VirginiaPremier™

Provider Newsletter

Summer 2021

PROV_0821-NFW20-100048

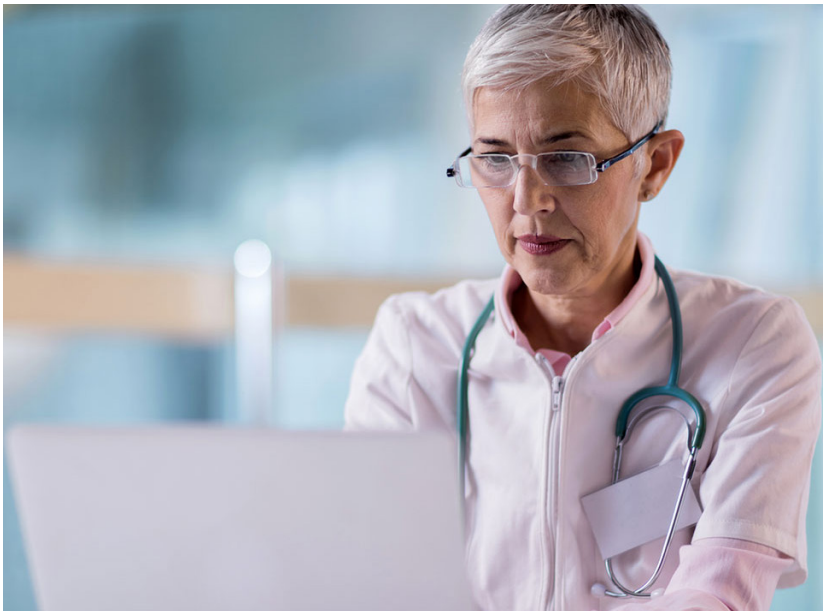
Table of Contents

COVID-19 Vaccine Updates: Helping Members Access Immunizations

As a healthcare provider, you understand how important immunizations are to saving lives. At Virginia Premier, we are doing everything we can to get our members immunized against COVID-19. We have contacted our members by phone, email and mail to offer them the vaccine. In addition, we have hosted in-house vaccine clinics.

If you need assistance in getting our members vaccinated, please reach out to your representative. We are here to help.

Document Diagnosis Codes Carefully to Meet CMS Requirements



According to the Centers for Medicare & Medicaid Services (CMS) Managed Care Manual Chapter 7, Section 40, health plans must "submit all required diagnosis codes for each beneficiary."

What this means for providers:

- Document and code to the highest specificity of the patient's condition.
- All diagnosis codes submitted must be documented in the medical record.
- Ensure that all diagnoses generated during the encounter are included on the claims.

OB Global Payment – Provider Billing Guidelines

Virginia Premier is implementing several changes related to OB global payments, effective **October 5, 2021**. Please review the changes below and share with your team as needed. If you have questions, please contact Virginia Premier at 804-968-1529.

Ancillary Services

The following services will pay $0 when the primary diagnosis is pregnancy, as they are included in the OB global bundled payment.

Service codes: 99212, 99213, 99214, 99215, 81000, 81002, 99221, 99222, 99223, 99231, 99232, 99233, 59409, 59414, 96365, 96366, 96367, 59200, 12001, 12002, 12004, 12005, 12006, 12007, 59871, 59430, S9442, S9443, S9444 and S9447

If the primary diagnosis is not pregnancy and does not meet the E&M code or laceration requirements, claims will pay normal Department of Medical Assistance Services (DMAS) professional services pricing.

Certain codes are reimbursable as separate services from the OB global bundled payment. These codes represent scenarios where members may not be seen at the practice for the full OB bundle (delivery only, member dis-enrollment, etc.).

These codes should be billed with the GB modifier to indicate a separately reimbursable service: 59400, 59425, 59426, 59430, 59510, 59610, 59618, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214 and 99215.

E&M Codes

The following E&M codes are excluded from OB global bundled payment when pregnancy "Dx = Z32.01" is on the claim. These service codes will be separately reimbursable under a global configuration.

Service codes: 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214 and 99215

If the diagnosis is not Z32.01 but the claim includes a primary diagnosis of pregnancy, service codes will pay $0 as included in the OB global payment. Otherwise, claims will pay normal DMAS professional services pricing.

Third- and Fourth-Degree Laceration Codes

These services will price outside of the OB global bundled payment when the primary diagnosis is pregnancy and the claim is submitted with Modifier 22.

Service codes: 12041, 12042, 12044, 12045, 12046 and 12047

If no modifier is included, services will pay $0 as these would be included in the OB global bundled payment. If primary diagnosis is not pregnancy, claims will pay normal DMAS professional services pricing.

Please note that these guidelines apply to providers contracted to receive global/bundled reimbursement. If you are contracted under a fee-for-service or unbundled methodology, you will continue to bill and be reimbursed according to the terms of your contract.

Virginia Premier Provider Portal: Secure Patient Information Just a Few Clicks Away

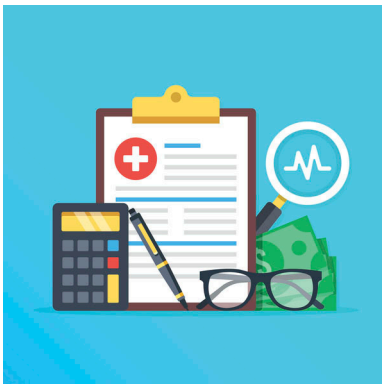
Virginia Premier values your time and wants to ensure you have easy access to the information you need to care for your patients. Our **provider portal** is available 24 hours a day, offering you the ability to:

- Request authorizations for durable medical equipment (DME), home care, therapy, and outpatient and emergent inpatient services.
- Verify member eligibility.
- Check claims and authorization status and view details.
- Create and submit CMS 1500 claims directly to Virginia Premier through a claims entry function.
- Submit claim reconsiderations online.
- View primary care provider (PCP) panel listings.

Available at no cost to participating providers, the portal is easy to use and offers a convenient alternative to a phone call.

Visit the **Virginia Premier website** to learn more. New users can register **online** to enjoy the portal's many time-saving benefits. Need help? Contact technical support by phone, 1-877-814-9909, or email, **connect@healthtrio.com**.

Updated Medical Payment Guidelines



Virginia Premier has updated the following medical payment guidelines:

- CAR T-Cell policy: Addition of Tecartus (brexucabtagene autoleucel) for treatment of relapsed mantle cell lymphoma
- Gene-based therapy for Duchenne muscular dystrophy: Addition of Viltepso (Viltolarsen)
- Gender reassignment surgery: Update of CPT coding

All of Virginia Premier's medical payment guidelines can be found on our **website**.

DMAS Announces Enhanced Dental Benefits for Adult Members

After **July 1, 2021**, Virginia Premier will no longer offer enhanced dental benefits to Medicaid and Family Access to Medical Insurance Security (FAMIS) members. Beginning **July 1, 2021**, the Virginia Department of Medical Assistance Services (DMAS) now offers comprehensive dental services for 750,000 adult Medicaid and FAMIS members 21 and older.

The DMAS dental benefits administrator is DentaQuest and benefits will be paid directly by DMAS. The existing DMAS benefit programs for adult pregnant members and Smiles For Children will not change.

More information is available on the **Virginia Medicaid website**. You can also review the DMAS **member fact sheet** and the **provider fact sheet**.

What Behavioral Health Providers Need to Know: Project BRAVO Implementation

As you may know, the Virginia Department of Behavioral Health and Developmental Services (DBHDS) and the Department of Medical Assistance Services (DMAS) are implementing changes to improve the availability of behavioral health services to Medicaid members. As you prepare for Project BRAVO (Behavioral Health Redesign for Access, Value and Outcomes), Virginia Premier wants you to be aware of the following updates.

Submit Your Documentation

If you haven't done so already, please submit any licensure documentation that you received from DBHDS regarding new services or changes to existing services via email: **VPCred@virginiapremier.com** or fax: 804-819-5171.

Your documentation must be current in our system to ensure timely and proper payment for services provided. If you have questions, please call 1-855-813-0385 (existing providers only).

Learn More About Treatment Code Changes

At the request of DMAS, we created a **crosswalk** to guide you through the changes – effective **July 1, 2021** – to treatment codes. The crosswalk document lists the previous treatment codes and the new codes that started July 1, as well as remit messages you may receive.

Please review this **document** carefully and share it with your team as needed. If you have any questions, contact Virginia Premier at 804-968-1529.

New DMAS Service: Assertive Community Treatment (ACT)

Also effective **July 1, 2021**, DMAS is offering a new service – ACT – to replace the previous program, Intensive Community Treatment (ICT). ACT will include services similar to those that were offered through ICT, but now expands services to weekends and holidays.

DBHDS and DMAS recently announced **new licensure requirements**. New conditional service licenses are effective on July 1, 2021, if applications were submitted and approved by the stated deadline.

Specialized service modification applications for small, medium and large ACT teams were due no later than May 15, 2021. Providers who do not have this conditional license issued by June 30, 2021, will not meet the DMAS requirements for reimbursement for ACT, MH-PHP and MH-IOP effective July 1, 2021.

Service modification applications for current providers of substance use disorders services for relicensing based on the ASAM Level of Care were also due no later than May 15, 2021. Providers who did not have this conditional license issued by July 1, 2021, will not meet the DMAS requirements for reimbursement through the Addiction and Recovery Treatment Services (ARTS) benefit.

These conditional licenses are a requirement for Medicaid reimbursement, without which claims for ACT services will be denied. If you do not become an ACT provider, you may continue to provide other "non-ICT" CMHRS services, such as mental health case management, mental health skill building, or psychosocial rehabilitation services, if you were previously approved by Virginia Premier to provide these services.

If you have questions or concerns, please contact your behavioral health contract manager.

New Coverage for Pregnant Individuals Regardless of Immigration Status

Effective **July 1, 2021**, Virginia Premier offers coverage for pregnant individuals, regardless of their immigration status. They can enroll when they know they are pregnant. We offer full, comprehensive coverage during the prenatal period, through labor and delivery, and 60 days postpartum.

This coverage is the same benefit package provided by FAMIS MOMS. Newborns will be evaluated for Medicaid eligibility following birth. Learn more about benefits for noncitizens on the **DMAS website**.

Report Critical Incidents Within 24 Hours

Providers must report critical incidents to Virginia Premier within 24 hours of learning about the event. To report, call 804-819-5703, ext. 38008. A critical incident is any incident that threatens or impacts the well-being of the member.

Critical incidents include, but are not limited to, the following: medication errors, severe injury or fall, theft, suspected physical or mental abuse or neglect, financial exploitation, and death of a member.

View the **critical incident reporting flyer** to learn more.

Authorization No Longer Required for Incontinence Supplies on Sept. 1

Beginning **September 1, 2021**, Virginia Premier will no longer require authorization for incontinence supplies within the Department of Medical Assistance Services (DMAS) limits for Medicaid members. Virginia Premier continues to align its policies with DMAS as follows:

- All claims for incontinence supplies which are within the DMAS limits will not require pre-authorization.
- All claims for incontinence supplies above the DMAS limits will require an authorization.
- All claims for incontinence supplies for members under 3 years of age continue to require an authorization.
- Reimbursement will not be provided for disposable underpads when used in conjunction with other incontinence products without an authorization.

Example: T4521 (Adult size disposable incontinence product, brief/diaper, small) for a member over age 3 allows for 180 units per rolling 28 days per member. Items over the limit require authorization.

For further information, refer to the DMAS Durable Medical Equipment and Supplies Manual Chapter IV (revision 6/25/2021) pages 80-83. Limits are available on the **Virginia Premier website** or in the Medicaid **Durable Medical Equipment Supplies and Listing Appendix B**.

Understanding the Adverse Effects of Antipsychotics in Children

The use of antipsychotics has increased among pediatric patients with behavioral health conditions.[1] Antipsychotics are known to have metabolic and other concerning adverse effects, including a higher risk of childhood obesity and weight gain, increase in blood glucose, elevated cholesterol, and other abnormal metabolic effects.[1,2] Given the possible adverse effects of these medications, monitoring of blood sugar (including glucose or HbA1C) and cholesterol (including LDL-C) should be completed annually.

Virginia Premier supports physicians in meeting quality metrics around laboratory monitoring in children and adolescents ages 6 through 12 on atypical antipsychotics. We send letters regarding these members to their primary care physician and behavioral health provider to aid in care coordination and appropriate clinical monitoring. Case managers also follow up with the member to assist in provider scheduling, transportation or other needs.

References

1. *Josephine Ho, M. M. (2011). Management recommendations for metabolic complications associated with second-generation antipsychotic use in children and youth. Paediatric Child Health, 575-580.*
2. *Tamara Pringsheim, D. L. (2011). Metabolic and Neurological Complications of Second-Generation Antipsychotic Use in Children. Drug Safety, 651-668.*

Chronic Care Management Services Support Better Outcomes

Virginia Premier offers chronic care management services to members who have long-term conditions that can have a major impact on the member's quality of life. This program offers telephonic education and printed materials to help the member along the journey toward effective disease self-management with help from their primary care physician.

Our assessment helps the member meet Health Effectiveness Data and Information Set (HEDIS®) goals, addressing issues related to the social determinants of health. We also incorporate motivational interviewing to help members make changes in behavior that can lead to long-term positive outcomes. Chronic care management helps members with the following conditions:

- diabetes
- asthma
- coronary artery disease
- heart failure
- hypertension
- chronic obstructive pulmonary disease (COPD)

If your patients have one of these conditions, please refer them to our chronic care management program at 1-866-243-0937, Monday through Friday from 8 a.m. to 5 p.m., except holidays.

Provider Transitions from Pediatric to Adult Care

As adolescent patients approach adulthood, it's time to initiate the healthcare transition process. Between the ages of 18 and 21, members should move from a child- and family-centered model of healthcare to an adult- and patient-centered model of healthcare, with or without transferring to a new provider.

As a provider, you can help patients make the transition from a pediatrician to an adult care practitioner. It involves planning for the transition and transferring and integrating the member into adult healthcare. The goals for both providers and the health plans include:

1. improving the ability of youth and young adults with and without special healthcare needs to manage their own healthcare and effectively use the healthcare services
2. ensuring an organized process in pediatric and adult healthcare practices to facilitate care transition preparation, transfer of care, and integration into an adult-centered practice.

How you can help as a provider?

- Assess your patients for readiness and self-care skills and offer education on identified needs.
- Start discussions early to prepare members on what to expect as they transition to an adult healthcare provider.
- Plan for the transition and incorporate the healthcare transition plan within the medical summary.
- Collaborate with the health plan to address any challenges or access support finding the right healthcare provider.

Resources:

- You can use our online "**find a provider tool**" to see all of the providers available in our network.

CLAS Training Improves Provider-Patient Communication

Virginia Premier ensures participating providers receive training on delivering culturally and linguistically competent care to our members. We strive to meet the needs of underserved and vulnerable populations by delivering healthcare that is quality driven, culturally sensitive, and financially viable. We believe all members should receive equitable and effective treatment which is non-discriminatory.

According to the Institute of Medicine's **Unequal Treatment Report**, social and cultural differences influence practitioner-patient communication and healthcare decision-making. Evidence suggests that practitioner-patient communication is directly linked to patient satisfaction, adherence and health outcomes. The National Committee for Quality Assurance (NCQA) also addresses cultural needs and preferences in its standards. Per NCQA standards, we must assess "the cultural, ethnic, racial and linguistic needs of [our] members and adjust the availability of practitioners within [our] network, if necessary." Virginia Premier meets this standard through the Cultural Competency Program.

We developed a cultural competency training to ensure every participating provider acknowledges and understands our member population. This training is distributed as providers enter the network and ongoing as needed. Training focuses on the Virginia Premier model of care and how to work with patients struggling with mental health, socio-economic issues, literacy challenges, language barriers, etc. The Virginia Premier network management team works hand in hand with providers to present the training during the onboarding process. We follow the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in healthcare.

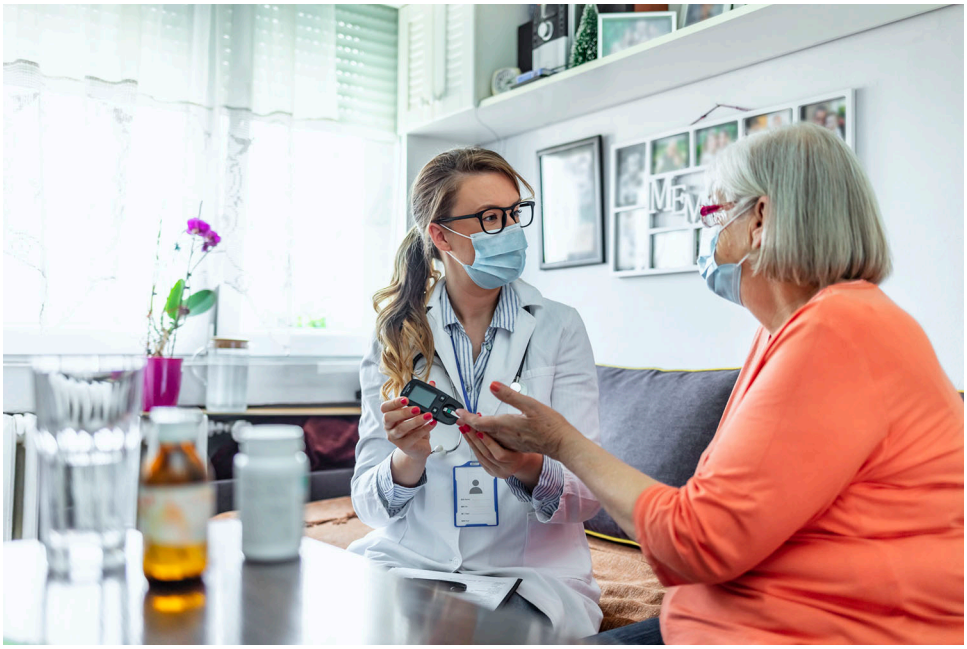
The program focuses on:

- providing an educational opportunity for participating practitioners to deliver culturally competent care in an effective and respectful manner
- strengthening the delivery of healthcare to culturally diverse populations
- training staff to meet members' cultural, racial, ethnic and linguistic needs and preferences
- helping practitioners communicate better with members whose primary language is not English
- promoting safe and more effective clinical practice and improving access for diverse populations
- ensuring network adequacy to meet the needs of the underserved population – using PCP match to members
- reducing health disparities within the clinical indicators

Medicare Star Ratings: What They Are and Why They Matter

The Centers for Medicare and Medicaid Services (CMS) uses Medicare Star Ratings to demonstrate how well Medicare Advantage and Part D plans perform among several categories including:

- staying healthy
- managing chronic conditions
- member experience
- member complaints
- problems receiving service
- members choosing to leave the plan
- customer service
- drug pricing
- patient safety



The data is compiled using operational measures, Consumer Assessment of Healthcare Providers and Systems (CAHPS®) measures, Health Outcomes Survey (HOS) measures, Healthcare Effectiveness Data and Information Set (HEDIS®) measures, and medication usage and safety measures.

The Medicare Star Ratings are publicly reported and offer a way for Medicare members to easily identify high-quality plans. Higher Medicare Star Ratings allow health plans to provide more robust member programs among other benefits. These additional benefits can help keep your patients, and our members, healthier longer and may improve their quality of life.

Please encourage your patients to schedule appointments for regular care (i.e., annual wellness exams and physical exams), manage their chronic conditions and take their medications as prescribed. Excellent customer service, short wait times and management of expectations for referrals benefit the health plan and providers like you.

Below are some of the Medicare Star metrics you can impact:

HEDIS Measures:

- breast cancer screening (BCS)
- colorectal cancer screening (COL)
- care for older adults – medication review (COA)

Quality Improvement:

- care for older adults – functional status assessment (COA)
- care for older adults – pain assessment (COA)

- osteoporosis management in women who had a fracture (OMW)
- diabetes care – eye exam (CDCA)
- diabetes care – kidney disease monitoring (CDCA)
- diabetes care – HbA1c poor control (>9) (CDCA)
- medication reconciliation post-discharge (MRP)
- statin therapy for patients with cardiovascular disease (SPC)
- controlling blood pressure

CAHPS and HOS Measures:

- annual flu vaccine (CAHPS)
- improving or maintaining physical health (HOS)
- improving or maintaining mental health (HOS)
- monitoring physical activity (HOS)
- reducing the risk of falling (HOS)
- improving bladder control (HOS)
- getting needed care (CAHPS)
- getting appointments and care quickly (CAHPS)

Part D (Pharmacy) Measures:

- statin use in persons with diabetes (SUPD)
- medication adherence for diabetes medications
- medication adherence for hypertension - RAS antagonists
- medication adherence for cholesterol (statins)

VirginiaPremier™

Call us at 1-800-727-7536 (TTY: 711)
or visit us online at VirginiaPremier.com.

Hours of Operations
Monday through Friday; 8:00 a.m. – 6:00 p.m.

Information in this newsletter – such as plan benefits for members, offerings to providers and other details – is subject to change.