Optima Health

providerNEWS
Summer 2022

Optima Health News 2

- COVID-19 Coverage Extension Update
- Jiva Update: Clarifying Process for Authorization Verifications and Self-Service
- Zelis Claims Review Implemented
- Inova Is Joining Our Network
- Dario Partnership Supports Members With Diabetes
- Partners in Pregnancy Referral Program
- Avalon Genetic Testing Implementation Delayed to 2023
- Ensure Your Online Provider Directory Information Is Updated
- New Sleep Testing Services Program: Launch Date Postponed

Provider Resources 7

- Understanding Requirements for PCP Panel Size
- Learn More About Required Trainings

DMAS Updates 8

- Learn More and Register for PRSS
- Updates to Mental Health Services Manual
- One-Time COVID-19 Support Payment for Aides
- Medicaid LTSS in Nursing Facilities, Screening After COVID-19

Authorizations and Medical Policies 12

- Announcing a New Process for Continued Stay Requests

Quality Improvement 13

- Raising Awareness About the Importance of Immunizations
- CAHPS Results Point to Importance of Effective Communication
- Transitions of Care: Effectiveness of Care HEDIS Measure

Important Phone Numbers 16

- 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 **October 31, 2022**. 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.

Jiva Update: Clarifying Process for Authorization Verifications and Self-Service

Recently, our behavioral health utilization management, medical utilization management, care management, and customer service representatives have received an increased number of calls to verify the status of authorizations. We know your time is valuable and want to clarify any confusion regarding faxed authorizations from our new system, Jiva.

Here is what you need to know:

- Prior to our Jiva implementation, providers received all authorizations via auto-fax at the same time each day.
- With the implementation of Jiva, providers will receive a fax as soon as the determination is made for the request for authorization. This helps achieve our goal to provide you with real-time information.
- Faxes will look different because they are coming through Jiva rather than our previous system.
- We encourage all providers to use the Jiva Portal to submit their requests. If you do not have access to the Jiva Portal, complete the Provider Connection registration form to get started. If you need assistance, please call the customer service lines listed in the table below.
- If you submit your authorization request via fax, you can verify the authorization in Provider Connection. If you use the Jiva Portal to submit your request, you should use the Jiva Portal to verify your authorization requests. For rapid and convenient service, we encourage you to use our portal before contacting provider customer service to check your authorization status.
- If your attempts to locate your authorization in either portal are not successful, please call provider customer service for assistance using the numbers listed below.
- For more information about Jiva, please refer to the resources on our website, including a tip sheet on requesting authorizations and a tutorial. You can also contact the following:

Medical Provider Customer Service

- 757-552-7474 or 1-800-229-8822
- Monday through Friday, 8 a.m.–5 p.m.,
- ProviderRelations@sentara.com

Behavioral Health Provider Customer Service

- 757-552-7174 or 1-800-648-8420
- Monday through Friday, 8 a.m.–7 p.m.
- ProviderRelations@sentara.com

Optima Health News

Zelis Claims Review Implemented

On March 2, 2022, we announced our partnership with Zelis to provide claims editing services. These services were originally planned to start on May 9, 2022, but were postponed and implemented on Monday, August 15 with our commercial and Medicare products. We will implement this program for our Medicaid products on October 1, 2022.

This partnership demonstrates our commitment to providing expedient and accurate claims processing that is consistent with clinically recognized industry standards set by the Centers for Medicare & Medicaid Services (CMS), the American Medical Association, etc.

As a reminder, Zelis will provide services including (but not limited to) the following:

- ICD-10 alignment with CPT/HCPCS coding accuracy
- clinical chart review
- laboratory coding
- coding and modifiers

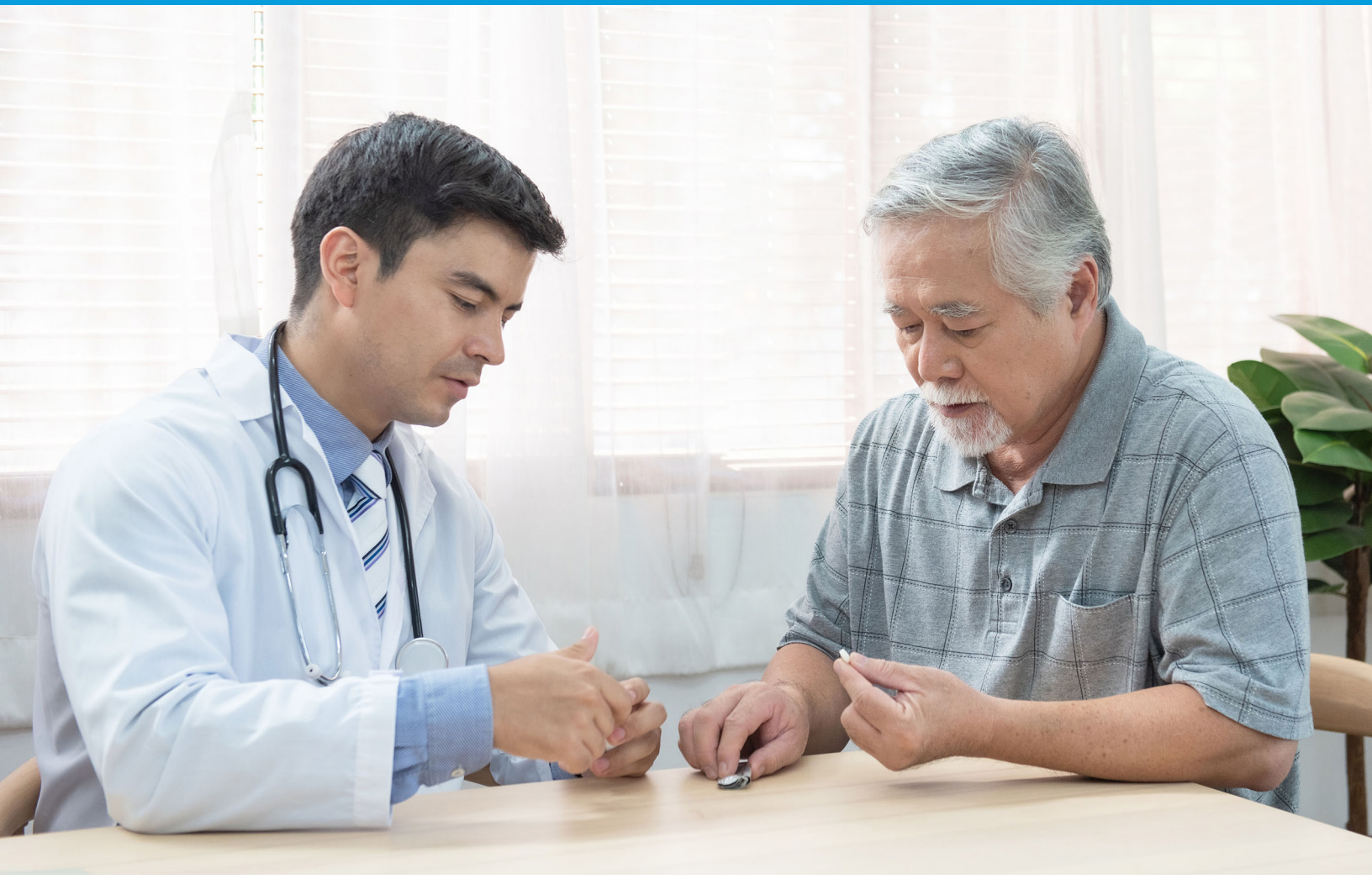
Zelis is considered a "business associate" of Optima Health, as defined by HIPAA. You may disclose protected health information (PHI) to Zelis without prior written participant authorization or consent. Zelis will perform periodic reviews of medical records to ascertain and/or verify charges billed to Optima Health.

Inova is Joining Our Network

We are pleased to announce that, effective September 1, 2022, Optima Health includes all Inova® Health System hospitals, facilities, physician practices, and providers as in-network for our commercial group and Individual & Family Plan members. Inova, along with our existing hospitals and providers including UVA Prince William and Haymarket Medical Centers; Sentara Northern Virginia and RMH Medical Centers; Virginia, Spotsylvania, and HCA Reston and Stonesprings Hospital Centers; Fauquier Health; and Mary Washington and Stafford Hospitals, will bring comprehensive in-network coverage in Northern Virginia for this population of our membership.

As a result, Optima Health is expanding its commercial group and individual plan offerings into Northern Virginia for 2023. Northern Virginians already have access to our Medicare and Medicaid health plans and will now also be able to enroll with Optima Health through their employers or the Individual Marketplace.

With Inova added to the network, members will have total coverage throughout the Commonwealth of Virginia.



Dario Partnership Supports Members With Diabetes

Optima Health is pleased to announce a new partnership to offer additional support to members with type 2 diabetes. DarioHealth helps people with chronic conditions, such as diabetes, to manage their health. This program provides a comprehensive digital solution for diabetes via a smartphone app. Participants receive personalized member experiences that drive behavioral changes to improve health through evidence-based interventions, specialized coaching, and more.

In the coming weeks, Optima Health will reach out to members who qualify for this program. As a provider, you do not need to take any action. This program will complement the care our members already receive and may contribute to improvements in health outcomes. See details below to learn more.

Is there a cost to Dario?

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

Dario Partnership Supports Members With Diabetes (continued)

How do members find out about Dario?

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

What members are eligible to participate in Dario?

Optima Health Medicaid and D-SNP members who meet the criteria, are eligible.

How do members qualify for Dario?

Members qualify if they:

- are covered by an Optima Health Medicaid or D-SNP plan
- are at least 18 years of age
- have been diagnosed with type 2 diabetes
- own a smartphone to use the app

Members may not qualify if they are pregnant or have:

- liver failure
- end-stage renal disease
- had an organ transplant or bone marrow transplant
- cystic fibrosis
- other exclusionary conditions

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

Partners in Pregnancy Referral Form

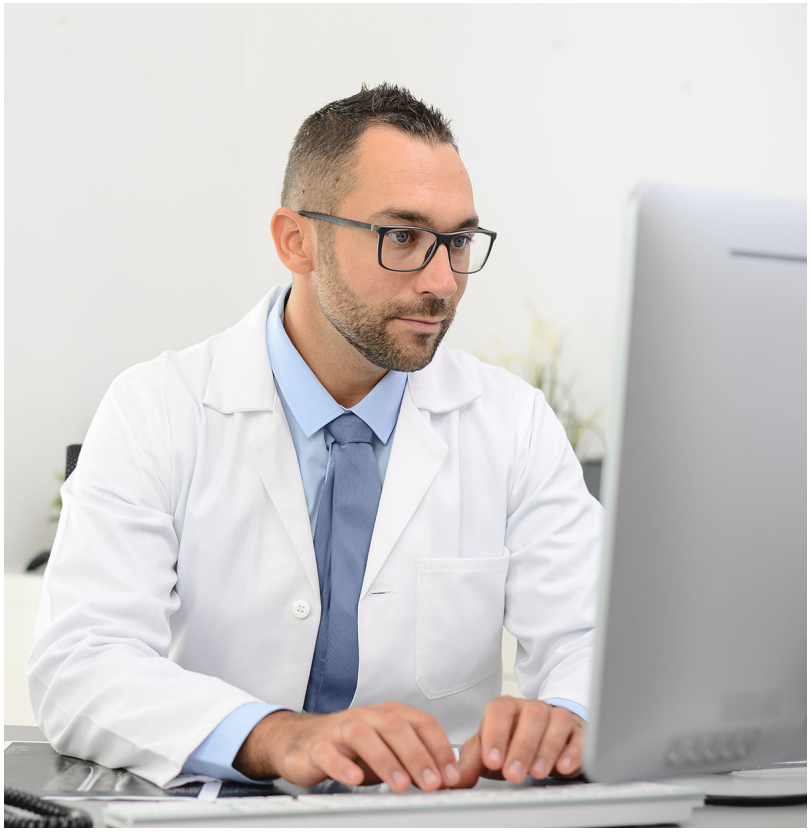
To assist in identifying pregnant members, Optima Health has added a Partners in Pregnancy Case Management Referral Form to the website.

You may print the form and fax it to 757-352-2694 or 1-833-666-0706. For added convenience, simply enter the required fields and hit submit. Your submission will be sent to the Partners in Pregnancy team, who will promptly reach out to the member to assess any case management needs further.

Avalon Genetic Testing Implementation Delayed to 2023

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

Ensure Your Online Provider Directory Information Is Accurate



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

This is a friendly reminder that LexisNexis will contact you quarterly 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. Their next outreach will start on September 26.

Here is what you need to do:

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

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 DMAS.

New Sleep Testing Services Program: Launch Date Postponed

Our new sleep diagnostic testing partnership with CareCentrix,® previously announced for implementation on October 1, has been postponed.

We will notify you once a new date has been set. For now, all contracted providers can provide home sleep tests for Optima Health members.

Provider Resources

Understanding Requirements for PCP Panel Size

As a reminder, primary care providers (PCPs) may have up to 1,500 Medicaid members paneled to them. Once this number is reached, PCPs may opt to utilize a mid-level practitioner to support additional members.

If no mid-level practitioner is available at your practice, providers will need to close their panel once 1,500 members have been assigned. New members cannot be added to closed panels. Please submit panel change requests using the electronic Provider Update Form. If you have any questions, please contact your Network Educator at 1-877-865-9075, option 2.

Learn More about Required Trainings

Ongoing training and education are essential to doing business with Optima Health. We offer a short list of required trainings, including the Optima Community Complete (D-SNP) Model of Care and Fraud Waste and Abuse. Each must be completed annually; **we suggest meeting this requirement every January**. Cultural Competency and Trauma-Informed Care modules only need to be completed once. These trainings are located on the provider website under the Provider Education heading. **To ensure your practice is credited with completing the trainings, please include the full provider TIN in the first name field and your practice name in the last name field.**

The most critical resource to help you understand our policies and procedures is the Optima Health Provider Manual. To help you navigate our health plan effectively, we provide a robust library of supplemental resources such as our Provider Orientation materials and Provider Toolkit, to name only a few. These provider resources and more can be found on our Provider Support page. We encourage you to visit optimahealth.com/providers to familiarize yourself with this platform, and we always welcome your feedback.

Finally, our provider partners can remain informed of important updates throughout the year by joining our live Quarterly Provider Webinars through which you can ask questions; Provider Alerts, which are sent by email as needed; and, of course, this quarterly newsletter.

Learn More and Register for PRSS

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, located here: https://virginia.hppcloud.com/. All provider types, including hospitals, nursing facilities, residential treatment facilities, and pharmacies must enroll as soon as possible.

Learn More and Register for PRSS (continued)

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.

Provider Education and Training Courses

DMAS offers a variety of prerecorded training opportunities to help providers to receive the maximum benefits from the PRSS portal. Please visit the MES website for a comprehensive listing of current courses.

We encourage you to take advantage of these recommended recorded training:

- **PRSS-111 Provider Enrollment Application:** This training course explains the provider enrollment process, identifies the different enrollment types and offers guidance on the documentation that providers need to prepare before enrolling. The training also includes an overview of what the provider enrollment application looks like and how to submit a provider enrollment application.
- **PRSS-118 Introduction to Provider and MCO Portal Delegate Management:** The goal of this virtual training is to offer instructions on this important process for providers, authorized administrators of providers, and delegates of providers. In PRSS, a provider's primary account holder and/or delegate administrators must register their delegates and assign them permission to access the provider portal to complete enrollments and other tasks.
- **PRSS-120- Introduction to the Provider Portal:** The goal of this virtual training is to introduce the provider portal registration process and the functions, features, and basic navigation within the provider portal.

Questions?

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

Updates to Mental Health Services Manual

DMAS has made changes to Chapter IV, the Covered Services and Limitations Chapter, and Appendix E, the Intensive Community Based Support Appendix, of the Mental Health Services Manual, previously known as the Community Mental Health Services (CMHRS) Manual. To familiarize yourself with these changes, please view the July 1, 2022 memo.

One-Time COVID-19 Support Payment for Aides

DMAS received federal approval to provide the one-time support payment for attendants/aides who provided agency-directed or consumer-directed personal care (T1019, S5126), respite care (T1005, S5150), or companion care services (S5135, S5136) to Medicaid members during the first quarter of the State Fiscal Year (SFY) 2022 (July 1, 2021 – September 30, 2021).

A roster of qualifying aides derived from Medicaid claims between July 1 and September 30, 2021, has been compiled. The final roster was distributed to providers via email in June 2022. The roster includes the following information, which is necessary to receive payment for each aide:

- member name
- associated aide
- payer source as derived from the claim

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

Very Important:

- The date of service for the claim is when the aide provided care for the member during the period of July 1, 2021 through September 2021. This can be a range of dates (including dates when services were not provided) or a specific date. Be sure the date of service does not exceed the date the aide last provided service for the member.

One-Time COVID-19 Support Payment for Aides (continued)

- The reimbursement amount is $1,117.60. The amount over $1,000 covers the provider's administrative costs, including required payroll taxes.
- Providers must not submit claims for attendants/aides who were not identified on the agency's final roster.
- Providers who have not received a roster should send a secure email to C19SUPPORT@mslc.com or call the MSLC COVID-19 Support Department at 1-888-832-0856.
- DMAS is waiving the timely filing requirement for G2021 through October 31, 2022, for claims submitted after 12 months from the service date. For these claims, agencies must attach a Timely Filing Waiver.
- A G2021 claim submitted with the Timely Filing Waiver that is received after October 31, 2022, will be denied for timely filing.

Learn more:

- additional billing instructions
- FAQs

Medicaid LTSS in Nursing Facilities, Screening After COVID-19

If you have not already done so, please view the DMAS memo dated June 10, 2022. This release shares vital information regarding a 90-day window (June 14, 2022 to September 12, 2022) for nursing facilities to complete screenings on those residents who do not possess a current, valid screening in the system. The most notable language includes:

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

You are encouraged to review this memo in its entirety. Send questions and inquiries to the DMAS Screening Unit at screeningassistance@dmas.virginia.gov.

Announcing a New Process for Continued Stay Requests

We have implemented a minor change in how we manage continued stay requests for members receiving intensive outpatient (IOP) or low-intensity residential (ASAM 3.1) care from an Addiction and Recovery Treatment Services (ARTS) provider. Effective immediately, we will process each request for a continued stay as a new authorization for H0015 (intensive outpatient) and H2034 (clinically managed low-intensity residential services).

Here is what you need to know:

- This change applies to ARTS providers.
- ARTS providers do not need to take any additional action when requesting authorization for a continued stay.
- You will receive a new determination letter and an additional authorization number for each extended stay requested (i.e., if you submit two requests for continued stay, you will receive a total of three authorization numbers).
- All authorization numbers are required for reimbursement.
- Later this year, we plan to implement a similar change for S0201 (partial hospitalization). However, we will notify providers before this change is implemented.

If you have questions, please call 1-800-648-8420, Monday through Friday, 8 a.m. to 7 p.m.

Quality Improvement

Raising Awareness About the Importance of Immunizations

Parents concerned about vaccine safety or misconceptions about the benefits and risks of vaccinations are one of the biggest hurdles faced in the timely immunization of children. As a healthcare provider, you have the power to be a positive influence on parents' decisions to vaccinate. Ensuring honest and respectful relationships with parents is the key.

Allowing parents to express their concerns regarding vaccinations and educating them on the benefits of immunization would help raise vaccination rates. At Optima Health, we are committed to protecting the children we insure. Together let's raise awareness of the importance of following the American Academy of Pediatrics Vaccination Schedule.

CAHPS Results Point to Importance of Effective Communication

The Consumer Assessment of Healthcare Providers (CAHPS) Survey scores are in, and Optima Health members have expressed that how providers communicate with them matters. How, as providers, can we improve the way we communicate to offer the best member/patient experience? A few simple steps include:

- Use active listening
- Use open-ended questions
- Use plain language
- Have patients paraphrase instructions

Make the most of technology: encourage patients to utilize their patient portal if they have additional questions or need clarification

Good communication has been proven to impact patient outcomes positively. Studies show that good communication's therapeutic value can reduce pain, improve blood pressure, and increase function, so there is no reason not to keep our communication as providers a top priority.

Sources:

Ranjan, P., Kumari, A., & Chakrawarty, A. (2015). How can Doctors Improve their Communication Skills?. Journal of clinical and diagnostic research : JCDR, 9(3), JE01–JE4. https://doi.org/10.7860/JCDR/2015/12072.5712

Transitions of Care (TRC): Effectiveness of Care HEDIS® Measure

Helpful Tips, Documentation Requirements and Codes for claim submission are listed below to help practices capture all the information they need to successfully close gaps.

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

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

Exclusions: Patients are excluded if they:

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

Documentation of the below four components must be in an outpatient record, as well as accessible by the primary care provider (PCP) or managing specialist.

Transitions of Care (TRC): Effectiveness of Care HEDIS Measure (continued)

Component	Criteria
1. Notification of Inpatient Admission and Discharge (within 72 hours)	• Can only be met through medical record review. • Documentation in the outpatient medical record must include evidence of receipt of notification of inpatient admission on the day of admission through two days after the admission (three total days). • Note: If the PCP's practice is not using the same EMR as the facility, the notification needs to go in the patient's medical record.
2. Receipt of Discharge Information (within three days of discharge)	• Can only be met through medical record review. • Documentation of receipt of discharge information on the day of discharge through two days after the discharge (three total days) with evidence of the date when the documentation was received. • If you are not receiving this information timely, please reach out to the facility as soon as possible.
3. Patient Engagement After Inpatient Discharge (within 30 days)	• Patient engagement (encounter /visit) provided within 30 days after discharge. • Do not include patient engagement that occurs on the date of discharge.
4. Medication Reconciliation Post-Discharge (within 31 days)	Medication reconciliation completed on the date of discharge through 30 days after discharge (31 total days). • Must be conducted by a prescribing practitioner, clinical pharmacist, physician assistant, or registered nurse. Other staff members (MA or LPN) may conduct the medication reconciliation, but it must be signed off by the required provider type. • Must be the outpatient medical record, but an outpatient face-to-face visit isn't required. • CPT codes 99483, 99495, and 99496 and CPT II code 1111F will close this measure gap.

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 note that, **effective November 1, 2021**, we discontinued accepting and processing Provider Update Forms that have not been submitted online. Please notify the appropriate individuals in your practice of this information.

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