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.
**Medallion 4.0**

During 2018, Medallion 4.0 will replace Medallion 3.0—the DMAS program that currently includes Optima Family Care (OFC) and FAMIS in Virginia.

Participating Optima Family Care/FAMIS providers do not have to take any action to continue to provide services to OFC/FAMIS members when Medallion 4.0 becomes effective.

On August 1, 2018, DMAS will begin the transition from Medallion 3.0 to Medallion 4.0 in the Tidewater region. The transition from Medallion 3.0 to Medallion 4.0 will continue through December 2018 across the remaining DMAS regions in Virginia.

Medallion 4.0 will be expanded to include individuals with Third-Party Liability (TPL) and those who receive Early Intervention (EI) Services.

Community Mental Health and Rehabilitation Services (CMHRS) for OFC/FAMIS will transition from Magellan to the MCOs as the DMAS transition from Medallion 3.0 to Medallion 4.0 is implemented.

Until the DMAS transition dates for each region, authorizations and claims for OFC/FAMIS members’ CMHRS services should be obtained from and submitted to Magellan.

*DMAS timeline continued on page 3...*
PROPOSED EFFECTIVE DATES

- August 1, 2018
- September 1, 2018
- October 1, 2018
- November 1, 2018
- December 1, 2018
Optima Community Complete (HMO SNP)

Optima Community Complete (HMO SNP), a Medicare Advantage Dual Special Needs Plan (DSNP), is available to individuals who are eligible for both Medicare and Medicaid. Full Medicaid, Qualified Medicare Beneficiary Plus (QMB+), and Specified Low-Income Medicare Beneficiary Plus (SLMB+) individuals who participate in the DMAS Commonwealth Community Care (CCC) Plus program, and are Medicare beneficiaries, can enroll in Optima Community Complete (OCC). The hallmark of the OCC plan is person-centered care coordination that optimizes the member’s experience to match their specific needs.

Members are strongly encouraged, but not required, to enroll in the same health plan for their CCC Plus and DSNP benefits. This same-plan enrollment allows members to receive their benefits seamlessly since they will have only one Care Coordinator to help manage their medical care. (Members in a DSNP in one organization who are in a CCC Plus plan in a different organization have a Care Coordinator at each organization.)

Enrollment in Optima Community Complete is available throughout the year and Optima Health is happy to assist your patient with the enrollment process. Please ensure that you obtain both ID cards for these dual-eligible members when providing care.

If your patient is already an Optima Community Complete member and you need assistance, you can contact their Care Coordinator at 757-552-8398 or toll-free 1-866-546-7924, to coordinate services. If you would like to join the Optima Community Complete network, and optimize your patients’ care, please reach out to Provider Relations at 757-552-7474 or 1-800-229-8822.

OCC Model of Care training is required for all participating OCC Providers. Providers can meet this training requirement by completing the online OCC Model of Care course available from the Education section of optimahealth.com/providers.
Reminder—Complete Your Cultural Competency Training

Being equipped to accommodate the needs of an increasingly diverse population is a growing concern in the healthcare community. Cultural competence and effective communication are keys to understanding a patient’s concerns and helping to ensure they understand their healthcare plan.

We strongly encourage all providers to complete cultural competency training. The Optima Health provider directory will display Cultural Competence as a feature on all provider profiles, informing members which providers have completed this important training.

Please visit the Education section of optimahealth.com/providers for links to cultural competency training opportunities. CME credits are available.

Upon completion of training, please complete the Provider Acknowledgement Form for Cultural Competency so we can credit you for this education.

Provider Acknowledgement Form for Cultural Competency

Please complete the acknowledgement below so that you can be credited with the completion of this training. Your record in the Optima Health provider directory will be updated to reflect that you have participated in training for Cultural Competency.

I acknowledge that I have completed the following course(s)

At least one box must be checked to continue.

☐ “Cultural Diversity” by Optima Health
http://sentara.articulate-online.com/9004660812

and/or

☐ “Think Cultural Health” by The U.S. Department of Health & Human Services
https://cccmb.healthyCourtCase.com/.

Your Information

All fields are required.

First Name: [___]

Last Name: [___]

Email Address: [___]

NPI: [___]
Credentialing Application Questions

If you have additional questions regarding your application or requesting a status update after you have submitted a Credentialing Application, you may contact the Optima Health Credentialing Department by emailing us at optima-credapps@sentara.com or by phone at 757-552-7193.

Clear Claim Connection (C3) Upgrade

Optima Health has upgraded to a new version of Clear Claim Connection (C3). The upgrade includes a new look and enhanced features, including the ability to include quantity, revenue code, bill type, and/or diagnosis code by line as needed. Providers should expect to see the changes to C3 beginning June 11.

C3 is a free online code auditing reference tool available to Optima Health providers through secure login to Provider Connection on optimahealth.com/providers.

If you have any questions, please contact Provider Relations at 757-552-7474 or 1-800-229-8822.

Record Retrieval for Risk Adjustment Validation (RADV)

Annually, Optima Health is required to provide medical records to the Department of Health and Human Services for evaluation through the Affordable Care Act's Risk Adjustment Data Validation (RADV) program.

Optima Health is coordinating with a vendor to retrieve records related to the RADV audit. Retrieval efforts for services provided during calendar year 2017 begin in June 2018 and extend through October 2018. If you receive a request, we ask you to respond in a timely and complete manner with the appropriate records.

You may direct any questions regarding this process to Provider Relations at 757-552-7474 or 1-800-229-8822.
After Hours Emergency Instructions

In accordance with NCQA standards, all Optima Health PCPs are required to have emergency directions for patients calling their office after hours. At the request of Optima Health, a telephone survey was performed by SPH Analytics for a random sample of 350 PCPs in December 2017. The purpose of the survey was to confirm that there was a recording that provided emergency directions or a live person that gave immediate instructions for an emergency.

Out of 350 PCPs contacted, only three providers had an after-hours telephone message that did not provide direction to their patients in an emergency. All calls answered by a live person were given the opportunity for emergency instructions prior to being placed on hold.

Policy Change for Advance Billing of Supplies and Services

Optima Family Care and Optima Health Community Care have previously allowed practices to bill for supplies and services, using HCPCS codes, thirty (30) days in advance. Examples include:

- blood glucose strips;
- lancets;
- normal, low, and high calibrator solution/chips;
- enteral formula, for pediatrics, nutritionally complete; and
- Home therapy; enteral nutrition via pump.

Effective with claim submission dates of service June 1, 2018, Optima Health will process payments for these services only when the invoiced/received date is greater than the end/through date on the claim. Payments will no longer be processed in advance of the end/through date.

Community Mental Health and Rehabilitative Services (CMHRS) Provider Designation

In order to provide CMHRS services to Optima Health Community Care (OHCC) and Optima Family Care (OFC) (Medallion 4) members, Behavioral Health Providers must be approved by Optima Health to provide the specific CMHRS service(s) at the location where the service(s) is being provided. The Optima Health CMHRS application is available on the Optima Health website at optimahealth.com/providers/education/behavioral-health-provider-resources.

Once the completed application and required documents are received, they will be subject to the Licensure, Corrective Action Plan and Audit Review (LCAR) process for approval to provide CMHRS services for OHCC and OFC Members. Providers will be notified of the specific CMHRS services they are approved for.
Billing OHCC LTSS Services that Span Months

The dates of service submitted on a single claim for Optima Health Community Care LTSS and Hospice services must be within the same calendar month. Separate claims must be submitted for each calendar month when the LTSS or Hospice dates of service span across more than one calendar month.

Member Billing for Optima Health Community Care/Optima Family Care Substance Use Disorder Treatment

Please remember that OHCC/OFC Provider solicitation or acceptance of money, or anything of monetary value, is not permitted in exchange for covered Substance Use Disorder (SUD) treatment services necessary to break the cycle of addiction.

Accepting payment for Medicaid–covered services from an OHCC/OFC member is considered “balance billing” which is federally prohibited in accordance with federal law and the Optima Health Provider Agreement.
July 2018 Pharmacy Changes

The pharmacy changes effective July 1, 2018 for plans with pharmacy benefits administered by Optima Health are now available at optimahealth.com/providers:

- select Pharmacy,
- select Formularies/Drug Lists
- scroll down to find the Current Quarterly Changes list.

Note: Pharmacy changes are made on a quarterly basis with effective dates of January 1, April 1, July 1, and October 1. For Groups without a four-tier pharmacy plan, drugs listed as moving to Tier 4 will remain at Tier 3.
Transition of Care

Transition of Care Management (TCM) – The movement of a patient from one setting of care (e.g., hospital, ambulatory primary care practice, ambulatory specialty care practice, long-term care, home health, rehabilitation facility) to another.

Why Take the Time for TCM?

- Better Patient Care
- Better Outcomes
- Reduces Risk of Readmission
- Reduces No–Show Rates
- Enhanced Billing Opportunity

During the 30 days beginning on the date the beneficiary is discharged from an inpatient setting, you must furnish these three TCM components:

1. **AN INTERACTIVE CONTACT**

   An interactive contact must be made with the beneficiary and/or caregiver, as appropriate, within two (2) business days following the beneficiary’s discharge to the community setting. The contact may be via telephone, email, or face-to-face. You or clinical staff can make it.

2. **CERTAIN NON-FACE-TO-FACE SERVICES**

   You must furnish non-face-to-face services to the beneficiary, unless you determine that they are not medically indicated or needed. Clinical staff under your direction may provide certain non-face-to-face services.

3. **A FACE-TO-FACE VISIT**

   You must furnish one face-to-face visit within certain timeframes as described by the following two Current Procedural Terminology (CPT) codes:

   - Transitional care management services with moderate medical decision complexity (face-to-face visit within 14 days of discharge)
   - Transitional care management services with high medical decision complexity (face-to-face visit within 7 days of discharge)

   The face-to-face visit is part of the TCM service, and you should not report it separately.
Medication Review is Crucial to Member Health Outcomes

Medication Reconciliation Post-Discharge (MRP) is a measure ensuring that our members who are discharged from the hospital have their medications reviewed and reconciled within 30 days of discharge.

Optima Health supports the efforts of CMS to strengthen the level of accountability for the care provided by physicians and other providers. The changes are seen as important steps to measure the quality of care coordination post-discharge as well as ensuring member safety.

What does this mean to you? As our partner in delivering high quality care to our members, we need your assistance and cooperation to ensure that our members are receiving the recommended services timely. The expectations for this measure include:

- Encourage your patients to maintain an accurate medication list and to bring this list with any updates to each appointment.
- Assess and monitor your patients’ understanding/knowledge and compliance with medication.
- Medication reconciliation conducted by a prescribing practitioner, clinical pharmacist, or registered nurse within 30 days of discharge. An outpatient visit is not required, but is highly encouraged.
- Documentation of the medication reconciliation in the member’s outpatient chart indicating:
  - Member’s discharge medications were reviewed with the current outpatient medications, or
  - No medications were prescribed upon discharge
Keep Your Practice Information Up to Date

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

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

Medical providers should contact their Network Educator at 1-877-865-9075 with this information; Behavioral Health providers should complete the Behavioral Health Provider Update Form.

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