

MEDICAID
PROVIDER GUIDE
2023



OptimaHealth 

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Purpose of the Guide

The Optima Health Medicaid Provider Guide provides an overview of the Optima Health Medicaid program. The Optima Health Provider Manual—a more extensive resource—is your trusted source for the health plan’s policies and procedures. Providers are also encouraged to review [Doing Business With Optima Health](#) to learn best practices for conducting business with us successfully.

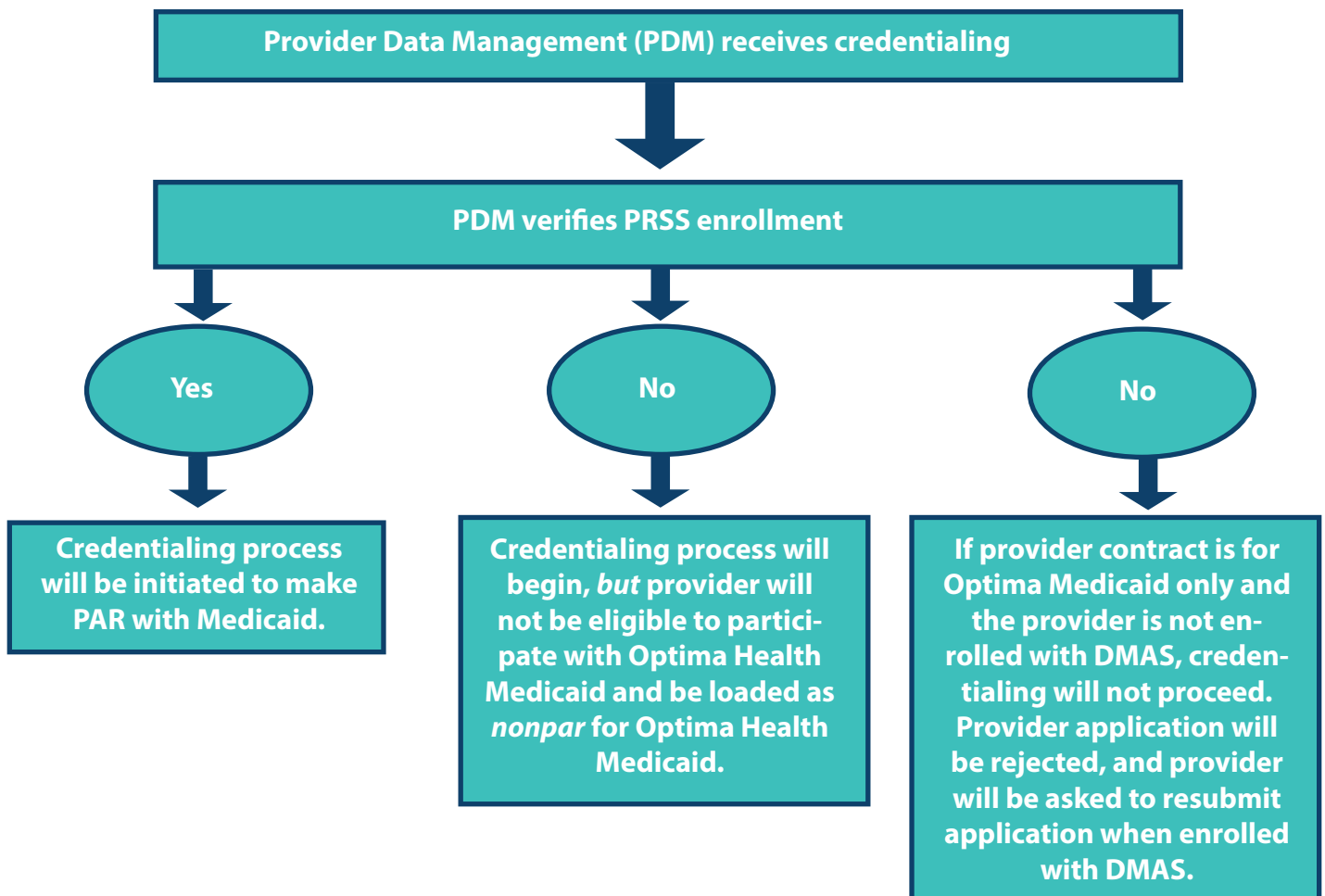


All Medicaid managed care network providers must enroll through PRSS to satisfy and comply with federal requirements in the 21st Century Cures Act.

Key Points:

- How to Enroll: From virginia.hppcloud.com/, go to “Menu,” then “Provider Enrollment,” and select either “New Enrollment” or “Enrollment Status.”
- Only one enrollment application is necessary in PRSS, even if you participate with more than one managed care organization (MCO).
- All new MCO-only providers must first enroll with PRSS prior to requesting credentialing with one or more of the managed care health plans.

DMAS/PRSS Verification Workflow



Always check member eligibility prior to providing services. This is an important step to ensuring reimbursement. Verification may be obtained through our [secure portal](#), or by calling Provider Customer Services: 1-888-946-1167.

Use the MediCall telephonic system and 270-271 eligibility transactions to verify member eligibility and managed care enrollment. Automated Response System (ARS) and MediCall will provide the name of the MCO the member is enrolled in and the plan's contact number.

Effective January 1, 2023, the verification system will only indicate MCO enrollment. Previously, enrollment in CCC+ and or Medallion 4.0 were specified.

To learn more, visit the Department of Medical Assistance Services (DMAS) [website](#) at: **dmas.virginia.gov/for-providers/cardinal-care-transition/**.

Member ID cards will bear the Cardinal Care logo:



2023 Optima Medicare Member ID Card
Optima Community Care
SAMPLE

Optima Health

OPTIMA COMMUNITY CARE

Member Name: JOHN DOE
Member Number: 9999999*99
Group Number: OCC
Medicaid #: 99999999999
PCP Name: JANE DOE
PCP Number: 1-123-456-7899
DOB: 01-01-1995
Member Effective Date: 01-01-22

RxBIN: 003858
RxPCN: MA
RxGRP: OHPMDCC

CardinalCare
Virginia's Medicaid Program

Detailed benefit information at optimahealth.com and our mobile app

Pre-Authorization may be required for: hospitalization, outpatient surgery, therapies, advanced imaging, DME, home health, skilled nursing, acute rehab, or prosthetics.
IN CASE OF AN EMERGENCY: Call 911 or go to the nearest emergency room. Always call your Primary Care Physician for non-emergent care.

Member Services: (hearing impaired/Virginia Relay: 711)	1-800-881-2166
Behavioral Health/VARTS Crisis Line:	1-888-945-1168
Transportation:	1-877-892-3666
Provider Services: (including Pre-Authorization)	1-888-945-1167
24/7 Nurse Advice Line:	1-800-394-2237
Pharmacist Help Desk: (including Pre-Authorization)	1-844-604-9165
Dental:	1-888-912-3456

Medical Claims P.O. Box 5028 Troy, MI 48007-5028	Behavioral Health Claims P.O. Box 1440 Troy, MI 48099-1440	Optima Health P.O. Box 66189 Virginia Beach, VA 23466
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2023 Optima Medicare Member ID Card
Optima Community Care
DATA FIELDS

Optima Health

OPTIMA COMMUNITY CARE

Member Name: <XXXXX XXXXX>
Member Number: <XXXXXXXX*XX>
Group Number: OCC
Medicaid #: <XXXXXXXXXXXX>
PCP Name: <XXXXXXXX XXXXXX>
PCP Number: <XXX.XXX.XXXX>
DOB: <MM/DD/YYYY>
Member Effective Date: <MM/DD/YY>

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2023 Optima Medicare Member ID Card
Optima Community Care - FAMIS
SAMPLE

Optima Health

OPTIMA COMMUNITY CARE

Member Name: JOHN DOE
Member Number: 9999999*99
Group Number: OCC
Medicaid #: 99999999999
PCP Name: JANE DOE
PCP Number: 123-456-7899
DOB: 01-01-1993
Member Effective Date: 01-01-22

RxBIN: 003858
RxPCN: MA
RxGRP: OHPMDCC

CardinalCare
Virginia's Medicaid Program **FAMIS**

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Optima Community Care - FAMIS
DATA FIELDS

Optima Health

OPTIMA COMMUNITY CARE

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Member Number: <XXXXXXXX*XX>
Group Number: OCC
Medicaid #: <XXXXXXXXXXXX>
PCP Name: <PCP Name>
PCP Number: <XXX.XXX.XXXX>
DOB: <MM/DD/YYYY>
Member Effective Date: <MM/DD/YY>

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Virginia's Medicaid Program **FAMIS**

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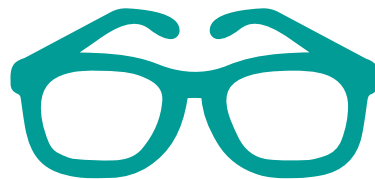
Standard Covered Services



- doctor, hospital and emergency services, including primary and specialty care
- prescription drugs
- laboratory and X-ray services
- maternity and newborn care
- home health services
- family planning services
- doula services

Enhanced Benefits

- eye exam and \$100 frames annually
- wellness rewards up to \$50
- weight management
- financial wellness
- pedometer
- free smartphone with 350 minutes, unlimited texts, and free monthly calls to health plan
- free unlimited wireless texts, minutes, and hot spot
- 24 free round-trip rides per year to grocery stores and [more](#)
- 14 meals delivered to home after hospital stay
- up to \$275 for GED prep/test
- up to \$75 for college application
- free mattress cover/pillowcase for members with asthma



CCC Plus:

- memory alarms and device

Healthy Moms and Kids:

- **Med 4** – OB programs, baby showers, incentives up to \$75, 400 free diapers (restrictions apply), grocery card for pregnant moms (restrictions apply)
- **FAMIS** – Up to \$75 for OB programs, baby showers, incentives

Vendor-facilitated Services

- **ASHN:** American Specialty Health Network; Chiropractor Network: Claims are paid through ASHN; Commercial and Medicare Only; 1-800-848-3555
- **DentaQuest:** Dental Network; Commercial and Medicare; Medicaid is handled by DMAS directly; 1-888-278-7310
- **Verida:** Transportation Vendor; Commercial, Medicare, and Medicaid: **transport_noner@Sentara.com**. *Formerly Southeastrans, Inc. (SET)*
- **Epic Hearing:** Discounted service for Hearing Aids; Commercial, Medicare, and Medicaid; 1-866-956-5400
- **MDLive:** Virtual Visits; Commercial, Medicare, and Medicaid
- **Nations Hearing:** Discounted Services for Medicare and Medicaid Members
- **Vision Services Plan (VSP):** Routine Vision Care Only Commercial, Medicare, and Medicaid
- **Community Eye Care (CEC):** a subsidiary of VSP will service all Medicare
- **LabCorp:** Commercial, Medicare, and Medicaid
- **Quest Diagnostics:** Commercial, Medicare, and Medicaid

Transportation Benefit

Benefit Overview

Verida (formerly Southeastrans, Inc.) administers the nonemergency transportation benefit for Optima Community Care members.

- transport to and from medical appointments with a participating provider
Exception – FAMIS members do not receive nonemergency transportation.
- limit of two escorts during transport
- case manager preapproval for trips exceeding 50 miles out of state
Exception – Children’s Hospital of D.C., Children’s Hospital of Pennsylvania, or Duke in North Carolina



Hours of Operation

- Monday–Friday, 6:00 a.m. – 6:00 p.m.
- closed weekends and on New Year’s Day, Memorial Day, Independence Day, Labor Day, Thanksgiving, and Christmas
- urgent and same-day reservations available 24 hours daily
- “Where’s My Ride” available 24 hours daily
- routine transportation appointments scheduled for Saturday and Sunday and weekdays after 5 p.m. allowed for regularly scheduled appointments to providers who routinely see patients during these time frames

Hospital Admission/Emergency Room Visits

Members may be transported from home to hospital only if being admitted. Members needing to go to the emergency room must call 911. Emergency ambulance services are not included in the transportation benefit.

Scheduling a Trip

- OCC members call 1-877-892-3986.
- Members may schedule using the Member Portal.
- Select Option #1 – “Where is my Ride.”
- Facilities may schedule using the Facility Portal. Contact Verida if you would like to set up an account.
- **Must** book at least five business days in advance of the appointment unless it is an urgent trip, which will be verified. May book up to 30 business days in advance. Weekends and holidays do not count toward these days.
- For all “Standing Order” trips (regular weekly/daily transportation to a facility or appointment), the provider’s office or case manager must submit a written request on behalf of the member. These are typically behavioral health, adult day care, dialysis, and chemotherapy-related appointments.
- Gas reimbursement – Members must request gas reimbursement at least five (5) days prior to being eligible for reimbursement consideration.
 - Verida determines the correct mileage through their transportation management system.
 - Mileage is pre-populated on the form.
 - Provider office signature is **required**.

Standing Orders

Access Standing Order or Standing Order Change Forms at: verida.com/virginia-facilities.

- Fax form to 1-404-581-5543 at least five days prior to first date of transport.
 - Call to schedule individual trips if member needs transport sooner before standing order goes into effect.
 - Allow 24 hours after the form is sent to confirm receipt.
- Fill out forms completely and legibly.
- Print and sign name.
- Questions may be directed to any standing order representative on the facility line at 1-844-856-7908.

Information Required for Standing Orders:

- Does member require hand-to-hand, door-to-door, or curb-to-curb?
- Does member require wheelchair assistance or other special instructions (such as bariatric, seizure precautions, behaviors, etc.)?
- Does member have special language and/or other communication requirements?



Minor Travel Documentation Requirements

Members under 18 years of age must be accompanied by a parent, legal guardian, or family-approved adult, unless an emancipated minor (can be a pregnant minor).

Minors between 13 and 17 years of age may travel alone to Medicaid-paid program services if a Consent for Minor Travel Form signed by the parent or legal guardian is on file with Verida prior to the date of transport.

If a parent, legal guardian, or family-approved adult is not available to travel with a child 12 and under, Verida shall arrange transportation with a provider that can provide an appropriately trained attendant, based on the child's individual needs, to accompany the member.

Registering a Complaint

Option #1 – (Preferred) – OCC members call 1-877-892-3986. Members are empowered to escalate to a Verida supervisor when necessary.

Option #2 – Member contacts Optima Health Member Services, 1-800-881-2166.

Option #3 – Third Party (outreach, case manager, business owner, Optima Health employee) files a complaint on behalf of member directly with Verida.

Doula Services Benefit



Benefit Overview

- Pregnant and postpartum members are eligible for:
 - eight prenatal or postpartum visits
 - one doula attendance at the delivery visit
- Members can be approved for additional visits after completion of the eight visits if it is deemed medically necessary.
- Members are not allowed multiple visits in the same day except when:
 - A prenatal visit occurs early in the day and the attendance at delivery is later.
 - The attendance at delivery occurs early in the day and a postpartum visit is later.

Initiating Doula Services

- Members must choose a community doula who has completed a Virginia Department of Health approved certification program.
- Doulas are then responsible for ensuring that the Doula Care Recommendation Form has been completed and signed by the member’s licensed healthcare provider prior to initiating services.
- Doulas must retain a copy of the signed recommendation form with the member’s medical records.

Fax Recommendation Forms to 757-352-2694 or 833-666-0706

The image shows a sample of a "Virginia Medicaid Department of Medical Assistance Services DOULA CARE RECOMMENDATION FORM". The form includes instructions for members, doulas, and licensed practitioners. It contains several text input fields for the following information:

- VA Medicaid member full legal name (first, middle, last)
- VA Medicaid member DOB or ID#
- Licensed Practitioner's Signature
- Licensed Practitioner's full legal name (first, middle, last)
- Licensed Practitioner's ID# number
- Date of recommendation (MM/DD/YYYY)
- Name of doula(s) (if known)
- Name/address of member's physician or provider (if known)

Sample Form

Care Management

- Members will receive communications and education regarding the new benefit.
- The Partners in Pregnancy (PIP) team will conduct outreach to pregnant members.
- PIP will complete the necessary documentation in our internal systems.
- If no provider recommendation form has been received:
 - The member will be contacted to verify doula contact information and provided education on the need for a completed provider form.
 - The doula will be contacted to request that the completed form is faxed to the PIP Biscom line

Doula Compensation and Billing

Covered Doula Services

- Doula services, rendered from date of conception through 180 days (six months) after delivery, may be reimbursed contingent on individual maintaining Medicaid eligibility.
- Doula services can only be provided in the community, in clinician offices (if a doula is accompanying the member to a clinician visit), or in the hospital.
- Rendered doula care must be documented in the member's medical record.

Benefit Extensions

Benefit extensions will be considered medically necessary if the member is experiencing a potential complication, or is at risk for or needs support managing one or more of the below:

- excessive anxiety
- breastfeeding knowledge, support, and assistance
- information about feeding and caring for the baby
- helping member or family learn to become comfortable with baby soothing and bonding methods
- promoting self-care
- postpartum depression

Optima Health **will** allow additional visits beyond the allowable nine (9) with an authorization from an eligible provider.

Critical Elements

1. **NPI Number:** All claims submitted to Optima Health must include individual and group practice NPI numbers and taxonomy codes. Claims received without an NPI number will be rejected or denied.
2. **Modifier HD** is required with claims submission for covered doula services.
3. **Taxonomy Code 374J00000X** is required for billing. Claims received without the taxonomy code will be rejected or denied.
4. **Recommendation form** from eligible provider required to be submitted to MCO prior to providing services for member.
5. **Diagnoses code Z32.2** (encounter for childbirth instruction) is required to bill doula services.

Billing Codes

Code	Description	Maximum Units Allowed Per Visit	Rate	Notes
99600-HD	Initial Prenatal Visit	90 minutes	\$14.99	Max 6 units of 15 minutes each (total of 90 minutes), one date of service
59425-HD	Standard Care, Prenatal Visit	60 minutes	\$14.99	Max 3 visits (initial prenatal and 3 prenatal visits) – bill in 15 min increments, total of 60 minutes per visit
59409-HD	Labor Support, Vaginal Birth	1 unit (flat rate)	\$350.00	
59514-HD	Labor Support, C- Section	1 unit (flat rate)	\$350.00	
59430-HD	Postpartum Care, Postpartum Visit	60 minutes	\$14.99	Max 4 visits – bill in 15 minute increments, total of 60 minutes per visit
99199-HD	Incentive Mother Postpartum	1 unit (flat rate)	\$50.00	
99199-HD	Incentive Newport* Postpartum	1 unit (flat rate)	\$50.00	*Must be billed under the newborn Medicaid ID

Incentive Payments

To receive the incentive payments, doulas need to have performed at least one postpartum visit. A \$50 value-based incentive payment can be received by the doula if the client is seen by an obstetric clinician for one postpartum visit. A \$50 value-based incentive payment can be received if the newborn is seen by a pediatric clinician for one visit after birth.

Special Needs Plan (SNP) and Model of Care (MOC) Overview

This serves as a general overview of the Optima Health Model of Care, with more detailed provider education available and [required for SNP providers](#) in the [Model of Care Provider Guide](#).

The Model of Care is an approach to identifying targeted populations for outreach, care management, and disease management, which specifies expectations for member engagement, assessment, care planning, interdisciplinary team meetings, and other interventions to improve member outcomes and experience.

An SNP is a Medicare Advantage (MA) coordinated care plan (CCP) specifically designed to provide targeted care and limit enrollment to special needs individuals. A special needs individual could be:

- an institutionalized individual
- dual eligible
- an individual with a severe or disabling chronic condition, as specified by CMS.

An SNP may be any type of MA CCP, including either a local or regional preferred provider organization (i.e., LPPO or RPPO) plan, a health maintenance organization (HMO) plan, or an HMO Point-of-Service (HMO-POS) plan.

There are three different types of SNPs:

- Chronic Condition SNP (C-SNP)
- Dual Eligible SNP (D-SNP)
- Institutional SNP (I-SNP)

Optima Health MOC Plans

Optima Health MOC plans are designed to ensure the provision and coordination of specialized services that meet the needs of the SNP-eligible beneficiaries. Our SNP plans for 2023 include: Optima Health MOC Plans Dual-Eligible SNP: Optima Community Care (HMO D-SNP) members enrolled in DSNP are both Medicare and Medicaid eligible, also called “dual eligible.”

Optima Health disease management programs include Diabetes Mellitus, Chronic Heart Failure, and Cardiac Conditions.

Chronic SNP: Optima Engage (C-SNP) The C-SNP (Chronic Condition Special Needs Plan) is a specialized care coordination plan (program) that is an extension of our Medicare Advantage Plan. The Centers for Medicare & Medicaid Services (CMS) requires that you have a Medicare Advantage plan to qualify for a C-SNP. C-SNP is solely Medicare related.

Member Verification and Enrollment in C-SNP – TIME SENSITIVE

Member enrollment into C-SNP is **extremely time sensitive**. CMS allows **seven (7) days** to complete the verification process. If enrollment and verification are not completed within this time frame, the **member cannot be enrolled in the C-SNP plan**.

It is critical that providers verify the member has been diagnosed with one or more of the qualifying chronic condition(s) on the same day the request is received.

Required Model of Care Education

Providers are required to review the **Model of Care Provider Guide** (MCPG) within 30 days of their initial orientation date as a newly contracted provider (and by January 31 each subsequent year). Attestation is required and will be recorded by provider (practice/facility) name, tax identification number (TIN), and email address. Out-of-network providers must review the MCPG when they sign the requisite Single Case Agreement (SCA).

The MCPG and Attestation can be located at the link below. The attestation must be executed by provider and verified by Sentara Health Plan (SHP) prior to SHP signing and returning Agreement.



[Model of Care Provider Education and Attestation](#)

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Overview

The Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program ensures pediatric patients receive regular screenings to avoid delays in diagnosis and treatment. By visiting the Department of Medical Assistance Services (DMAS) website, providers can access educational materials, schedules, approved screening tools, and other resources needed to provide the best care for patients.

Optima Health's Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Provider Guide is also available online for review or printing.

[EPSDT Supplement B and OHP EPSDT Guide](#)



The majority of the consolidated Optima Health provider agreement amended with the implementation of Cardinal Care incorporates existing requirements from the M4 and CCC+ contracts, **effective April 1, 2023.**



[DMAS Provider Manuals](#)

- [EPSDT Supplement B](#)

[MES Provider Portal](#)

[Commonwealth of Virginia Referral Directory by City/County](#)

Optima Health Quick Reference Resources

- [Optima Health Provider Manual](#)
- [Provider Orientation](#)
- [Provider Toolkit](#)
- [Optima Health Claims and Billing Quick Reference Guide](#)

E-Booklets

- [Early and Periodic Screening, Diagnostic and Treatment \(EPSDT\) Provider Guide](#)
- [Doing Business With Us](#)

Slide Presentations

- [Transitioning to Cardinal Care](#)

