPSTF) recommendations.

Coverage applies to all FFS and MCO FAMIS and full-benefit Medicaid members, for whom the following billing codes will be covered when dates of service are on or after March 9, 2021, and billing requirements are met, as outlined below. See the DMAS fee file (MMIS) from within the MES webpage for FFS rates:

- 71271: Computed tomography, thorax, low dose for lung cancer screening, without contrast material(s)
- G0296: Counseling visit to discuss need for lung cancer screening using LDCT (service is for eligibility determination and shared decision making)

Providers must ensure that Medicaid beneficiaries meet all of the following billing requirements and maintain corresponding documentation when billing the codes listed above:

- 50–80 years of age
- tobacco smoking history of at least 20 pack years
- current smoker, or former smoker who has quit smoking within the last 15 years

Service authorization is not required for either of the billing codes listed above for any FFS or MCO members.

While claims should only be submitted for members meeting the criteria above, they will not be denied based on accompanying diagnosis codes.

For patients still actively smoking, we recommend referring patients to the smoking cessation treatment and counseling services covered for the same population.

Medicaid HHCS Electronic Verification Project Update

The Centers for Medicare and Medicaid Services (CMS) allows states to apply for a one-year Good Faith Extension for the implementation of Electronic Visit Verification (EVV) requirements for Home Health Care Services (HHCS).

The Department of Medical Assistance Services (DMAS) has applied for the Good Faith Extension and is now working toward a July 2023 implementation date for this EVV requirement. DMAS will collaborate with provider representatives and DMAS-contracted vendors to develop and implement a technical specification guide for supporting and transitioning to these requirements.

Quality Improvement

Annual Wellness Visits: Help Close Care Gaps

Optima Health partners with providers like you to improve health every day by making it easy for our members, your patients, to get the care they need when they need it. To close care gaps by December 31, 2022, we need your help to complete annual wellness visits (AWVs) and annual physical exams (APEs). We are encouraging our members to make appointments with your office.

Please make every effort to accommodate these important appointment requests before December 31 to achieve optimal outcomes. For more information, visit optimahealth.com/providers. Here is some important information regarding these visits:

The AWV and APE can be completed in the same visit for Optima Medicare members:

- Optima Medicare permits billing of both the AWV and APE, as a supplemental benefit, in the same visit.
- The Initial Preventive Physical Exam (IPPE, aka "Welcome to Medicare Visit") billing code is G0402.
- The AWV billing codes are G0438, G0439, and G0468.
- The APE billing codes are 99384–99387 and 99394–99397
- Members are eligible for one AWV and one APE each calendar year.
- Members are eligible for a $25 reward for completion of the AWV and an additional $25 reward for the completion of the APE

The AWV and APE are the gateway to building relationships with your patients and improving care.

- Include care gap closure in annual wellness visits and annual physical exams for efficiency.
- Include comprehensive coding of clinical conditions with the claim for better documentation.
- Gaps in care must be closed by the end of the year; start early to avoid the time crunch in Q4.
- Early diagnosis and intervention can minimize costs of care.
- Share this resource with your clinical care teams.

Provide limited secure EMR access and submit your supplemental data early.

- Reviewing, faxing, and/or mailing medical records as part of the annual HEDIS process takes time and effort.
- Granting limited, secure EMR access to our quality staff allows us to directly retrieve relevant HEDIS medical record information.
- Use the HEDIS fax number or secure email to send in medical records:
- 1-844-518-0706 or optima_quality@sentara.com.
- Questions? Please call a member of the HEDIS team at 1-844-620-1015

Low Acuity, Non-Emergency ER Visits on the Rise

In recent months, we have noticed an increase in the number of members with low acuity, non-emergent conditions visiting the emergency room (ER). We are finding that members are being advised to return to the ER multiple times for follow-up after the initial visit rather than being referred for follow-up with their primary care physician (PCP). They are also being asked to wait a certain number of days after being seen in the ER before they can be seen in their PCP's office. Optima Health is educating members on where to go when in need of medical care based on the severity of their condition, wait times, and cost. As a provider, you are a critical resource to helping Optima Health get our message across to members.
Urgent Care vs. Emergency Department: Know Where to Go

24-Hour Nurse Advice Line
Members are encouraged to call the free 24-hour Nurse Advice Line when their physician is not available and they don't know what to do. The Nurse Advice Line is staffed by nurses who can help members understand medical topics and make good decisions about their health.

Physician's Office
Members are directed to their primary care physician's office for routine or preventive care, and to keep track of their medications and overall health. This includes general health issues such as:

- earaches
- headaches
- mild asthma
- skin rashes
- sore throat
- immunizations and screenings
- routine checkups

Urgent Care Center or Virtual Physician Visit
Members are encouraged to schedule a virtual physician visit or obtain services from an urgent care center like Minute Clinic, First Med, Patient First, or Velocity when they experience the following:

- cough/cold/runny nose
- throat pain or sore throat
- ear pain
- pain/burning when urinating
- headache
- nausea/vomiting
- fever less than 104°F
- loose stools/diarrhea
- rash
- back pain
- minor injuries, cuts, burns

Low Acuity, Non-Emergency ER Visits on the Rise (continued)

Emergency Room and Calling 911
Members are directed to the ER when they have a serious or life-threatening medical condition. Members with less serious conditions may face longer wait times. We also understand that member cost-share tends to be higher for services provided in the ER.

Examples of conditions that might require a trip to the ER include:

- bleeding that won't stop or coughing up blood
- confusion
- drug overdoses
- head injury
- seizures or loss of consciousness
- severe chest or abdominal pain
- severe cuts and burns
- severe vomiting or diarrhea
- shortness of breath
- sudden change in vision

These guidelines are intended as general information and are not an all-inclusive list of medical problems that can be treated in these settings

Use of Imaging Studies for Low Back Pain (LBP)

This HEDIS Measure reports on how many patients aged 18–75 have not had an imaging study within 28 days of a primary diagnosis of low back pain.

Imaging includes MRI, CT, Lumbosacral Comp, and X-ray.

The following are clinically-indicated reasons for imaging fewer than 28 days from diagnosis of low back pain:

- Lumbar Surgery
- Fragility Fracture
- Cancer
- IV Drug Use
- HIV
- Spondylopathy
- Neurologic Impairment
- In hospice or using hospice services anytime during the year
- Osteoporosis
- Palliative care/Advanced illness frailty
- Prolonged Use of Corticosteroids
- Spinal Infection
- Recent Trauma
- Major Organ Transplant

New or Changed Measures Added by NCQA for MY2023:

Medicaid Only – first year measure

- Topical Fluoride for Children (TFC)
- Oral Evaluation, Dental Services (OED)

Medicare Only – first year measure

- Deprescribing of Benzodiazepines in Older Adults (DBO)
- Emergency Department Visits for Hypoglycemia in Older Adults with Diabetes (EDH)

Measures Newly Specified for Electronic Clinical Data Systems (ECDS) Reporting

- Cervical Cancer Screening (CCS-E)
- Social Need Screening and Intervention (SNS-E)

Revised Measures (MY 2022)

Comprehensive Diabetes Care (CDC) has been revised into three standalone measures:

- Blood Pressure Control for Patients with Diabetes (BPD) examines members 18–75 years of age with diabetes (Type 1 and 2) whose blood pressure (BP) was controlled (<140/90 mm Hg) during the measurement year.
- Hemoglobin A1c Control for Patients with Diabetes (HBD) examines members 18–75 years of age with Diabetes (Type 1 and 2) whose Hb A1c was at the following levels during the measurement year:
  - HbA1c control (<8.0%)
  - HbA1c poor control (>9.0%)
- Eye Exam for Patients with Diabetes (EED) examines members 18–75 years of age with diabetes (Type 1 and 2) who had a retinal eye exam

Quality Improvement

Provider Alert: 2022 Healthy Rewards Program

Optima Medicare offers members the opportunity to earn rewards for healthy behaviors. Members can complete the following preventive screenings, exams, or vaccinations in 2022 to earn a reward.

Activity	Reward	Who is Eligible?
Annual Flu Vaccine	$10	All members
Annual Wellness Visit	$25	All members
Annual Physical Exam	$25	All members
Breast Cancer Screening (mammogram)	$25	All members
Colorectal Cancer Screening	$25	All members
Diabetic Eye Exam	$10	Members with diabetes
Diabetic HbA1c Testing	$10	Members with diabetes
Diabetic Kidney Function Testing	$10	Members with diabetes

*Rewards cannot be used to buy tobacco or alcohol. Rewards cannot be converted to cash. Members can only receive one reward per applicable service per year. Rewards take 8–10 weeks to process following the receipt of the claim. Services must be completed in 2022 using in-network providers.

Newborn Birth Statistics: Remember to Report to Meet DMAS Requirements

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

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

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

Baby stats are required by the Department of Medical Assistance Services (DMAS) and are needed for HEDIS measures. Please include baby stats with the original claim submission to avoid denied claims and other delays.

Optima Medicare Star Rating

Our overall corporate goal is to make Optima Medicare a five-star health plan, which will require the support of all clinical and administrative staff as well as the full engagement of our members. Optima Medicare's star rating last year was four stars, and we hope to maintain that rating once the Centers for Medicare & Medicaid Services (CMS) releases the current year's performance this fall. Star ratings are critical in attracting new members and receiving additional funding that allows us to provide top benefits and quality healthcare.

For the final months of 2022, we are prioritizing quality gap closures and Annual Wellness Visit (AWV) completions for our members. The AWV completion is critical for health discussions, advanced care planning, and care gap closure. Health plan members are receiving notification of open gaps that need to be closed by December 31, 2022. Please prioritize wellness appointment requests to ensure they receive the needed preventive care so that gaps can be closed.

Medicare Stars Fall Priorities
We held Fall Health Fairs in the Norfolk and Richmond areas in October 2022 to assist members in gap closure and provide on-site health screenings as well as a variety of information on healthy lifestyles and living with chronic disease. Be on the lookout for more information in the coming weeks and remind members of this important event.

Additionally, we have targeted four quality measures that are heavily weighted in our health plan star ratings. We have established workgroups for developing campaigns to assist in completion by December 31, 2022. As you complete visits, please ensure the following measures are addressed and coded (when applicable)

Breast Cancer Screening	
Measure: The percentage of women 50–74 years of age who had a mammogram to screen for breast cancer. Key Points: • All types and methods of mammograms (screening, diagnostic, film, digital, or digital breast tomosynthesis) qualify for numerator compliance. • Must be performed any time on or between October 1 two years prior to the measurement year and December 31 of the measurement year	Documentation Requirements: • Bilateral mastectomy any time during the member's history through December 31 of the measurement year can be used as an exclusion • Exclusions: Hospice or palliative care CPT Codes for Filing Claims: • CPT Codes: 77061-77063, 77065-77067 · HCPCS: G0202, G0204, G0206

Optima Medicare Star Rating (continued)

Colorectal Cancer Screening	
Measure: The percentage of members 50–75 years of age who had appropriate screening for colorectal cancer. Key Points: The following screening methods meet criteria: • Fecal occult blood test (iFOBT or gFOBT) annually (measurement year) • FIT-DNA (e.g., Cologuard) test in the past 3 years (measurement year and 2 years prior) • Flexible sigmoidoscopy in past 5 years (measurement year and 4 years prior) • CT colonography (e.g., virtual colonoscopy) in the past 5 years (measurement year and 4 years prior) • Colonoscopy in past 10 years (measurement year and 9 years prior)	Documentation Requirements: Documentation in the medical record must include a note indicating the date when the colorectal cancer screening was performed. A pathology report that indicates the type of screening (e.g., colonoscopy, flexible sigmoidoscopy) and the date when the screening was performed meets criteria. Exclusions: History of colorectal cancer or total colectomy CPT Codes for Filing Claims: • CPT/HCPCS Codes: 82270, 82274 • FIT-DNA Test Recommended Codes: CPT: 81528 • Flexible Sigmoidoscopy Recommended Codes: CPT: 45330-45335, 45337-45342, 45346-45347, 45349-45350 • CT Colonography Recommended Codes: • CPT: 74261-74263 • Colonoscopy Recommended Codes: • CPT: 44388-44394, 4397, 44401-44408, 45355, 45378-45393, 45398

Optima Medicare Star Rating (continued)

Controlling Blood Pressure	
Measure: The percentage of patients 50–74 years of age with a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90) during the measurement year. Key Points: • Be sure to record the BP in the medical record. • Do not round up or down when recording the BP. If the initial BP was elevated, take it a second time after a few minutes rest. • Be aware that the new guidelines allow self reported blood pressures to be documented in the EMR during telehealth visits if the blood pressure was taken with a digital machine in the home. • Patients of Optima Medicare have an OTC benefit allowance they can utilize to purchase a digital/remote blood pressure cuff. • Encourage patients to get a BP cuff that takes readings higher on the arm for better accuracy; wrist cuffs are not recommended. • Consider communicating to patients the positive effects of monitoring blood pressure frequently. • Utilize digital/remote blood pressure cuffs during telehealth visits to help capture data for this measure.	Documentation Requirements: • If a BP is listed on a vital flow sheet, it must have date of service listed as well. • If your office uses manual blood pressure cuffs, do not round up the BP reading. • Patient self-reported BP should be documented during the telehealth visit with a note saying the blood pressure was obtained with a digital cuff in the home. • The use of CPT Category II codes helps Optima Medicare identify clinical outcomes such as diastolic and systolic readings. It can also reduce the need for some chart review. Please note, CPT II codes are for reporting purposes only and are not separately reimbursable. If you receive a claim denial, your reporting code will still be included in the quality measure. Exclusions: Diagnostic screenings are not included in the measure. Must be filed with a claim. CPT Codes for Filing Claims: · 3077F: BP >= 140 · 3074F: Systolic < 140 · 3080F: Diastolic >=90 · 3079F: Diastolic 80-90 · 3078F: Diastolic < 80 · Remote Blood Pressure Monitoring: 93784, 93788, 93790, 99091, 99453, 99454, 99457,99473, 99474

Optima Medicare Star Rating (continued)

Diabetes Care - Blood Sugar Controlled

Measure:

The percentage of adults with diabetes (Type 1 and Type 2) whose most recent HbA1c level is less than 9%, or who were not tested during the measurement year

Key Points:

- Request to see patients with known diabetes in quarter 1 of the calendar year to allow for early intervention
- If an A1c >/= 8 is discovered, be sure to follow up and engage with patients for active diabetes management
- Frequency of visits depends on level of A1c control:
  - 1x every year for prediabetes
  - 2x a year if member does not use insulin and blood sugar level is within target range
  - 4x a year if member is taking insulin or has trouble keeping blood sugar level within target range

Benefits of Self-Monitoring at Home:

- Creates positive choices surrounding diet, exercise, and daily treatment goals
- Allows the patient to take charge and meet their A1c targets based on their treatment plan
- *Optima Medicare offers a $10 incentive for members who have diabetes and complete an A1c test (one reward per year)

Documentation Requirements:

- Need date and most recent result during measurement year in chart—use reported value and not threshold for result ·
- The last HbA1c of the year counts toward the measure score (*early intervention and A1c rechecks are key)
- Exclusions: Patients with ESRD, on dialysis, or receiving hospice or palliative care are exempt from this measure
- CPT Codes for Filing Claims:
  - CPT: 83036, 83037 (HbA1c >9%) CPT-CAT-II: 3046F (HbA1c >/= 7% & <8%) CPT-CAT-II: 3051F (HbA1c >/= 8% & <9%) CPT-CAT-II: 3052F (HbA1c <7%) CPT-CAT-II: 3044F

Optima Medicare Star Rating (continued)

Diabetes Care - Eye Exam	

Measure:
 	
The measure evaluates adults with diabetes (Type 1 and Type 2) who had a retinal or dilated eye exam or bilateral eye enucleation performed during the measurement year by an optometrist or ophthalmologist
 	
Key Points
 	
• Exam must be read by an optometrist or ophthalmologist
• At a minimum, documentation in the medical record must include one of the following:
  • A note or letter prepared by an ophthalmologist, optometrist, PCP or other healthcare professional indicating that an ophthalmoscopic exam was completed by an eye care professional (optometrist or ophthalmologist), the date when the procedure was performed and the results.
  • A chart or photograph indicating the date when the fundus photography was performed and one of the following:
  • Evidence that an eye care professional (optometrist or ophthalmologist) reviewed the results.
  • Evidence results were read by a qualified reading center that operates under the direction of a medical director who is a retinal specialist.
• Evidence results were read by a system that provides an artificial intelligence (AI interpretation.
	Documentation Requirements:
	
	• If the patient had a negative retinal or dilated eye exam (negative for retinopathy) by an eye care professional in the year prior to the measurement year, they are not required to receive one in the current year.
	• Notation limited to a statement that indicates “diabetes without complications” does not meet criteria.
	
	Exclusions: Patients with ESRD, on dialysis, or receiving hospice or palliative care are exempt from this measure
	
	• CPT Codes for Filing Claims: · 67028, 67030, 67031, 67036, 67039-67043, 67101, 67105, 67107, 67108, 67110, 67113, 67121, 67141, 67145, 67208, 67210, 67218, 67220, 67221, 67227, 67228, 92002, 92004, 92012, 92014, 92018, 92019, 92134, 92201, 92202,92225-92228, 92230, 92235, 92240, 92250, 92260, 99203-99205, 99213-99215, 99242-99245
	• With evidence of retinopathy CPT-CAT II: 2022F, 2024F, 2026F
	• Without evidence of retinopathy CPT-CAT II: 2023F, 2025F, 2033F
	• Diabetic Retinal Screening Negative in the Prior Year 3072F

Optima Medicare Star Rating (continued)

Diabetes Care- Kidney Health Evaluation for Adults with Diabetes	

Measure:
 	
The percentage of members 50–75 years of age he measure evaluates adults with diabetes (Type 1 and Type 2) who have received an annual kidney health evaluation defined by an estimated glomerular filtration rate (eGFR) and a urine albumin-creatinine ratio (uACR), during the measurement year.
 	
Key Points
 	
• Replaced the medical attention for nephropathy measure
 	
Best Practices:
 	
• Consider prescribing ACE/ARB inhibitors for diabetic patients as appropriate
• Use the appropriate CPT II code to report patient is on treatment for nephropathy
• For point-of-care nephropathy testing, document the date of the in-office test with the result
• Submit the CPT code for test performed and CPT II codes to report nephropathy result value
	Documentation Requirements:
	
	• Patients who had a quantitative urine albumin test and a urine creatinine test within four days during the measure year meet the criteria *The above tests must have service dates documented within four days or less apart from each other
	• Exclusions: Patients with ESRD, on dialysis, or receiving hospice or palliative care are exempt from this measure
	
	CPT Codes for Filing Claims:
	
	• Estimated glomerular filtration rate (eGFR):
	• 80047 – Basic metabolic panel (Calcium, ionized)
	• 80048 – Basic metabolic panel (Calcium, total)
	• 80050 – General health panel 80053 – Comprehensive metabolic panel
	• 80069 – Renal function panel
	• 82565 – Blood creatinine level
	• Urine albumin-creatinine ratio (uACR):
	  • 82043 – Urine microalbumin
	  • 82570 – Urine creatinine

Authorization Updates

Optima Health would like to notify you of the following authorization updates made since the last version of *providerNews*:

Policy	Determination/Coverage
BH 03 Autism Spectrum Disorders Treatment Plan	Archived: Use Milliman for Commercial and DMAS manual for Medicaid
BH 05 Targeted Case Management	Archived
DME 20 Foot Orthotics, Diabetic Shoes, and Brace	Updated Policy: Created 2 new policies: Diabetic Shoes and Foot Orthotics. Added additional criteria for diabetic shoes—must have diabetes AND a foot condition.
DME 35 Traction Devices and DME 41 Standing Frames and Gravity Assist Traction Devices	Updated Policy: Remove gravity-assisted devices from DME 41 and place in DME 35 while removing coverage for Medicaid and Commercial plans (Medicare is already not covered)
DME 57 Weight Scales	Archived Policy: Pay upon request
DME 60 Home Phototherapy, Ultraviolet Light Therapy for Vitiligo	New Policy: Home Phototherapy, Ultraviolet Light Therapy for Vitiligo considered Not Medically Necessary
DME 60 Ultraviolet Light Therapy System for Home Use	Updated Policy: Changed title, coverage added for all LOBs
DME 61 Non-surgical Eyelid Weights	New Policy: Non-surgical Eyelid Weights considered Not Medically Necessary
Imaging 15 Three-dimensional (3D) Rendering of Imaging Studies	Archived Policy: Pay upon request
Imaging 48 Magnetic Resonance Perfusion	Archived Policy: Pay upon request
Medical 02 Bone Scaffolding	Updated Codes in Policy: Require pre-authorization for codes that previously paid upon request: 20930, 20931, 20932, 20933, 20934, 20936, 20937, 20938. For code 20939 changing from paid upon request to not covered.
Medical 20 Polysomnogram	Updated Policy: Adding coverage for Medicare using the LCD criteria. Medicare used to pay upon request.
Medical 34A Immunoscore Colon Test	Updated Policy: Immunoscore Colon Test considered Not Medically Necessary
Medical 34A and Medical 34C Bone Marrow Failure Syndrome	Updated Policy: Bone Marrow Failure Syndrome considered Not Medically Necessary
Medical 34A Oncomap™ ExTra	Updated Policy: Oncomap™ ExTra considered Not Medically Necessary
Medical 34C McKusick-Kaufman Syndrome Single Gene Test	Updated Policy: McKusick-Kaufman Syndrome Single Gene Test considered Not Medically Necessary

Authorizations and Medical Policies

Policy	Determination/Coverage
Medical 99 Transplant Rejection Testing	Updated Policy: Allosure CareDx for lung transplant rejection testing, Molecular Microscope® Diagnostic System for Kidney (MMDx® Kidney), myTAIHEART, and Heart Molecular Microscope Diagnostic System (MMDx-Heart) considered Not Medically Necessary
Medical 177 Miscellaneous Wound Management Therapies	Updated Policy: MolecuLight procedure considered Not Medically Necessary
Medical 178 Colonic Lavage Therapy	New Policy: Colonic Lavage Therapy considered Not Medically Necessary
Medical 179 Electric cell-Signaling energy waves (EcST and ESI)	New Policy: Electric cell-Signaling energy waves (EcST and ESI) considered Not Medically Necessary
Medical 206 Intraoperative Radiation Treatment	Archived Policy: Pay upon request
Medical 300 Fecal Incontinence Treatments	Updated Policy: Remove coverage for Optima Medicare for reusable Manual Pump Operated Enema Systems
Medical 334 Non-invasive Assessment of the Vasculature for Cardiovascular Risk	New Policy: Carotid intima-media thickness, Peripheral arterial tonometry (PAT) (e.g., the Endo-PAT2000 device), CardioVision MS2000, CVProfilor, and HDI PulseWave devices and the QuantaFlo System considered Not Medically Necessary
Obstetrics 13 Doula Services	New Policy: Coverage for Medicaid only beyond initial 9 allowable visits
Surgical 10 Reconstruction Breast Surgery-Areola Tattoo	Updated Policy: Nerve reimplantation or nerve repair in conjunction with reconstructive breast surgery considered Not Medically Necessary
Surgical 11 Breast Reduction	Archived: Created one policy for all breast surgery policies
Surgical 18 Surgical Treatments for Obstructive Sleep Apnea	Updated Policy: Change age requirement for DISE and Hypoglossal Nerve Stimulation from age 18 and older to age 22 and older
Surgical 29 Breast Implants Removal Replacement	Archived: Created one policy for all breast surgery policies
Surgical 37 Prophylactic Mastectomy	Archived: Created one policy for all breast surgery policies
Surgical 60 Ophthalmic Procedures	Updated Policy: Trabeculotomy by Laser considered Not Medically Necessary
Surgical 118 Lumbar Fusion	New Policy: Added coverage for procedures that used to pay upon request for all Lines of Business
Surgical 119 Facet Joint Procedures	Updated Policy: Posterior Vertebral Joint Replacement considered Not Medically Necessary
Surgical 129 Vestibular Implant	New Policy: Vestibular Implant considered Not Medically Necessary
Surgical 132 Percutaneous Transluminal Coronary Lithotripsy	New Policy: Percutaneous Transluminal Coronary Lithotripsy considered Not Medically Necessary

Policy	Determination/Coverage
Surgical 133 Transvenous Implantable Cardioverter Defibrillator	New Policy: Adding coverage criteria for codes that used to pay upon request for all LOBs
Surgical 134 Transvenous Phrenic Nerve Stimulation for Central Sleep Apnea	New Policy: Transvenous Phrenic Nerve Stimulation for Central Sleep Apnea considered Not Medically Necessary
Surgical 135 Knee Arthroscopy	Updated Policy: Add coverage criteria for all LOBs. Codes used to pay upon request.
Surgical 205 Gastrointestinal Procedures	Updated Policy: remove coverage of Angelchik Anti-reflux Prosthesis for Medicare Plans (currently not covered for Medicaid and Commercial plans)
Surgical 205 Gastrointestinal Procedures	Updated Policy: Gastric Peroral Endoscopic Myotomy (G-POEM), Zenker Peroral Endoscopic Myotomy (Z-POEM), and Diverticular Peroral Endoscopic Myotomy (D-POEM) considered Not Medically Necessary
Surgical 217 Open Treatment of Rib Fracture with Internal Fixation	Updated Policy: adding coverage criteria for all LOBs for codes that previously paid upon request: 21812 and 21813
Surgical 228 Recombinant Platelet-Derived Growth Factor	Archived policy: Use Milliman and removing coverage criteria for pressure ulcers
Surgical 231 Percutaneous Spinal Augmentation	Updated Policy: Adding coverage criteria for Medicaid for percutaneous sacroplasty which used to pay upon request
New code 0327U	No policy: Pay upon request

Authorization Required for Outpatient Services

Effective January 1, 2023, Optima Health will be requiring an authorization for outpatient physical therapy (PT), occupational therapy (OT), and speech therapy (ST) for MAPD and DSNP members.

Our providers may utilize 15 visits before authorization is required and may request authorization from Optima Health for PT/OT/ST services for additional visits by fax, phone, or provider portal. To ensure continuation of these services, please submit your request for additional services before the first 15 visits to ensure no disruption in access to these services.

Important Phone Numbers

Provider Relations	757-552-7474 or 1-800-229-8822 OHCC: 1-844-512-3172
Provider Relations Fax	757-961-0565
Behavioral Health Provider Relations	757-552-7174 or 1-800-648-8420
Medical Care Management (Pre-Authorization)	Commercial and individual products: 757-552-7540 or 1-800-229-5522 OHCC, OFC, Medicare HMO and OCC:1-888-946-1167
Network Educators	757-552-7085 or 1-877-865-9075, option 2
Health and Preventive Services	757-687-6000
Proprium Pharmacy	1-855-553-3568
Proprium Pharmacy Fax	1-844-272-1501

Keep Your Practice Information Up to Date

Please notify Optima Health of any changes to provider or practice information within 60 days, or as soon as possible, especially changes to:

- provider rosters
- panel status
- address/phone numbers
- practice email address for official communication from Optima Health

Medical providers should now update their information electronically using our Provider Update Form. Please notify the appropriate individuals in your practice of this information.

Thank you for your partnership in providing accurate information to our members!