

SHP

Participating Facility

Reference Guide

Revised October 2008

Sentara Health Plans

The SHP Participating Facility Reference Guide was produced for use by participating facilities in conjunction with the specific contracts issued for each service. Information noted in the contract will take precedence over any information contained within.

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Introduction

As a participating provider, you are an integral member of our team. We thank you for making it possible for SHP to promote the maintenance of health and the management of illness and disease by providing access to quality health care and the best in customer service to our community. SHP leadership and key operations are located in Virginia to best support our local community focus.

1. Overview

1.1 Optima Resources

SHP provides a number of resources for providers to obtain information regarding SHP membership, products, policies and procedures:

1.1.1 On-Line:

Up-to-date contacts, policies and procedures, forms and reference documents are available to all providers through www.optimahealth.com. No sign in is required to access basic information, including this guide, on www.optimahealth.com.

Additional information and operational functions are available anytime for SHP Providers who register for Provider Connection. Provider Connection is a free service for Optima Providers, but does require registration for security purposes. Providers may register for Provider Connection via www.optimahealth.com by completing the online Provider Connection SHP Enrollment Form.

Registered providers can perform the following functions at their convenience with secure transactions using Provider Connection:

- Check Member Eligibility
- Check Referral (when applicable) and Authorizations Status
- View Detailed Claim Status
- Pre-adjudicate claims using Clear Claim Connection
- Download SHP Documents and Forms
- View and download Remits and Pended Claim Reports
- Submit online Reconsiderations for certain claims

1.1.2 Participating Provider Reference Guide:

This guide identifies contacts and resources within SHP, provides basic information for Member identification, credentialing procedures, requirements for pre-certification/authorization and claim and reimbursement procedures. The guide also provides directions to locate detailed lists, contact information and policies that are frequently updated, on-line by topic, at www.optimahealth.com. In addition to the guide being available on-line, it is also available on CD or

paper, by request. The online version of the Guide is updated quarterly and the CD and paper versions are updated annually.

1.1.3 Telephone:

Providers may contact Provider Relations at 1-800-229-8822 or 757-552-7474. A complete directory of phone and fax numbers for SHP departments (including contacts for after hours) may be found on-line at www.optimahealth.com under “Contacts” and in this Guide.

1.2 Fair Business Practices Act (FBPA)

In accordance with SHP Provider Contracts and FBPA, if a specific policy or procedure is not outlined in your contract, in this guide or available through Provider Connection, SHP will make this information available within ten (10) business days of a Provider’s written request for information. Providers may contact their Network Educator or Contract Manager to request copies of specific policies.

1.3 HIPAA Privacy Statement

SHP is in compliance with the Privacy Rule and Security Rule under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). To ensure the protection of confidential information and patient health information, SHP has implemented privacy and security policies and procedures, has developed required forms, has established safeguards to protect patient health information, and conducts HIPAA awareness training.

2. SHP Key Contacts

2.1 After Hours Nurse Advice Line

Phone: 1-800-394-2237 or 757-552-7250

2.2 Medical Care Services

Phone: 1-800-229-5522 or 757-552-7540

Fax: 1-877-800-2839 or 757 552-7429

Pharmacy Fax 757-552-7516

2.3 Optima Behavioral Health Services

Phone: 1-800-648-8420 or 757-552-7174

Fax: 757-552-7499

2.4 Provider Relations

Customer Service Unit & Eligibility Verification

Phone: 1-800-229-8822 or 757-552-7474

Fax: 757-552-7316

2.5 Quality Improvement

Phone: 1-866-425-5257 or 757-552-7350

Fax: 1-866-783-5196 or 757-552-7476

2.6 SHP Health and Preventative Services

Phone: 757-687-6000

Fax: 757-687-6161

2.7 Telephone for Deaf and Disabled (TDD)

Phone: 1-800-225-7784 or 757-552-7120

2.8 Fraud and Abuse Hotline

Phone: 1-866-826-5277 or 757-687-6326

2.9 On-line

www.optimahealth.com “Contact Us”

2.10 Network Management

Contract Managers Telephone (757) 552-8892

- Hampton Roads region:
- Telephone 1-877-865-9075 or (757) 552-7085 Fax (757) 552-7114
- Central and western Virginia region
 - Telephone 1-877-865-9075 Fax (804) 510-7459 or 877-455-9201

2.11 Credentialing

Telephone (757) 552-7475

Fax (757) 552-8887 or (757) 687-6342

2.12 Appeals Department

Telephone (757) 687-6404

Fax (757) 687-6232

3 SHP Product Overview

SHP offers a number of health plans designed to meet the needs of most large and small employer groups as well as individual and families, throughout much of Virginia and Northeastern North Carolina. In addition, SHP offers plans for government programs such as Medicare Advantage, FAMIS and Virginia Medicaid. Product offerings and designs are subject to change and may vary by geographic area as SHP continues to address the needs of an evolving health care environment. Current detailed information is available for each SHP Product with example ID cards at www.optimahealth.com under Health Plan Products. SHP Products fall into the following general categories:

3.1 HMO (Health Maintenance Organizations)

- Members receive care from a contracted network of providers (physicians, hospitals, specialists, labs, etc.)
- A primary care physician (PCP) coordinates care
- Optima Family Care and FAMIS plans do not require referrals. Some Commercial HMO plans continue to require referrals. Commercial plans that do not require referrals have an indicator on the ID card
- Emphasis on preventive care such as well baby visits, physicals, immunizations, annual GYN exams, and mammography

3.2 POS (Point of Service)

- Two plans in one with an in-network benefit and an out-of-network benefit
- Members receive maximum benefits by using in-network providers.
- Higher out-of-pocket costs and deductibles may apply when Members see out-of-network providers.

3.3 PPO (Preferred Provider Organization)

- Members have the freedom to select any provider for care, with lower out-of-pocket costs for seeing network providers
- No requirement for PCP selection
- No referrals needed to see specialists
- Includes SHP Individual and Family PPO Plans
- Includes Health Savings Account (HSA) qualified PPO plans. These plans have in Network deductibles for all services except Preventive Care services that have co-payments. SHP partners with HealthEquity to manage the pre-tax Health Savings Accounts for HSA PPO Members. Members may make payment to providers, for such Member expenses as deductibles, co-pays and co-insurance using their HealthEquity debit card, online using the HealthEquity online payment tool with electronic funds transfer (EFT) or by phone. If an HSA Member pays online using EFT, providers will receive a HealthEquity check and Explanation of Payment

3.4 Employer Funding Options

- **Fully Funded Group Plans**: Employers may seek health coverage for their employees through SHP through fully insured plans without assuming the risk themselves. Fully funded group plans are subject to Virginia's Ethics and Carriers' Fair Business Practices Act.
- **Self-Funded Group Plans**: Employers who choose to assume financial risk themselves may opt for a full range of health benefit plan designs that are administered by Optima Health. Each self-funded plan may be customized for the specific employer using a PPO, POS, or HMO, or High-Deductible Healthplan PPO product design. Self-funded group plans are subject to federal ERISA rules and regulations.

3.5 Individual, Family, and Government Programs

- **Individual and Family Plans** are fully underwritten, meaning that SHP takes the risk.
- **Government Programs** SHP offers a Medicare Advantage PPO plan as well as an HMO plan for Medicaid and FAMIS. Both of these plans must comply with Medicare and Medicaid regulations, respectively.

4. Member Identification Cards

4.1 SHP Member ID Cards Content

SHP Members receive identification cards for each enrolled member of the family. The card is for identification purposes only and does not verify eligibility or guarantee payment of covered services. Members should present their card at the time of service. The sample cards shown in this guide are representative versions of cards for general SHP product categories and will vary slightly due to specific differences within products and employer groups. Additional examples of product ID cards are available at www.optimahealth.com.

In general, information on the **front** of the card includes the following information:

Product name	Optima Family Care ID cards say “Optima Family Care” and include the 12-digit Medicaid ID number. FAMIS cards also say Optima Family Care but will have the subgroup heading, “FAMIS”, on the card.
Group name	Not applicable for Medicare Preferred Plans And Individual and Family PPO Plans
Referrals Required	All but a very few SHP plans have eliminated referral requirements. Those that have will show the statement “No Referrals Required”
Member name	The name from the enrollment application or request for a name change. OFC/FAMIS name changes must be made through DMAS.
Member’s identification number	This is a nine or ten digit number (1234567*01). The first digits identify the subscriber and are followed by an asterisk (*). The last two (2) digits identify the Member within the subscriber’s enrolled family. For Optima Family Care this number is always 01, whether the Member is the subscriber, spouse or child. For all other plans: 01 = Subscriber 2/21 = Spouse/Ex-Spouse. Ex-Spouses will remain the 02 Member. Any new spouse will be assigned as the 21 Member.

03, 04, 05, etc. = Child

DOB	Date of Birth is indicated for FAMIS and Optima Family Care only
Plan number	Not applicable for Family Care or FAMIS
Group number	Not applicable for Medicare Preferred plans
Effective date	Member effective date with Optima
Benefit effective date	New cards are issued to all Members at the group's enrollment date if changes in co-payments occur. Not applicable for Medicare Preferred plans
PCP telephone number	Not applicable for PPO plans
After Hours Program telephone number	See Care Coordination number for Medicare Preferred plans
Member Services telephone number	See back of Medicare Preferred Cards
Fully-funded group cards	Show the statement "Underwritten by..." at the bottom of the card
www.optimahealth.com	SHP 24 hour information resource for Members and Providers

When applicable, co-payment amounts for the following services are listed on the front of the card as follows for all products except SHP Medicare plans:

OV	PCP office visit copay
SOV	Specialist office visit copay
IP	Inpatient copay
OP	Outpatient copay
DX1	Copay for radiological and diagnostic tests performed outside the physician's office, excluding lab work
DX2	MRI, CT, PET & MRA scan copay
ER	Emergency Room copay
UCC	Urgent Care Center copay
RX	Pharmacy copay
RX Ded	Pharmacy annual deductible
Coins	Co-insurance
Deductible	Medical deductible

Exception: Cards for Optima Medicare plans indicate the following copay information on the **front** of the card:

- Office Visit Copay Amounts
- Inpatient Hospital Copay Amounts
- Emergency Room Copay Amounts
- Medicare Part D and Part B Prescription Drug Information for Pharmacy Claim Processing

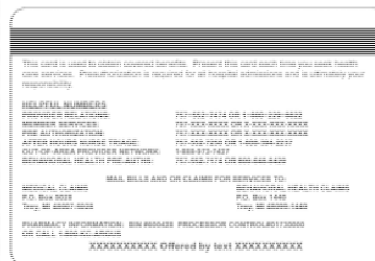
Information on the **back** of SHP cards includes applicable items from the following:

- Pre-Authorization information (Medical and Mental Health)
- Billing or claims address
- Emergency care information
- Provider Relations number for questions
- Prescription drug claim processing information for pharmacies
- Out of area provider information (not applicable for Optima Family Care, FAMIS and Medicare Preferred)
- Optima Family Care cards provide a phone number for 24 hour transportation needs
- Optima Medicare Preferred cards also list a contact number for hearing impaired Members, a phone number for 24 hour Care Coordination and the billing address for chiropractic claims

4.2 Example of HMO and POS Product Card Format



4.3 Example of PPO Product Card Format



4.3 Example of Medicare PPO Product Card Format



4.4 Other Cards

Select groups that use SHP claims administration will have, “Administered by SHP” at the bottom of the card. The SHP logo will appear somewhere on the front of these cards.

5 Eligibility Verification

Since a Member's eligibility status could change at any time, Member coverage should be verified at each encounter. Providers may access Provider Connection or call Optima's Interactive Voice Response (IVR) System 24 hours a day, seven days a week for rapid up-to-date eligibility verification. SHP will verify coverage based on the most current data available from the employer/payer. Retroactive changes could alter the Member's status; therefore, verification of eligibility **is not** a guarantee of payment.

To view eligibility information on-line, sign in to SHP's Provider Connection using www.optimahealth.com. Choose "View Eligibility".

To use the IVR System, call 1-800-229-8822 or 757-552-7474 and press 2 to verify eligibility. There are three options available to search for a Member:

Press 1	To enter SHP Member number
Press 2	To enter Social Security number
Press 3	To enter Medicaid ID number

The IVR provides:

- The SHP Member ID number if a SSN or Medicaid number is used to search for the Member.
- The SHP ID number if the Member is disenrolled
- Member's "eligible as of" or "terminated as of" date when applicable
- Member's Group number
- Primary Care Physician's (PCP) name when applicable

Specific copay or benefit information is available 24 hours a day on www.optimahealth.com or by speaking with a provider service representative during business hours.

6 Credentialing for Facilities and Ancillaries

6.1 Facility and Ancillary Provider Credentialing/Re-Credentialing

All facilities and ancillary providers are expected to hold certification and/or licensure appropriate to the provider type. The credentialing process begins after the provider has notified the assigned Network Educator of their interest in participating with Optima and a determination has been made by Optima that there is a need for the provider to be added to the Network. At a minimum, the Optima Facility Credentialing and Re-Credentialing processes will:

- Be conducted at least every 3 years
- Confirm that the provider is in good standing with state and federal regulatory bodies
- Confirm that the provider has been reviewed and approved by an accrediting body
- Implement standards of participation for any provider that has not been approved by an accrediting body and the process for assuring review of CMS site audit.

Facilities must provide SHP with copies of current accreditation certificates, Medicare certification survey results and state licensures, as applicable to each contracted facility.

As a rule, a facility that does not hold the expected certification may be credentialed only after SHP's Quality Improvement department reviews the Certification Survey letter and copy of CMS-2567 (Statement of Deficiencies and Plan of Correction) issued by the Center for Quality Health Care Services and Consumer Protection within the Virginia Department of Health. If the Certification Survey letter and CMS-2567 indicates no deficiencies were cited, the contract process will continue. If the Certification Survey letter and CMS-2567 indicates deficiencies have been cited, these documents and the home health agencies' action plan of correction will be forwarded to the Quality Improvement Department for clinical review to determine if the action plan of correction is adequate to address the issues identified. Quality Improvement will notify Network Management of their review of the stated action plan in the CMS-2567 form. If Quality Improvement is satisfied with the stated action plan of correction, the contract process will continue with the understanding the home health agency will resolve all cited deficiencies. If Quality Improvement is not satisfied with the stated action plan, the contract process will stop

Any facility that has its Medicare certification suspended due to cited deficiencies must notify SHP immediately.

The specific credentialing requirements for each provider type are as follows:

6.1.1 Hospitals: Prior to contracting with a hospital, Network Management will obtain documentation of JCAHO accreditation and monitor accreditation expiration dates and scheduled surveys. Hospitals are usually required to be JCAHO accredited in order to become a contracted provider. The only exception made for JCAHO accreditation is when a facility is newly opening. If the hospital is initially opening, documentation of patient safety plans and records from any state or federal regulatory body that has

reviewed the hospital must be forwarded to SHP. JCAHO accreditation must be acquired within 3 years to continue the contract with SHP.

6.1.2 Home Health Agencies: SHP will only contract with home health agencies that are accredited by an appropriate accrediting body, i.e. JCAHO, CHAP or ACHC or if not accredited, is a Medicare certified home health agency. Prior to contracting with a home health agency, Network Management will determine whether the agency is in good standing with all regulatory bodies.

6.1.3 Skilled Nursing Facilities and Nursing Home: Prior to contracting with a skilled nursing facility, Network Management will determine if the facility is accredited by JCAHO. If the facility is JCAHO accredited, Network Management will obtain a copy of the current accreditation certificate, indicating the accreditation coverage dates and any scheduled survey dates.

6.1.4 Free Standing Ambulatory Surgery Centers (ASC): Prior to contracting with an ASC, Network Management will determine if the ASC is accredited by JCAHO or AAAHC. If the ASC is JCAHO or AAAHC accredited, Network Management will obtain a copy of the current accreditation certificate, including the expiration date and any scheduled survey dates.

6.1.5 Sleep Studies Centers

All sleep labs must be accredited by the American Academy of Sleep Medicine (AASM) by July 1, 2009.

1. In keeping with the Medicare supervision guidelines referenced in the Independent Diagnostic Testing Facility (IDTF), Publication 100-08 Medicare Program Integrity, 43CFR 410.33 (b)(2), the physician must show evidence of proficiency which may be documented either by certification or criteria established by the carrier for the service area in which the IDTF is located. SHP has elected to use the AASM guidelines and will credential physicians who are board certified or eligible by July 1, 2009. Final certification must be obtained no later than December 31, 2011.
2. In keeping with the AASM guidelines, sleep technicians supervising sleep studies on SHP patients must be certified or enrolled in an approved program by the Board of Registered Polysomnographic Technologists (BRPT) or other pre-approved certification body by July 1, 2009.
3. All sleep labs will comply with Medicare guidelines and criteria as referenced in the Medicare Program Integrity for IDTFs, 43 CFR 410.33.
4. All sleep labs must maintain an appropriate level of patient to technician ratio of 2:1 per the AASM guidelines, effective immediately

Please contact your Network Educator for credentialing requirements for any other type of facility.

7 Clinical Care Services and Medical Care Services

7.1 SHP Clinical Care Services

A number of integrated medical and behavioral health areas comprise Clinical Care Services, facilitating health and clinical services for SHP Members.

Areas within Clinical Care Services are:

- Credentialing
- Quality Improvement
- Health and Preventive Services
- Health Care Services
- Medical Care Services
- Pharmacy Care Services

Information regarding each of the Clinical Care Services areas may be found in specific sections of this guide.

7.1.1. Quality Improvement Program

Purpose

The purpose of the Quality Improvement Program is to provide a foundation for the development of programs and activities directed towards improving the health of our Members. It is designed to implement, monitor, evaluate, and improve processes that are within the scope of SHP. Several committees within the organization work on Quality Improvement (QI) issues. Membership includes SHP staff and participating practitioners and may include representatives from other organizations.

Each year, SHP develops a QI Program and Work Plan that outlines our efforts to improve clinical care and service to our Members. Providers may request a copy of the current QI Program and Work Plan by calling 1-866-425-5257.

NCQA Accreditation

As part of our commitment to quality, SHP voluntarily participates in the accreditation process administered by the National Committee for Quality Assurance (NCQA). NCQA is an independent, non-profit organization whose mission is to improve health care quality.

NCQA evaluates health care in three different ways: through the accreditation process (a rigorous on-site review of key clinical and administrative processes), through the

HEDIS® performance measures, and through a comprehensive Member satisfaction survey.

HEDIS®

Healthcare Effectiveness Data and Information Set (HEDIS®) performance measures are a part of the NCQA accreditation process. The information that is provided by HEDIS® helps employers and customers understand the value and quality of care provided by their health plan. Participating in the HEDIS® process allows the community the ability to evaluate their plan for cost and quality, and for making comparisons among other health plans.

Some of the major areas of performance measured by HEDIS® are:

- Effectiveness of Care
- Access/Availability of Care
- Satisfaction with the Experience of Care
- Health Plan Stability
- Use of Services
- Cost of Care
- Informed Health Care Choices
- Health Plan Descriptive Information

To request a copy of SHP's HEDIS® Performance Measures, request a CD (or hard copy) of our clinical guidelines or ask questions concerning the QI process, please contact the Quality Improvement department at 757-552-7350 or toll free at 1-866-425-5257. Current information on HEDIS® measures, clinical guidelines, well child forms, and preventative health guidelines is available to Providers on line at www.optimahealth.com.

7.2 Clinical Guidelines

Each year, SHP produces a clinical guideline publication that is coordinated with the assistance of local primary and specialty care physicians. These guidelines are based on published national guidelines, literature review, and clinical experience. They offer the most current recommendations in disease management techniques. They are not meant to replace clinical judgment in dealing with individual patient care decisions, but are intended to facilitate a collaborative approach between primary care physicians and consultants in the management of patient care. Clinical Guidelines are available to providers [at www.optimahealth.com](http://www.optimahealth.com) under Provider Resources and on CD.

Continuity and Coordination of Care

SHP strives to ensure that all Members receive the highest quality of care and utilizes systematic methods of detecting problems specific to continuity and coordination of care. Ongoing collaboration between primary care physicians and specialists, as well as

between primary care physicians and other types of providers promotes a continuous plan of care that benefits the Member. Other types of providers include hospitals, home health agencies, skilled nursing facilities, nursing homes, and ambulatory surgical centers. A release of information from the Member is required for a behavioral health practitioner to communicate with the PCP regarding behavioral health treatment.

It is Optima's policy to monitor and identify potential problems with continuity and coordination of care for all of our Members. Information on continuity and coordination of care will be collected at the time of the HEDIS® chart reviews. Optima also monitors continuity and coordination through transitions in care (changes in management of care between practitioners, changes in settings or other changes in which different practitioners become active or inactive in providing ongoing care for a patient).

When a provider terminates, a Member in an active course of treatment or who requests services from that provider (if the provider continues to accept SHP reimbursement) may continue to receive services from that provider for 90 days unless the provider was terminated for cause. Pregnant women in the second trimester may continue treatment through postpartum care (6 weeks after delivery). Terminally ill Members may continue to receive services directly related to the treatment of the terminal illness for the remainder of his/her life.

7.3 Medical Record Documentation Guidelines

These guidelines are available to Providers on www.optimahealth.com.

7.4 Medical Record Policies

Participating providers must treat all communications and records pertaining to the Member's health care as confidential and no records may be released without the written consent of the Member or as otherwise permitted by state or federal law. In the case of an un-emancipated minor, the release of information requires the authorization of the legal guardian. The Code of Virginia requires a health care provider to accept a photocopy, facsimile, or other copy of the original document signed by the patient providing authority for the requester to obtain the records, as if the copy were an original document.

Participating providers must obtain a separate Release of Information, or waiver, from those Members with certain conditions, such as sexually transmitted diseases.

7.4.1 Charging for Copies of Records:

- Providers may charge Members for copies of X-rays, microfilm or other micrographic process at rates not to exceed those delineated in applicable law. In addition, providers may charge postage or shipping costs and a handling fee not to exceed ten (10) dollars.
- Providers **may not** charge SHP for copies of medical records or for the completion of forms.

7.5 Advance Directives

Every competent adult and emancipated minor has the right to execute an Advance Directive. As detailed below, state and federal regulations require that patient medical records must document whether or not a patient has executed an advance directive.

- The federal Patient Self-Determination Act requires that “a provider of services” must document in the individual’s medical record whether or not the individual has executed an advance directive. The Virginia Health Care Decisions Act states “It shall be the responsibility of the declarant to provide for notification to his attending physician that an advance directive has been made. In the event the declarant is comatose, incapacitated or otherwise mentally or physically incapable of communication, any other person may notify the physician of the existence of an advance directive. An attending physician who is so notified shall promptly make the advance directive or a copy of the advance directive, if written, or the fact of the advance directive, if oral, a part of the declarant's medical records.” Participating providers must demonstrate compliance with all applicable state and federal laws and regulations.
- SHP may participate in programs to educate the community regarding patients’ rights to make health care decisions and to execute advance directives. The Customer Operations department will provide information regarding advance directives to Members upon enrollment and re-enrollment via the Member Guide and will provide additional information and forms upon request. Network Management conducts provider staff education on advance directives during provider orientations along with regular updates and reminders. Copies of Advance Directive forms are available at SHP’s Provider Web site: www.optimahealth.com under Provider “Forms and Documents”. Quality Improvement audits physician compliance with this policy in regular medical record reviews and communicates findings as part of the re-credentialing process.

7.6 Member Access Procedures and Member Resources

7.6.1 Member Health Care Encounter Procedure

- In an emergency situation, treatment should proceed without question of eligibility or coverage. Eligibility verification can be obtained as soon as appropriate after treatment.
- In non-emergent situations, Members should present their I.D. Card and another form of identity verification (e.g. driver’s license).
- Patient registration staff should check the card for eligibility and benefits
- Providers should confirm that an authorization has been received if necessary. For plans that require referrals, providers should confirm that a referral has been received from the PCP.

- Providers' staff may access Provider Connection at www.optimahealth.com anytime or call Provider Relations at 1-800-229-8822 or 757-552-7474 during business hours for verification if a Member's status is in question.

7.6.2 Member's Rights and Responsibilities

Policy Statement

The Member Bill of Rights and Responsibilities assures that all Members are treated in a manner consistent with SHP's mission, goals and objectives and assures that Members are aware of their obligations and responsibilities upon joining SHP and throughout their membership with SHP:

Members Have the Right:

- To be treated in a manner reflecting respect for his/her privacy and dignity as a person
- To be informed regarding his/her diagnosis, treatment and prognosis in terms he/she can reasonably be expected to understand
- To receive sufficient information to enable him/her to give informed consent prior to the initiation of any procedure and/or treatment
- To participate with practitioners in decision making and to refuse treatment to the extent permitted by law, and to be made aware of the potential medical consequences of such action
- To a candid discussion of appropriate or medically necessary treatment options for his/her conditions, regardless of cost or benefit coverage
- To expect that all communications and records pertaining to his/her health care will be treated as confidential. Any data shared with employers is not Member identifiable unless specific consent has been obtained. No records will be released without his/her written authorization to protect access to his/her medical information. In the case of a minor, release of information is allowed only by the authorization of the legal guardian or court order.
- To select his/her own primary care physicians and to expect the physician to provide or arrange for, and coordinate, all care the Member requires
- To express a complaint or appeal about SHP or the care provided and to expect a response to that complaint or appeal within a reasonable period of time
- To reasonable access to necessary medical services
- To be informed of SHP's policies and procedures regarding services, benefits, practitioners and providers, and Member rights and responsibilities, and to be notified of any significant changes in those policies and procedures
- To discuss his/her medical record with the physician, and to receive upon request a summary copy of that record (at a nominal charge) as required under State Law. SHP's staff can only release records with the Member/patient's physician's approval and signed consent
- To obtain from SHP a certificate of credible coverage that shows prior, continuous coverage. With this certificate, the Member may be able to receive coverage under

the next health plan with either no waiting period for pre-existing conditions or a reduced waiting period

- To make recommendations regarding Member rights and responsibilities

Members Have the Responsibility

- To present their SHP identification card and another valid form of identification when presenting for care (not required in the event of emergency care)
- To work with the primary care physician to help establish the proper patient/physician relationship
- To schedule appointments and arrive on time for those appointments, or notify the primary care physician's office if the Member must cancel or come late for a scheduled appointment. Charges for missed appointments are not covered by SHP
- To meet the financial obligations regarding Member premiums and co-pays when services are rendered
- To ask any questions and understand the answers about the illness and/or treatment
- To obtain prior authorization from the primary care physician before seeking consultation or other medical services, except in potentially life-threatening situations
- To obtain and carefully consider all information necessary to give informed consent for a procedure or treatment
- To weigh the potential consequences of any refusal to comply with physician instructions or recommendations
- To be courteous, considerate and cooperative in dealing with the PCP's, his/her office staffs and employees of SHP, and to respect the rights of fellow SHP Members
- To express opinions, concerns or complaints in a constructive manner to avoid similar problems in the future
- To read and be aware of all material distributed by SHP explaining policies and procedures regarding services and benefits, and to follow those policies and procedures when receiving care
- To the extent possible, provide SHP and providers with complete and accurate information necessary to care for the Member, and for the Member's medical record and SHP membership records. This includes notifying SHP of any changes in status such as phone number, address, and number of dependents (e.g. birth, marriage, divorce, etc.) and information regarding other health insurance coverage for coordination of benefit purposes. Optima Family Care Members should also notify the Department of Social Services of any status changes. FAMIS Members should notify the FAMIS Central Processing Unit (CPU) at 1-866-87FAMIS
- To assist SHP in compiling a complete medical record by providing or by authorizing SHP to obtain necessary medical information. It is the Member's ultimate responsibility to furnish SHP with any medical records needed to process a complaint, grievance or appeal of a denied claim when SHP has been unable to obtain this information
- To follow the plans and instructions for care that they have agreed upon with his/her practitioners

7.6.3. Special Needs Members

SHP and Optima Behavioral Health Services (OBHS) will use all reasonable means to facilitate health care services for Members with physical, mental, language and cultural barriers. To ensure the needs of Members with physical, mental, language, and/or cultural barriers are properly accommodated; Members with special needs should be instructed to call Member Services at the number on the back of their ID card. In the event that a Member Services representative needs assistance in accommodating the Member, the representative may contact Medical Care Services (MCS) or Optima Behavioral Health Services (OBHS) for additional resources and assistance.

For the purposes of communications with hearing impaired Members or those Members who speak little English or are non-English speaking, SHP and OBHS utilize various resources, including a TTY (also referred to as TDD) phone line at 1-800-225-7784 or 757-552-7120, as well as the AT&T Language Bank for foreign language interpretations.

The TDD phone line is available for Members Monday through Friday, 8:00 a.m. through 7:00 p.m. for incoming calls, and is answered by Customer Operations staff. This number is published in the Member materials and assists the Members in contracting SHP for questions regarding their health plan benefits, eligibility, claims, mental health services, or any other questions/information related to their health plan benefit coverage.

The Americans with Disability Act requires providers to make auxiliary aids (e.g. TTY phone), sign language and foreign interpreter services available to Members who request them, and to SHP employees who provide services to Members. Members will be notified of such services via Member materials (Member/Enrollment Guides). Pre-authorization is required.

Members who require special services (e.g. substance abuse, childbirth classes, smoking cessation) may have these services arranged by SHP to ensure access to such services.

Optima Family Care Members that have been identified as hearing impaired and who speak limited or no English and who require interpreter services may have these services arranged by SHP, as directed by the DMAS contract.

Members covered under all other plans (HMO and PPO/POS products) may be provided assistance with the coordination of interpreter services; however, all charges for interpreter services will be the responsibility of the provider as directed by the Americans with Disabilities Act (ADA).

7.6.4. Resources for Sign Language/TTY Services and Language Interpreters

The resources listed below may be utilized for the purposes of communication with and assisting Member that are hearing impaired or non-English speaking or with limited English:

Hearing Impaired:

Virginia Department for the Deaf and Hard of Hearing

www.vddhh.org

Voice/TTY- 804-662-9502

Voice/TTY- 1-800-522-7917

Virginia Relay

www.varelay.org

Voice- 1-800-828-1140

TTY- 1-800-828-1120

Foreign Language:

AT&T Language Line

www.LanguageLine.com

1-800-874-9426

American Red Cross- Richmond Chapter

Language Bank

www.greaterrichmond.redcross.org

804-780-2250

Serves Richmond City, Henrico, Chesterfield, Hanover, Goochland, and Powhatan counties.

American Red Cross- York/Poquoson Chapter

www.york-poquoson.redcross.org

757-898-3090

Serves Peninsula areas

7.7. SHP Health and Preventative Services

SHP's Health and Preventive Services is dedicated to improving the health and preventing disease of individuals and populations. The scope of the department encompasses health plan Members, providers, employer groups, Sentara employees and our health improvement community partnerships. You may contact Health and Preventive Services on-line at www.optimahealth.com or at 1-757-687-6000 to request information and to register for classes.

- **Health and Preventive Services** by SHP offers health improvement programs for all Members which include health risk identification and risk reduction strategies.
- Members may complete a personal health profile and afterwards, they will receive a detailed report with specific risk reduction strategy recommendations.
- Diabetic, asthmatic and pregnant health plan Members are referred to our clinical care services teams.

- Health and Preventive Services uses a structured health risk reduction program that begins with health risk identification. HPS contacts identified high-risk Members directly. The follow-up program is designed to assist Members in reducing identified health risks, assuming responsibility for their health and achieving their optimal personal health. In all communications with health plan Members, Health Educators encourage the Member to maintain their recommended preventive health schedule, to communicate with their physicians and to follow their physician's advice.

Health Wise Self-Care: Health and Preventive Services promotes self-care. Both health plan Members and physicians may request a copy of the self-care guide.

Health Risk Reduction Programs: A number of Health Risk Reduction classes and programs are available free of charge to health plan Members on a regular basis throughout the year. A current list of programs is available at www.optimahealth.com. In addition, on-site individual programs are offered for 15 or more patients or for physician office staff.

Resources

Health and Preventive Services maintains a comprehensive library of prevention literature and information about community resources for patient education and is a resource for participating Optima providers. Please contact the department for specific preventive health educational needs.

All health risk information and interventions are electronically managed within the department using custom-designed risk reduction programs. Upon request the staff is happy to share their expertise and to provide instruction about targeted risk reduction interventions, our electronic management of population health risks, childhood and adult immunization and health improvement programs.

Communications

Health and Preventive Services participates with the SHP Physician Advisory Committee to obtain essential feedback about preventive health practices and recommendations for innovations or revisions in existing services to better meet the needs of health plan Members.

Health and Preventive Services contributes news and current preventive health initiatives for the provider newsletter, SHP Network News and other Sentara Publications.

Community Health Partnerships

Community health improvement partnerships and coalitions contribute to the success of our population preventive health strategies. Departmental representatives are active in city, regional and state community health improvement organizations including the

Access Partnership, Consortium for Infant and Child Health, Project Immunize Virginia, Virginia Business Coalition on Health, American Red Cross, American Lung Association and the American Heart Association.

Awards

SHP has won awards from the Disease Management Association of America (DMAA) for the LifeCoach Diabetes and Partners in Pregnancy programs and from the Environmental Protection Agency for asthma management in people's homes.

7.8 Health Care Services

Health Care Services Teams are comprised of clinical professional staff, behavioral health clinicians, and non-clinical staff. These teams are integrated around populations of Members in specified managed care products. This allows for a complete plan of care for the patient encompassing case management, behavioral health and disease management services.

Referrals for SHP's Health Care Services (written or verbal) may be made by:

- A. Provider
- B. Member (self referral)
- C. SHP

To refer Members for Health Care Services you may call provider relations and be referred to the appropriate team. For OB Management Services, Providers may contact Partners in Pregnancy directly at 1-866-239-0618.

Types of issues which may be referred to Health Care Services:

- Complex medical issues and multiple services
- Non-compliance with treatment plans
- Frequently utilizes services without consulting PCP or Specialist
- Frequent ER use
- Disease management such as metabolic cardiovascular diseases, respiratory disease (asthma/COPD), obesity

Members are assigned to the Health Care Services Teams based on their individual medical/behavioral needs and the type of group coverage. The following levels of service are assigned along with goals and outcomes:

- Care Coordination
- Case Management
- Complex Case Management

7.9 Medical Care Services

A core function of Medical Care Services is its responsibility for administering SHP's Utilization Management programs to determine whether planned medical services are medically necessary and to ensure that such services are provided in the most appropriate setting.

7.9.1. Medical Care Policies/Criteria

Medical Care Policies are used to determine medical necessity. Medical Care Management develops policies using the following:

- Review of Milliman Care Guidelines
- HAYES Medical Technology Directory
- Specialty journals, medical/professional journals, Pub-Med, research studies/outcomes articles
- Government regulations, requirement
- Assistance of appropriate network providers/specialists
- Benefits Committee Review
- Computer medical search

The Medical Directors of SHP review Medical Care Services Policies. Approved policies are distributed to all appropriate departments and all policies are available to physicians upon request. For copies of policies and criteria, please call Medical Care Services at 1-800-229-5522 (toll free) or 757-552-7285 SHP does not offer its staff incentives based on authorizations or denials.

7.9.2. Pre-authorization requirements by product

Under an HMO product or the managed care level of benefits under a POS product, pre-authorized services are those which require the provider to seek approval from Medical Care Services (MCS). MCS evaluates the service for medical necessity. Failure to pre-authorize services may result in the denial of payment and the provider may be held responsible for the services.

Under the Medicare PPO product, there are limited pre-authorization requirements. The Member is responsible for ensuring out of network authorization, if needed, and the provider must notify SHP of an inpatient service within 48 hours of the admission.

7.9.3 Pre-authorization Forms

Because the pre-authorization process to establish medical necessity requires a working clinical knowledge and Member medical history, SHP has designed specific authorization

forms for a variety of services that require pre-authorization. Access to a complete and current listing of those forms and the ability to download them can be found at www.optimahealth.com. Providers may submit completed pre-authorization forms and any necessary supporting documentation to the fax number indicated on the form.

Please note on the form if the authorization requires expedited review and meets the following definition for an expedited review:

Failure of an immediate review would result in loss of life or limb or result in permanent injury

In the event that SHP nurse reviewers require additional clinical information or clarification with regard to information submitted with regard to the Member, they will call providers directly.

Elective admissions/requests must be submitted for pre-authorization ten (10) days prior to scheduling an admission or procedure(s) to ensure clinical reviews and authorizations are complete. Treatment at non-participating facilities must receive pre-authorization from SHP.

7.9.4 Medical Care Service Availability

Medical Care Service personnel are available by telephone: 1-800-229-5522 (toll free) or 757-552-7540 during normal working hours (8:00 a.m. to 4:30 p.m., Monday through Friday). **At other times, you may leave all pertinent medical/admission information and Member information for pre-authorization on the confidential answering machine. The number is 1-800-229-5522 Option 3 or (local) 757-552-7540, Option 3. Please make sure to leave all pertinent information with a return call number when requesting pre-authorization.**

SHP Medical Care Services (MCS) fax numbers:

1-877-800-2839 (toll free)
757-552-7429

Provider staff should provide the following information when pre-authorizing a Member by form or by telephone:

- Attending physician's name
- Patient's name and ID number
- Name of admitting hospital
- Date of planned admission
- Admitting diagnosis, reason for admission/procedures and any applicable codes
- Procedures to be performed and date
- Proposed treatment plan and prior treatment[s] attempted and/or completed
- Summary of test results (if applicable)

The Medical Care Service staff will assess:

- Medical necessity for requested procedure
- Appropriate level of care
- Appropriateness of treatment

See the list below for all services which require pre-authorization by SHP.

7.9.5 Procedures Requiring Pre-Authorization

Pre-authorization only determines medical necessity. It does not determine the level of payment or coverage and therefore does not guarantee payment. Payment decisions are also based on eligibility for services on the procedure date and benefits provided through the Member's health plan. Pre-authorization may, at the sole discretion of SHP, be required for:

- All inpatient hospitalizations, including transfers between hospitals
- Notification for hospital admissions (under the Optima Health Medicare PPO).
- All outpatient surgeries/short stays/observations and IV Therapy and drug infusions.
- All skilled nursing facility admissions
- All acute rehabilitation services.
- Elective treatment at non-participating facilities must receive a pre-authorization from the SHP prior to the service being scheduled. Failure to have the service pre-authorized may result in non-payment
- Foreign language interpreter services

All of the following services require pre-authorization regardless of the place of service:

- Durable Medical Equipment (DME) - all rental, all repairs/replacement, and single items over \$750.00. Some Plans may require pre-authorization on single items over \$250.00. Please check to ensure benefit level.
- Repairs to DME/Prosthetic equipment (including the Optima Health Medicare PPO, see below).
- Home Health/Hospice/IV infusions (including the Optima Health Medicare PPO, see below).
- Orthotics/Prosthetics - all rental, all repairs/replacement, and single items over \$750.00. Some Plans may require pre-authorization on single items over \$250.00. Please check to ensure benefit level.
- Plastic Surgery
- Ambulance Transportation (Non-emergent)
- All Rehabilitation programs (cardiac, vascular, vestibular, pulmonary, etc).
- Therapies (PT, OT, ST)
- Early Intervention Services

- OB Certification
- Transplant Services
- Oral Surgery and Related Services
- PET, CT, CTA, MRI, MRA, MR-CT
- Interventional radiology
- Hyperbaric Therapy
- Electronic Bone Stimulator
- Sleep Studies
- Any surgical or diagnostic procedure for which anesthesiology or conscious sedation is billed.
- Injectable Drugs, including but not limited to Synvisc/Hyalgen, Synagis, Rabies, Remicaid & IVIG (refer to www.optimahealth.com for a complete listing)
- Genetic Testing (If covered by group)

7.9.6 Medicare PPO does require prior authorization for the following services:

- DME items over \$750
- Motorized scooters
- Customized orthotic or prosthetics over \$250
- Home Health Services
- PET, CT, CTA, MRI, MRA, MR-CT (Effective 1/1/08)

7.9.7 Pre-authorization is NOT required for the following:

- Blood Transfusions
- Colonoscopy (screening, diagnostic, and surgical)
- EMG
- EEG
- Echocardiogram
- EKGs
- PVL
- X-rays
- Lab Tests
- Bone Density Studies (Bone Densitometry), (A pre-authorization is needed if it is performed more than once in 24 months.
- Gallium Scans
- Mammograms
- Spinal Tap
- Routine GYN Exam
- DME or prosthetic items costing less than the group's minimum dollar threshold per single item, and the rendering provider is a contracted DME provider
 - **NOTE: *The minimum dollar threshold varies by group. Please verify benefit with SHP.***
- Emergency/UCC Care

7.9.8. Behavioral Health Services Pre-authorization Requirement

OBHS manages a variety of plans. Some plans offer an out-of-network benefit or allow direct practitioner access. Most plans do not require pre-authorization for payment before services are rendered. Some plans require pre-authorization for certain outpatient services and some plans have mandatory EAP. OBHS Customer Service is available to verify benefits at 1-800-648-8420.

7.9.9 Utilization Management

7.9.9.1 Pre-Service Review

Any service requiring elective pre-authorization needs to be submitted as soon as possible, or at least 10 days prior to scheduling procedure. Nurse Reviewers need to have documentation clearly demonstrating the Member's need for a procedure, including documentation of medical necessity and failed treatments. This time frame enables the Nurse Reviewers and Medical Directors to review all submitted documentation, request other information or test results to make authorization determinations. These elective decisions will be rendered within 15 days from receipt of all requested information. Emergency requests due to potentially life altering situations will be done within 72 hours.

7.9.9.2 Admission Review

Health Care Services Hospital-review case managers conduct admission reviews within one working day of the patient's admission. If, at the time of review, there is no record of a pre-admission certification request, SHP will determine if the admission was medically necessary. If the admission was medically necessary, SHP will pay the claim for PPO/POS products, only. Members failing to obtain pre-authorizations within 48 hours may be subject to a \$500.00 penalty or may be denied payment. Hospitals must report all admissions to SHP within 24 hours. Failure to do so may result in denial of payment to the hospital.

7.9.9.3 Post – Service/Retrospective Review

Any service or admission that was not authorized (or for the SHP Medicare PPO, prior notification was not received) may be retrospectively reviewed. Reviews and decisions will be completed within 30 working days of receipt of all requested information.

7.9.9.4 Concurrent Review

Concurrent or continued stay review is performed on a daily basis (Monday-Friday) on all hospitalized patients by Hospital-review Case Managers (RNs). Hospital case managers do telephonic review and/or do chart reviews via fax to determine whether the hospitalization remains appropriate or whether it should be modified given significant

changes in the patient's condition. If continued hospitalization is uncertain, the Medical Director may discuss the case with the attending physician (peer to peer).

7.9.9.5. Adverse Decision/Denial for Payment

When a denial for payment is issued by the health plan, both you and your patient will receive written notification that includes an explanation of the medical or benefits decision and information on the appeal process. In the event that you would like to have the request reconsidered, Medical Directors are available to discuss the criteria the decision was based on to determine medical appropriateness. Medical Care Services can be contacted at 1-800-229-5522 (toll free) or 757-552-7285.

7.9.9.6 Inpatient Denials

If the attending physician continues to hospitalize a Member who does not meet the medical necessity criteria, all claims for the hospital from that day forward will be denied for payment. The claim will be denied "services not pre-authorized, provider responsible (D26)". The Member cannot be billed.

If the Member remains hospitalized solely because a test ordered by the attending physician is not performed because of hospital related problems (such as scheduling and pre-testing errors), then all claims from that day forward for the hospital will be denied. The claim will be denied "services not pre-authorized, provider responsible (D26)". The Member cannot be billed.

If the family member insists on continued hospitalization (even though both the attending physician and SHP agree that the hospitalization is no longer medically necessary), the claims related to the additional days will be denied. The claims will be denied "continued stay not authorized, Member responsible".

For all medically unnecessary dates of service, both the provider and Member will receive a letter of denial of payment from SHP. The letter will note which dates of service are to be denied, which claims are affected (hospital and/or attending physician), and the responsibility for the charges.

8. Claims

8.1 General Information and Filing Requirements

- The preferred method for claim submission to SHP is electronic claim submission. Claims can be submitted through the clearinghouse, PayerPath, or can be submitted directly by a provider or vendor. For details, see section 9, below.
- All claims must be submitted within the guidelines of the product (see the “Timely Filing” section 8.12, below) or they will be denied as a late claim submission.
- Claims submitted must be for participating providers within the practice.
- Submit paper claims on standard UB (facilities) or CMS 1500 (professional providers) forms
- **All** claims **must** be “clean claims” (as defined by the Virginia Ethics and Fairness in Carrier Business Practice Act) in order to be eligible for reimbursement.
- **A “clean” claim will be processed and paid by SHP within 40 days of its receipt. Processing delays may occur for claims that require additional or clarifying information, coordination of benefits, referral, code review or medical review**

8.2 National Provider Identifier (NPI)

All claims submitted to SHP on and after May 1, 2008 must include individual and group NPI numbers. Claims received after this date without an NPI number will be rejected or denied. Multi specialty providers must include both individual and group NPI numbers and taxonomy code. Optima Family Care providers are also required to register their NPI number with DMAS.

8.3. Inpatient Coding

Providers must use procedure and diagnosis codes from the most current International Classification of Diseases manuals.

Please refer to the most current version of the Uniform Bill Editor for a complete and current listing of Revenue Codes, Bill Type, and other facility claims requirements.

8.4 Outpatient Coding

8.4.1 Current Procedure Terminology (CPT) Procedure Codes

CPT codes may be required in addition to revenue codes as specified by CMS or elsewhere in this guide. A listing of CPT procedure code ranges and their descriptions can be obtained from the most current AMA CPT Codebook.

Codes deleted from the prior year will be accepted until March 31 of the following year

8.4.2 HCPCS Procedure Codes

Level II HCPCS codes are informally known by their section code classification (A codes, B codes, etc.). A listing of Level II HCPCS codes and their descriptions can be found in the most current HCPCS book.

Level III HCPC codes may or may not be accepted. Please address any questions to your Network Educator.

Codes deleted from the prior year will be accepted until March 31 of the following year

8.4.3. Modifiers

Modifiers are used on CMS claim formats. They are not used on UB claim formats. A modifier allows the reporting provider to indicate that a service or procedure has been altered by some specific circumstance but not changed in its definition or codes. The use of modifiers lessens the need for a separate procedure listing that may describe the modifying circumstance.

CPT and national modifiers apply to both CPT and HCPCS Level II coding systems. If the alteration specified by a particular modifier is not immediately clear on the claim, providers may need to submit substantiating documentation in order for the claim to be paid. A current listing of CPT and HCPCS modifiers may be found in the AMA's CPT reference for the current year.

8.5. Specific UB Claims Information

8.5.1. Revenue Codes

Revenue codes are limited to three (3) numbers. Revenue codes are not a guarantee that the service is covered. Covered benefits/services are detailed in the group or individual contract with SHP.

- List revenue codes on the bill in ascending numeric order.
- Revenue codes must be valid for the Type of Bill.
- SHP contracts require CPT or HCPCS codes to be billed in conjunction with all ambulatory surgery and outpatient services.

8.5.2. Diagnoses. The principal diagnosis is the condition established after study to be chiefly responsible for causing the hospitalization or use of other hospital services. ICD-9 codes are required for inpatient and outpatient claims. Additionally, each inpatient diagnosis code must report a "Y" or "N" in the contiguous field to report whether symptoms warranting the diagnosis were present on admission ("Y") or not ("N").

8.5.3. Bill Type A Bill Type is a three-digit code that indicate the type of facility at which care was provided (in the first digit), the type of care provided (in the second digit)

and the frequency of the bill (in the third digit). Bill type is particularly important when submitting an interim bill, or a replacement/resubmission bill, since bill type is a key indicator in determining whether the claim has already been submitted and processed. Please refer to the most current Uniform Bill Editor for specific information. See also section 8.18, below.

8.6 The CMS 1500 Claim Form

SHP utilizes the most current version of the CMS 1500 claim form or its electronic equivalent. Freestanding ancillary providers, except for freestanding dialysis centers, may use this claims format.

Listed below are some of the fields that cause most frequent payment delays:

- Complete all patient identifying information in boxes 1-11. The **Member's ID and group number** should be placed in **boxes 1a and 11**.
- The Member name submitted on the claim must match the Member name on the Member ID card.
- In box 12, either the patient's signature or the words "signature on file" are required.
- ICD-9 diagnosis codes are required on all claims or the claim will be denied for invalid diagnosis code and must be resubmitted for reconsideration within 365 days of receipt of denial on remittance.
- For unlisted or miscellaneous procedure codes (codes ending in 99), an English description of services or complete list of supplies, at a minimum, must be provided.

8.7 Remittance Advice

A Remit is an explanation of reimbursement. The Remittance Advice details claim adjudication. Remittance advices may be downloaded from www.optimahealth.com.

8.8 Negative Vendor Status

This term is used for information purposes on claims that are paid to vendors with negative balances. Vendors can enter a negative status when retractions are greater than positive payments. Retractions are done to correct overpayments. An example of a common overpayment issue is if SHP paid a claim as the Member's primary carrier, but should have paid as secondary. Reversing the claim to pay as secondary could create a negative balance if the dollar amount for other claims being paid would not cover the reversal. The provider would then be in a Negative Vendor status and receive no additional payments until new claims are approved for payment or a refund is received at SHP.

8.9 Interim Reports

When providers enter a Negative Vendor status, they begin receiving a Negative Vendor Interim Statement rather than a check and a remit. The Negative Vendor Interim Statement reports all claims received and processed to that vendor's account for that month. It is to be used for information purposes only and should not be used for posting. When enough claims have been received to balance out the negative amount, or the provider refund check has been received, the provider will receive a remit. Claim payments will resume.

8.10 Pending Claims

If a claim needs to be reviewed by claims processing or clinical staff it will be assigned a "suspend" code. The "suspend" code states the reason for the suspension. The pending claims report is sent with remittance statements. Suspend code descriptions appear at the end of the report.

If a claim has been on your pending report for more than 40 days from the date of the report, call Provider Relations at 1-800-229-8822 (toll free) or 757-552-7474 to resolve its status.

If your claim has not been paid or denied, and is not pending for any reason, please call Provider Relations at 1-800-229-8822 (toll free) or 757-552-7474 for follow-up information. If the claim is confirmed as not received, a second request must be submitted. If the claim has past the 365 day timely filing deadline, documentation of the original claim submission is required with the second request.

8.11 Authorization/Referral Search

The Authorization/Referral Search Program matches newly received referrals or authorizations to pending claims. This program finds referrals or authorizations entered after claims are pended. The program also checks for additional suspension reasons such as medical review or COB. If none are found, the claims are released.

8.12. Timely Filing Policy

The filing deadline for all Commercial plans and Optima Family Care is **365 days** from the date of service. Medicare PPO timely filing requirements follow Medicare timely filing guidelines.

Any claim submitted more than 365 days from the date of service will be denied as a Late Claim submission unless documentation supporting an acceptable reason for the delay or proof of timely filing is included. Acceptable reasons for delayed filing include coordination of benefits with a primary carrier or inaccurate carrier information provided by the patient.

8.13 Late Claim Appeals

Requests for waivers to the timely filing requirements must be made in writing within the reconsideration filing deadlines and should be submitted to the following address:

Claims Process Manager
SHP Claims Department
4417 Corporation Lane
Virginia Beach, VA 23462

In situations where a provider does not agree with the reconsideration decision on a claim, or would like to request an exception be made to a claims policy due to an exceptional circumstance, an appeal should be filed with the Claims Process Manager at the Corporation Lane address above. For more detailed information, please see the “**Section 14 Appeals**, below.

8.14 Changes in Insurance Information

If a provider receives corrected insurance information from the Member and provides supporting documentation (for example, original dated registration, new registration, etc.) the provider may submit a claim to SHP within **90 days** of receipt of the new information.

8.15 Retroactive Disenrollment

SHP will use reasonable efforts to determine in a timely manner that a Member has been disenrolled. Should an employer group retroactively disenroll one of its members; SHP will retract claim payments for that Member made for dates of service falling after the effective date of the Member’s disenrollment. The provider will be given **30 days** notice prior to the retraction of the claim. In no event will SHP retract claim payments made for services that occurred more than **365 days** from the date of the retraction.

8.16 Claims Denied in Error

Providers must follow-up with SHP within **365 days** of the date of service for claims the provider suspects have been denied in error. If after researching the claim, SHP discovers that the claim was denied in error, the provider is entitled to payment.

8.17 Worker’s Compensation

Any claim with an injury diagnosis code for a patient over the age of 16 will be suspended while SHP communicates with the Member to determine if the injury is work-related. We will automatically send a letter to the Member requesting information about the injury. The Member has **30 days** to respond to the request for information. If no

response is received, the claim will be denied. You may collect full payment directly from the Member.

If a claim is paid under an SHP benefit plan prior to determining that it is a Workers' Compensation claim, SHP will reverse the payment. The claim should be submitted through the employer's Workers' Compensation plan.

8.18 Duplicate Claims, Denials, and Reconsiderations

Any requests for reconsideration for claims that have been denied must be filed within 365 days of the date of service.

8.18.1 Duplicate Claims

Duplicate claim submission is one of the biggest obstacles encountered during the claims process. If you are unsure whether or not a claim has been filed, please call Provider Relations at 1-800-229-8822 (toll free) or 757-552-7474 to inquire on the status of your claim. SHP checks for duplicate claims by comparing the Member number, vendor number, the date of service, procedure code and total charges of the current claim to claims that are stored in the Member's history. Some service lines may be paid and other service lines denied as duplicates or the entire claim may be denied as a duplicate.

A "new claim" is a first submission by the provider. It has not been previously billed or processed and does not reference another claim.

A "re-billed" or "corrected claim" (also known as a "request for reconsideration"), is a claim being resubmitted by the provider for the same patient, date of service and/or procedures. *Please see the Reconsiderations immediately below, for detailed information.*

8.18.2. Reconsiderations

A "new claim" is a first submission by the provider. It has not been previously billed or processed and does not reference another claim.

A "re-billed" or "corrected claim" (also known as a "request for reconsideration"), is a claim being resubmitted by the provider for the same patient, date of service and/or procedures. The "re-bill" or "corrected claim" or a "request for reconsideration" may have:

- A different CPT code
- A description previously lacking with a miscellaneous code
- A copy of a required referral attached
- Medical records or operative notes attached
- Late charges, or other amended information

The provider should reference the original claim number **and note “recon” or “reconsideration” on the claim form in block 19 of the CMS 1500 form or block 2 of the CURRENT UB form. Those using the UB04 should use block 80/remarks field to note that the claim is a reconsideration.** A resubmitted claim may be mistaken as a duplicate claim if the information is not properly noted.

Providers will receive a remittance advice indicating that the denial will be upheld when reconsiderations are submitted without complete information. If the provider is not satisfied with the initial reconsideration outcome, an appeal may be requested.

A “Request for Reconsideration” is required prior to initiation of the appeals process.

Medicare PPO claims reconsiderations should be submitted as completely new claims following Medicare guidelines

The process for electronic submission of a claims reconsideration request can be found in Section 9, below.

8.18.3 Reconsideration of a Payment or Denial Policy

Requests for claims reconsideration should include the claim document number or copy of the remit and any missing information which resulted in the original denial (for example, corrected CPT code, corrected diagnosis, operative notes, treatment sheet, etc.) or detailed information concerning the request. Refer to sections 18.8, Reconsideration and Section 14 Appeals for more detailed information, and to Section 9 “Electronic Claims” for reconsiderations or second requests which may be sent electronically.

8.19 Payment Retractions for Retroactive Denial of Previously Paid Claims

Consistent with the requirements of the Virginia Fair Business Practices Act (FBPA), SHP will notify providers at least 30 days in advance of the retroactive denial and resulting payment retraction of any previously paid claim. Notice of the pending denial and payment retraction will be sent to a provider via a specific report detailing the pending action. The report will include the reason for the retroactive denial. At the end of the 30-day notice period the pending denial/payment retraction will be processed. The complete denial and payment retraction will be detailed on the remittance advice.

8.20 Interest on Delayed Payments

SHP pays interest on clean HMO and Medicare PPO claims after 30 days from the date of receipt, and on clean POS or PPO claims after 15 days from the date of receipt. However, if the claim is not “clean”, meaning that the claim requires additional information before it can be processed, any interest payment would be calculated from

the date of receipt of the information required. The interest rate is determined by the Commonwealth of Virginia and is updated semi-annually. These payments will show on remits.

8.21 Subrogation

In Virginia for fully insured products, subrogation is not permitted. In the event of an accident in which a third party is responsible for the damage, the Member must be treated as if his/her only insurance is an SHP product. SHP or the physician acting on SHP's behalf **may not** collect any damages collected from a third party. If another party pays, the money **must** be returned to the patient. SHP and the physician may coordinate benefits with another health insurance plan.

9. Electronic Claims and Reconsiderations

Participating Providers who use SHP's electronic claims program enjoy a number of benefits: documentation of claims transmission, faster reimbursement, fewer claims suspensions and lower administrative costs. When providers file claims electronically and directly to SHP, there is NO PER CLAIM CHARGE. You may also choose to submit through a clearinghouse in which case claims submission cost will be determined by your contract with the clearinghouse. Please refer to www.optimahealth.com for specific requirements for electronic claims submission.

9.1 Setting up Electronic Claims Submission

If you wish to implement electronic claims processing, directly to SHP, you may e-mail EDITTEAM@sentara.com. You may call Provider Relations at (757) 552-7474 or 1-800-229-8822 for information on clearinghouses that are set up to submit claims to SHP, or you can ask your clearinghouse or software vendor.

9.2 Filing Claims Electronically

- Claims submitted electronically must be for participating providers.
- All claims must be submitted within the Timely Filing Policy provisions stated in your contract or as indicated by SHP policy. Please see the Timely Filing Policy in section 8.12 of this guide.

Claims submitted electronically which cannot be accepted by SHP will be rejected with error messages detailing the reason for the rejection. A current listing of electronic claim rejection reasons can be obtained from your Network Educator.

9.3 Claims Requiring Additional Information

Claims requiring additional information may be sent electronically in certain cases- see Electronic Reconsiderations or Second Submissions, below. . Operative or office notes may not be sent electronically; they should be sent by mail to Optima's data entry vendor at the address, below.

**Claims
PO Box 5028
Troy, Michigan 48007-5028**

A cover sheet including the patient's name, Member ID, claim number date of service and amount requested should be sent with the attachment to expedite processing. Patient and provider identification should be on each page submitted, since stapled documents may be separated for scanning.

If the claim is resubmitted with the appropriate resubmit code, the claim will suspend for review. SHP will review the claim and the notes to determine the appropriate adjustment to the reconsideration, as well as the original claim to ensure accurate payment.

Please note that any reconsideration not listed above, including timely filing and secondary payers (COB), must be submitted by paper.

9.4 Electronic Reconsiderations or Second Submissions

Provider Reconsideration forms are available under “Forms and Documents”: online at www.optimahealth.com or by calling Provider Relations. Electronic Reconsiderations can be accepted in an electronic claim file one of two ways: through a clearinghouse or software vendor, or through www.optimahealth.com.

Claims sent through a clearinghouse or software vendor follow the normal electronic claims submission process with one exception: they must have a 7 frequency code in the CLM05-3 segment of the 2300 loop of the 4010A1 837 professional guide. Contract your software vendor or clearinghouse with questions about how to send this code.

- Procedure/service codes
- Service periods/dates
- Charges
- Units/visits/studies/procedures
- Hospitalization dates
- Name or ID number of referring physician
- Provider ID
- Original entry error in ID or birth date

If a claim is resubmitted without the appropriate resubmit code as described above, the claim will be denied as a duplicate (a denial starting with D13).

9.4.1 Procedure for Reconsideration through optimahealth.com

Registered Providers may electronically submit reconsiderations online through Provider Connection at www.optimahealth.com by selecting “View Medical Claim Status”, entering the Member’s SHP ID Number, selecting the claim in question and choosing the “Reconsider Claim” option. Providers are able to make changes or corrections on line for the following: procedure code, diagnosis code, requested amount, or quantity.

The “View Medical Claim Status” option online will allow you to review the status of your online reconsideration the next day after submission.

Choose the “other” category for changes other than those listed above, including changes that require documentation, such as medical records or operative notes; reconsiderations

with more than 50 line items and payment retractions. Selecting “other” will bring up the claim form online for preparation of a completed printable form for paper submission. Paper claims submitted for reconsideration must indicate resubmission on the claim, in block 19 of the CMS1500, or block 80 or any otherwise unoccupied block of the UB-04 format.

9.5 Status Reports

Provider sites receive “status” or “response” reports that will give the total number of claims transmitted, filed, denied, rejected (invalid) and pended. Pended claims require review. A pended claim does not necessarily mean that the provider has to furnish additional information.

9.6 Support

Contact your current EDI vendor for:

- Problems with transmission

Contact SHP Provider Relations at: 1-800-229-8822 (toll free) or 757-552-7474 for:

- Consistent rejections of claims, although information is correct
- Status of claims received electronically
- Questions concerning the adjudication or payment of claims sent electronically

You can also email your request at EDITTEAM@sentara.com. When sending requests to this mailbox, please include the Member’s SHP identification number, the requested amount on the claim, the date of service, the indicated reason for the rejection, and your tax id, or NPI.

10. Facility Services

10.1 Inpatient Services

Inpatient services are billed with revenue codes 10X, 11X, 12X, 13X, 15X, 16X, 17X, 18X, 19X, 20X, 21X, 22X, and 23X. Revenue code 14X (private, deluxe) may not be a covered benefit. Under HMO products, a co-payment maybe applied. Deductible and coinsurance maybe applied under other products.

MCS will assign an authorization for service. **An authorization is issued for medical necessity, but it is not a guarantee of payment.**

An inpatient stay must be billed with different “from” and “through” dates. The **date of discharge** does not count as a full confinement day since the Member is normally discharged before noon and; therefore, there is no reimbursement.

Patients re-admitted to the hospital within five (5) days for the same or similar diagnosis will be considered as one admission for billing and payment purposes. This protects the Members from having to pay multiple cost-share amounts for related readmissions within a short period of time.

Furloughs (revenue code 18X) occur when a patient is admitted for an inpatient stay, discharged for no more than 10 days, and is then re-admitted under the same authorization. Examples include situations in which surgery could not be scheduled immediately, a specific surgical team was not available, or further treatment is indicated following diagnostic tests but cannot begin immediately.

If a claim is received with **private room charges** (revenue code 14X) and the private room charges are not covered under the Member’s plan, SHP will automatically pay the claim at the semi-private room rate.

As a rule, if the hospital contract with SHP changes during the Member's inpatient stay, payment is based on the hospital contract in effect at the date of admission.

10.1.1 Interim billing indicates that a series of claims may be received for the same confinement or course of inpatient treatment that spans more than thirty consecutive days. Interim billing may be based on the month's ending date (Medicare) or based on a 30-day cycle from the date that charges begin. Use the appropriate Bill Type for each claim.

10.1.2 Newborn Claims

Under **HMO (fully and self-insured) products**, coverage for a newborn child or adopted child of an insured Member will begin at birth if the newborn is added to the Subscriber’s plan within thirty-one (31) days of birth. Normal newborn charges for care rendered in

the hospital (while the mother is confined) will be paid whether the newborn is enrolled in the plan or not. The newborn's nursery charges must be included on the mother's facility bill. However, under the Family Care product, two separate claims should be submitted for the mother and newborn if the reimbursement method is APDRG. If the newborn must stay in the hospital after the mother has been discharged (boarder baby), the newborn must be enrolled, and must have an inpatient pre-certification under the newborn's own ID number in order for the charges to be covered. The "boarder baby's" date of admission should equal the mother's date of discharge.

Under PPO, Out Of Area PPO, POS, and Out Of Area products, a newborn receives 31 days of additional care whether or not the newborn is added to the plan. Under these products, newborns are covered for 31 days from the date of birth even if the Member does not enroll the newborn in the plan. SHP does not delineate between sick or well newborns, or whether the care is rendered in an inpatient facility or physician's office. All care is covered for 31 days. The charges should be billed under the Member's ID number if the newborn is not added to the Member's policy.

Under **OFC product**, eligible children born to women enrolled in Family Care will be covered until the child is disenrolled or to the end of the child's third month (including the birth month).

If the Member's group benefits change during the inpatient stay, payment will be based upon the benefit in effect on the date of admission, through the end date of coverage. If a Member loses coverage during the stay, coverage ends on the date of policy termination.

Under the Point of Service product, if a non-participating provider refers a Member to a participating facility (hospital), all hospital charges and ancillary charges (anesthesiology, radiology, pathology, diagnostic testing, etc.) are covered at the managed care level of benefit. This is applicable for all hospital services (not just inpatient services).

For commercial and OFC claims, APDRG/ DRG information must be entered in Field 31. If the provider is paid based upon APDRG/ DRG Reimbursement and the provider does not indicate the APDRG/ DRG information, the claim is denied "provider error, submit corrected claim, provider responsible" (D95). For Medicare, the requirement is for MS-DRGs.

10.1.3 Inpatient Denied Days (all admission types)

Under SHP, all inpatient stays must be authorized as medically necessary and concurrency authorized for continued acute stay.

If the attending physician continues to hospitalize a Member who does not meet medically necessary criteria, all claims for the hospital from that day forward will be denied. The claim will be denied "services not pre-authorized, provider responsible" (D26). The Member cannot be billed.

- If the Member remains hospitalized because a test ordered by the attending physician is not performed because of hospital related problems (such as scheduling and pre-testing errors), then all claims for that day forward from the hospital will be denied. The claim will be denied "services not pre-authorized, provider responsible" D26. The Member cannot be billed.
- If the Member or family insists on continued hospitalization (even though both the attending physician and SHP agree that the hospitalization is no longer medically necessary), then claims related to the additional days will be denied. The claim will be denied "continued stay not authorized, Member responsible" (D75). The Member can be billed.

For all medically unnecessary dates of service, both the provider and Member will receive a letter of denial from SHP. The letter will note which dates of service are to be denied, which claims are affected (hospital and/ or attending physician), and the individual responsible for the charges. The letter also describes the process to initiate an appeal. A Medical Director is always available to discuss cases prior to a denial being issued. Please see also Section 14 Appeals.

10.1.4 Skilled Nursing Facility Services

Placement in a Skilled Nursing Facility requires pre-certification. Medical Care Services will make the necessary arrangements with the facility. Case managers are available to make the necessary arrangements to transition the patient home.

Payment for a skilled nursing facility confinement is based upon an all-inclusive per diem rate. Claims should be submitted on a UB04 claim form with revenue codes in the 19x series. If a claim is received for supplies from a medical supplier, the claim will be denied "not a contracted service, provider responsible" (D85). Medicare SNF claims are paid on a Revenue Utilization Group (RUG) per diem basis.

If a Member has exhausted their SNF benefit or has been moved to custodial care, the SNF service is no longer a covered benefit. Case Managers will review for concurrent skilled nursing facility services and authorize a continued stay as appropriate.

All therapies should be included in the skilled nursing facility bill. A separate bill for therapy services should not be submitted, if the patient was still confined to the facility at the time services were rendered.

10.2 Pre-Admission Testing

Pre-admission testing may occur up to ten (10) days prior to the ambulatory surgery or inpatient stay. The testing may include chest x-rays, EKG, urinalysis, CBC, etc. The tests should be performed at the same facility at which the ambulatory surgery or inpatient stay is ordered. The tests should be billed on the inpatient or ambulatory surgery claim. The

admission date for ambulatory surgery must be the actual date of surgery and not the date of the pre-admission testing. See also Section 10.8.1 below.

- SHP will only pay separately for pre-admission testing if the surgery/ confinement is postponed or canceled.
- If the pre-admission testing is billed separately from the ambulatory surgery or inpatient stay and the surgery was not postponed or canceled, the pre-admission testing will be denied "provider billing error, provider responsible" (D95).

10.3 Air Ambulance

For air ambulance transportation, the service must be billed separately from the inpatient stay, and must include the corresponding CPT code. Air ambulance charges are not included in the reimbursement for the inpatient admission. If the Member was admitted, SHP will waive the co-payment.

10.4 Certified Registered Nurse Anesthetist

Certified Registered Nurse Anesthetists (CRNA) may provide anesthesia services in an inpatient or outpatient setting; however, CRNA services are usually reimbursed as part of a facility claim. If, however, the CRNA is employed by an anesthesiologist and has obtained an individual NPI, [s]he may receive reimbursement directly, at 50% of the allowed rate for an MD anesthesiologist, when the CRNA's own claim, billed using the CMS1500 format, includes the appropriate modifiers.

10.5 Outpatient Services

General Information

To locate providers of the outpatient facility services listed in this section, please select the search tool in the Provider column of the home page at www.optimahealth.com. Select the Find A Facility, or Find A Healthcare Service option. Enter the product type, and then select the provider specialty type, and enter the city and state.

Members may receive certain services (i.e., diagnostic tests, chemotherapy, radiation therapy, dialysis, physical therapy, nutritional counseling, etc.) on an outpatient basis per contract. Participating providers must use bill type 131 for outpatient services. Providers must bill with the appropriate revenue code and associated CPT/HCPCS code (if available) or as directed below.

If no dollars are billed on the claim, SHP will automatically assign zero dollars as the Billed Amount.

If no quantity is reported, SHP will automatically deny the claim back to the provider, requesting additional information.

Outpatient facility services generally have a patient cost-share associated with them. That may be waived if the patient is subsequently admitted.

10.6. Billing Guidelines

The following matrix identifies specific outpatient facility services and how these services should be billed, and some related payment information:

Service	Revenue Code	Comments
False Labor and its associated observation room charges	720/721 with corresponding CPT/HCPCS code	<ul style="list-style-type: none"> Review the diagnosis code to ensure that false labor is billed correctly. SHP will manually add all charges to the false labor charges and pay under revenue code 721 based on contract.
Blood transfusions, storage, administration and any associated observation room charges	38X,39X with corresponding CPT/HCPCS Code	<ul style="list-style-type: none"> SHP will process all charges to the 38X/39X procedure charge and pay under the 38X/39X revenue code. SHP does not consider the claim to be an ambulatory surgery claim.
Chemotherapy (Drugs to eradicate or minimize cancer)	636 with corresponding CPT/HCPCS code	<ul style="list-style-type: none"> Include appropriate J codes for all medications.
IV Therapy (Antibiotics, hydration, etc.)	26X with corresponding CPT/HCPCS code	<ul style="list-style-type: none"> For medications, add associated J codes, if applicable <u>Pre-authorization is required if medications are being administered.</u>
AICD Implant Checks (Automatic Implantable Cardioverter Defibrillator)	921 with corresponding CPT/HCPCS code	<ul style="list-style-type: none"> Associated CPT codes must be billed.
Pacemaker Checks (telephone)		<ul style="list-style-type: none"> Associated CPT codes must be billed.
Nutritional Counseling	942 with corresponding CPT code 942 with corresponding HCPCS code (diabetic diagnosis only)	<ul style="list-style-type: none"> Pre-authorization is required for non-diabetic nutritional counseling. Include CPT code. If an office or other outpatient visit is billed, the office visit is denied “provider billing error, provider responsible” (95). Office visits may not billed. If billing nutritional counseling with a diagnosis of diabetes, bill with appropriate HCPCS code. Pre-authorization is not required with diagnosis of diabetes.
Hemodialysis		<ul style="list-style-type: none"> Add associated CPT//HCPCS (Q codes) codes or use revenue codes for each date of service.

Nerve Blocks	372 with corresponding CPT/HCPCS code	<ul style="list-style-type: none"> • Pre-authorization is required. • An itemized statement is required. • Associated CPT codes must be billed.
Radiation Therapy	333 with corresponding CPT/HCPCS code	<ul style="list-style-type: none"> • Claims may be received for a one- month period of time. • Associated CPT codes must be billed.
Sleep Apnea/ Sleep Studies	74X with corresponding CPT/HCPCS code	<ul style="list-style-type: none"> • Facilities must be explicitly contracted to provide this service. Pre-authorization is required. • Associated CPT/HCPCS codes must be billed.
Colonoscopy, Endoscopy, Proctoscopy, Sigmoidoscopy	750 with corresponding CPT/HCPCS code	<ul style="list-style-type: none"> • If observation room charges (revenue code 760) are billed with a diagnostic procedure, SHP will add the observation room charges to the diagnostic procedure charge. • If 250 or 636 revenue code is billed without an associated CPT or J code, the 250 or 636 revenue code will be denied "non-allowed expense, provider responsible" (D21). • Contrast materials, isotopes, etc. are included in the procedure reimbursement and are denied "non-allowed expense, provider responsible"(D21).
Diagnostic procedures (CPT code range of 60000 or 90000) such as spinal punctures, cardiac cath, etc. procedures and their associated observation room charges	Varies with corresponding CPT/HCPCS code	<ul style="list-style-type: none"> • If observation room charges (revenue code 760) are billed with a diagnostic procedure, SHP will add the observation room charges to the diagnostic procedure charge. • If 250 or 636 revenue code is billed without an associated CPT or J code, the 250 or 636 revenue code will be denied "non-allowed expense, provider responsible" (D21). • Contrast materials, isotopes, etc. are included in the procedure reimbursement and are denied "non-allowed expense, provider responsible" (D21). <ul style="list-style-type: none"> • If a recovery room (revenue code 710) is billed in conjunction with a diagnostic procedure (series 60000 or 90000), SHP will deny the recovery room "non-allowed expense, provider responsible" (D21). This recovery room is considered as part of the procedure and should not be billed separately. If a radiology procedure (series 70000) and radiology medical surgery supplies (revenue code 621) and/ or recovery room (revenue code 710) are billed, SHP will deny the radiology medical surgery supplies and the recovery room "non-allowed expense, provider responsible" (D21).

10.7 Outpatient Facility Notes:

- **Clinic charges** are a non-allowed expense. SHP will deny the clinic charge "non-allowed expense, provider responsible" (D21).
- **Pharmacy** (revenue code ranges 25X or 636) or med-surgical supplies (revenue code 27X range) should not be billed in conjunction with a radiology or diagnostic procedure code. SHP will auto deny the pharmacy and/ or med-surgical supplies "non-allowed expense, provider responsible" (D21).
- If **pharmacy** (CPT codes for injectable immunization serum) or med-surgical supplies (CPT codes) are billed in conjunction with a CPT procedure code, SHP will pay the pharmacy and/ or med-surgical supplies (for example, immunizations) as well as the procedure (subject to any referral and/or authorization requirements).
- When contract provisions call for reimbursement methods other than case rates, providers submitting claims with revenue codes in the 25x series for amounts totaling \$500 or more, and/or revenue codes in the 27x series for amounts totaling \$500 or more must submit sufficient information for SHP to determine whether the miscellaneous drugs and supplies are covered. The appropriate CPT, HCPCs, or NDC codes should be submitted.
- Immunizations may be provided by the outpatient facility in situations where a shortage exists, or the Primary Care Physician (PCP) is unable to obtain the vaccine. In these instances, only the administration of the vaccine and the vaccine should be submitted on a CURRENT UB claim form. The vaccine may be billed with a 250 or 636 revenue code and corresponding J code. The administration of the vaccine should be billed with a revenue code 940 and the corresponding CPT codes (e.g. 90471- 90474 or 90782).

10.8 Laboratory Services

Laboratory services for SHP Members may only be performed by SHP contracted lab providers. All laboratories, including physician offices, participating with SHP , must have the appropriate CLIA certificate.

Apart from physician in-office labs, there are three types of outpatient laboratory services: hospital outpatient labs, reference labs, and specialty labs. Hospital outpatient labs may be billed for services associated with outpatient care, such as ER, observation, false labor, and blood banking. Hospital outpatient lab services are billed as line items on a facility claim.

Most other outpatient lab services are considered reference lab services. This means that a patient goes to a lab draw site also known as a patient service center, where one or more specimens are drawn, and sent to a reference laboratory. The reference laboratory can provide high quality services, and standard reporting, for a large number of laboratory services. SHP can accept reference lab billing in either a CMS or UB format.

Facilities that act as draw sites cannot process the lab work themselves and must send the specimen to the contracted Reference Labs for processing. Charges for venipuncture will not be reimbursed by SHP. **The draw fees are reimbursed to the draw site by the contracted reference lab.**

A specialty outpatient lab is one that offers a limited number of less-frequently requested tests, often associated with specific medical specialties. Please contact your Network Educator if you have questions about these labs.

10.8.1 Pre-Operative Lab and X-Ray

Members scheduled for surgery at a participating hospital may obtain services through a participating reference lab or be sent directly to the admitting hospital with a prescription for pre-operative testing.

If surgery is scheduled with fewer than three days notice, the lab testing should be performed by the admitting hospital.

10.8.2 Reference Lab Providers

SHP is contracted with a number of laboratory providers across the region. Any lab test not included on the In-Office Lab list must be sent to a participating reference lab. Providers have the option of sending the patient with orders to a participating draw site. Providers may locate the nearest participating lab provider by using the “Find A Healthcare Service” tool on www.optimahealth.com, by calling SHP Provider Relations or by obtaining the most current listing from their Network Educator. Since locations and providers are subject to frequent additions and changes, the most reliable locator for current information is www.optimahealth.com.

10.8.3 Labs Contracted to Service Areas Outside of Hampton Roads for Specific SHP Products Only:

Certain reference labs are contracted for selected products only. Please check using the “Find A Doctor” tool on www.optimahealth.com (see guidance under Section 10.5., above), by calling SHP Provider Relations or by obtaining the most current listing from your Network Educator.

10.9 Ambulatory Surgery Services (including Outpatient Surgery)

Ambulatory surgery center claims, as well as claims for outpatient surgery performed in a outpatient hospital setting, must be billed using a bill type 831 and revenue code 360 or 490 and the associated CPT surgical code.

Pre-authorization is required. **An authorization is issued for medical necessity, but it is not a guarantee of payment.**

For **multiple surgical procedures**, the hospital or facility must bill each surgical procedure with a charge amount included.

A co-payment may be applied under HMO products. Deductible and coinsurance amounts may be applied under other products.

10.10 Observation Room

Members may be seen in an observation status (revenue code 760, 762) for up to 72 hours. If the claim is billed with an observation room revenue code (760, 762), and/or a procedure, the applicable ambulatory surgery co-pay will be applied (under HMO products). Deductible and coinsurance may apply under indemnity products.

10.11 Emergency Room Services

Emergency services are those health care services that are rendered after the sudden onset of a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a **prudent layperson** who possesses an average knowledge of health and medicine to result in:

- serious jeopardy to the mental or physical health of the individual
- danger of serious impairment of the individual's bodily functions
- serious dysfunction of any of the individual's bodily functions
- in the case of a pregnant woman, serious jeopardy to the health of the fetus

Examples of emergency services include, but are not limited to, heart attacks, severe chest pain, cardiovascular accidents, hemorrhaging, poisonings, major burns, loss of consciousness, serious breathing difficulties, spinal injuries, shock, and other acute conditions.

For commercial products, all emergency services are subject to retrospective review of the dictated treatment sheet. The facility must bill revenue code 450 for emergency room services. SHP uses diagnosis codes (which have been determined to be automatically payable) in conjunction with the level of care indicated by the emergency medicine physician to indicate emergent status. Claims cannot be denied non-emergent without review of a complete treatment sheet.

There are no follow-up days associated with an emergency room visit. Emergency room providers must direct patient to the appropriate physician for follow up care. A co-payment may apply under HMO products. Deductible and coinsurance amounts may be applied under other products.

If the Member is directly **admitted to the same hospital** where the ER service was performed, the emergency room facility charges should be added to the inpatient or

ambulatory surgery bill submitted by the facility. The Member is not responsible for separate emergency room co-pay (only the inpatient or ASC co-pay). If the Member is not directly admitted to the same hospital, the emergency room charges are paid separately from the inpatient charges. In this situation, the Member may visit the emergency room, return home, and be admitted later in the day (normally within 24 hours).

Under an HMO product, if the determination has been made that the emergency service is not medically necessary, the claim is denied "not a medical emergency, Member responsible (D23).

10.11.1. Optima Family Care /FAMIS Product and the Emergency Department

- If the service is determined to be **emergent** and the provider is **participating**; the claim is paid at the contracted rates. FAMIS Members may be subject to a co-pay.
- If the service is determined to be **non-emergent** and the provider is **participating**, the claim is paid with a triage fee. FAMIS Members may be subject to higher co-pay for non-emergent services.
- If the facility is paid a triage fee, the provider may **not** balance bill the Member.
- If an OFC Member of any age visits an emergency room for **dental care** (normally for pain medication/ management until the Member can visit his or her own dentist), the claim will be subject to retrospective review.

10.11.2 Behavioral Health Emergency Assessment and Referral

Emergency assessment and referral services are available specifically for Optima Behavioral Health Services 24 hours a day, seven days a week with qualified clinicians available at all times. The Member should call OBHS at 800-648-8420.

11 Ancillary services

Depending on the plan, covered ancillary/other services such as Home Health, DME, and Prosthetic Appliances require pre-authorization by the Medical Care Services (MCS) Department. Details are outlined in the information provided below.

11.1 Artificial Limb Benefit

A separate artificial limb benefit is a core benefit, but coverage varies by product and/or employer. Please call Provider Services to determine coverage and patient cost-share for the specific Member you are treating or you may inquire about specific benefit limitations and patient cost-share at the time of pre-authorization of services. Pre-authorization is required.

11.2 Audiology Services

Audiology services are covered when authorized by Medical Care Services (MCS). Please note that Medicare PPO Members do not need authorization.

Hearing aids are covered under some benefit plans. The Medicare PPO does not cover hearing aids. However, all SHP Members including Medicare PPO Members have access to a value added hearing aid discount program. This value added hearing aid discount program can be accessed when the Member does not have a hearing aid benefit. Please contact Provider Relations at 1-800-229-8822 (toll free) or 757-552-7474 for specific coverage.

11.3 Dialysis Services

- Dialysis billing and reimbursement guidelines are established to parallel the Dialysis Medicare guidelines.
- Dialysis claims must be submitted on a UB 92 claim form.
- Dialysis treatments are reimbursed on an all-inclusive composite rate per treatment. The hemodialysis composite rate is also considered to be an all-inclusive rate.
- The Optima Medicare PPO uses the Medicare fee schedule, coding and guidelines as the methodology for payment.
- Payment for Epogen and ESRD-injectable drugs in addition to the composite rate follows Medicare guidelines.
- Dialysis claims must indicate the appropriate revenue, CPT and/or HCPCS codes.
- Non-routine dialysis lab work must be sent to a participating reference laboratory for processing.

11.4 Disposable Medical Supplies

- Commercial plans **DO NOT** cover supplies, except for ostomy supplies, diabetic supplies, holding chambers (spacer/aerochamber) and peak flow meters. These items do not require authorization.
- Optima Family Care does cover supplies based on DMAS guidelines. All covered supplies require authorization, except ostomy supplies, diabetic supplies, wound care supplies (billed in conjunction with an authorized skilled nursing visit), spacing devices (holding chambers; Aerochamber, InspireEase) and peak flow meters. These items do not require authorization.
- The Medicare PPO does cover supplies based on CMS guidelines, but does not require authorization for services under \$250.00.
- Spacers (which are different than spacing devices) are included with the medication and **are not** separately reimbursable.
- Insulin pump supplies are **NOT** included in diabetic supplies and require an authorization.

For Commercial plans, supply items are typically furnished with the initial month's rental or initial purchase. If DMAS allows supply items to be billed separately, in addition to the initial month's rental or purchase, these supply items will require a separate authorization in order to be paid. Supplies used in conjunction with a nebulizer, apnea monitor and cpap/bipap do require an authorization, regardless of whether the equipment itself requires an authorization or not.

In summary all **COVERED** disposable supply items (excluding ostomy and diabetic supplies) that will be separately billed to SHP must be authorized. All **COVERED** replacement supply items also require an authorization.

11.5 Durable Medical Equipment (DME)

Durable medical equipment (DME) includes equipment or items, which can be purchased or rented, which are able to withstand repeated use, which are medically necessary and which are typically used in the home. Some supply items that fall under the DME category are covered services and typically require pre-authorization. Most products have a calendar year benefit maximum. Optima Family Care & FAMIS have no maximum dollar limitation on benefits. Contact Provider Relations at 1-800-8822 (toll free) or 757-552-7474 for specific Member benefit information. Medical Care Services (MCS) will assign authorizations for DME services that require authorization. Authorizations are issued for medical necessity but do not guarantee payment.

11.5.1 DME Equipment Rental and Purchase Policy

The following applies to Commercial Plans and Optima Family Care:

- SHP's Medical Care Services will determine if equipment being rented should convert to purchase within the first three months of rental.
- Should accumulated rental payments exceed 110% of the purchased price of the equipment, SHP considers the equipment purchased and all rental payments are stopped.
- If equipment is being rented and subsequently purchased, all accumulated rental payments are offset against the purchase price, only the difference is paid and the equipment is considered purchased.
- All equipment rentals must be billed in monthly increments (except codes E0935 RR – CPM Machine and E0202 RR – Phototherapy Blanket rented on a daily basis). The appropriate date range and a quantity of 1 (one month's rental) should be indicated on the claim form.
- Copayments vary by product and employer. Please contact Provider Relations at 1-800-229-8822 (toll free) or 757-552-7474 for details.

DME Authorization

- All DME equipment rentals, regardless of dollar amount, require an authorization. Services must be provided by contracted DME providers.
- DME equipment single purchase items with requested charges equal to or greater than the group's minimum threshold amount must be authorized. Services must be provided by contracted DME providers.
 - NOTE: The minimum dollar threshold varies by group. Please verify the Member's benefit with SHP
- Providers may fax a completed DME Authorization Request Form, available at www.optimahealth.com, to Medical Care Services (MCS) to request an authorization.
- Requested changes in authorizations must be faxed to Medical Care Services within thirty (30) days of the original authorization.
- Medical Care Services will apply Medicare limitations for the Medicare PPO.

11.5.2 Billing and Reimbursement:

If a miscellaneous HCPCS code is billed for an item when a specific HCPCS code exists, the item will be denied with comments stating to resubmit the claim with specific HCPCS codes.

Medical Care Services (MCS) will determine if the equipment being rented should convert to purchase within the first three (3) months of the rental. Equipment rental payment ends when a Member becomes disenrolled:

All equipment rental must be billed in monthly increments (except codes E0935 RR – CPM Machine and E0202 RR – Phototherapy Blanket rented on a daily basis), utilizing the appropriate date range and indicating a quantity of 1 (one month's rental).

If SHP determines that a Member became disenrolled during the time period covered in the date range, SHP will process the claim as indicated below:

- The line item billed will be changed to indicate the dates the Member was covered by SHP.
- A quantity of one (1) will be shown for the covered days and the full months rent will be paid.
- A second line item will be added indicating the dates the Member was not covered by SHP.
- A quantity of zero (0) will be shown for the non-covered days and an adjustment code, D28, indicated with a comment, “Member disenrolled on XX date, full month rental payment made”.

11.6 Home Health & IV Therapy

Home Health and IV Therapy services require pre-authorization for all products except the Medicare PPO. To arrange and obtain pre-authorization for Home Health or IV Therapy Services, call SHP Health Medical Care Services. Requests to update or revise the authorization, must be faxed to Medicare Care Management within thirty (30) days of the original authorization.

Home Health care benefits are not payable for custodial care. Custodial care is defined as “treatment or services designed mainly to help the patient with daily living activities.” These activities include help walking, getting in and out of bed, bathing, preparing meals, acting as companion, etc.

Co-payments apply to therapy (physical, speech or occupational) services rendered in the home.

11.6.1. Home Health Obstetric Post-Delivery Services

Home Health Services are available, **if pre-authorized**, to assess both the mother and child after discharge. These services include but are not limited to:

- Drawing lab studies on the newborn
- Providing bili-lights and bili-blanket therapies
- Providing breast feeding education and information for the mother
- Checking mother’s condition in the home.

No supplies or pharmacy items should be billed in conjunction with therapy services. Standard supplies are included in the skilled nursing visit. Extensive supplies used in conjunction with an authorized skilled nursing visit for wound care services are reimbursable if specifically authorized by Medical Care Services (MCS).

11.6.2. Pharmacy and Home Health

Pharmacy medications (revenue code 25X) are reimbursable in connection with a Skilled Nursing visit (revenue codes 550, 551, 559, 561, & 571), Private Duty Nursing visit (552, 553, 572, 582, & 584), or IV Therapy (260 revenue code).

11.7 Hospice Services

Hospice care is available to Members who are diagnosed with a terminal illness and have less than six (6) months to live. Hospice care services (revenue code 651) include:

- Care of the Member and the family as a unit.
- Palliative care (relief of pain) rather than heroic measures.
- Bereavement counseling.
- Pastoral services.

The Member must **elect** the hospice program. Following the Member's election, all hospice care must be pre-authorized by Medical Care Services (MCS). **Please note that Optima Family Care does not cover hospice services. Once the Member elects hospice care, the provider should submit the necessary documentation to have the Member disenrolled. Hospice services may be provided and billed to Virginia Medicaid. Hospice is covered through SHP for FAMIS Members.**

Optima Medicare Members may receive care from any Medicare-certified hospice. Original Medicare coverage (rather than Optima Medicare) pays for the hospice services. Optima Medicare Preferred will continue to cover all other (non-hospice related) services.

11.8 Medical Transportation Services/Ambulance

Ambulance/stretchers service is covered for most plans when provided by an agency authorized to provide such a service to transport a Member. Wheelchair transportation is typically not covered by Commercial plans. However, wheelchair transportation may be authorized by Medical Care Services (MCS) on a case by case basis.

- Ambulance/stretchers service is covered from the place where the Member was injured to the nearest hospital where treatment can be furnished when medically necessary. Any other ambulance/stretchers service transport must be pre-authorized.
- Members are responsible for a co-pay each way for ambulance services. This applies to both emergent and non-emergency services.
- Ambulance providers must obtain prior authorization for applicable services whenever possible for all products except the Medicare PPO. In cases requiring services after routine business hours or other circumstances where services were

provided in good faith, SHP will not withhold authorization if patient is a current SHP Member, medical necessity warrants the services, **and the authorization request is made within 30 days of the service.**

11.9 Optima Family Care Transportation Program

Optima Family Care covers non-emergency transportation for eligible Members for medical appointments as well as emergency transportation. If an Optima Family Care Member has no other means of transportation, transportation will be provided to and from a medical appointment with a participating provider.

SHP has contracted with a vendor to administer the transportation program (taxi and wheelchair) for Optima Family Care. **The Member is expected to call** 1-877-892-3986 five (5) days in advance of a scheduled medical appointment to have the transportation pre-authorized and arranged. The vendor does not cover scheduled ambulance/stretchers transportation. Non-emergency ambulance/stretchers is approved and arranged by SHP Medical Care Services for Optima Family Care Members.

FAMIS Members do not have coverage for non-emergency transportation. For more information regarding transportation, please call 1-877-892-3986 (toll free)

11.10 Dietician/Nutritional Counseling

Coverage is limited to medically necessary conditions that must be managed by nutritional assessment or behavior modification. These include, but are not limited to:

- Pregnancy
- Diabetes mellitus
- Morbid obesity
- Heart disease
- Hyperlipidemia
- Obstructive Sleep Apnea

All plans will cover diet evaluation and instruction by a dietician or physician. The patient is responsible for an office visit co-pay each session.

11.11 Oxygen Policy

Members may receive oxygen (O₂) through a Durable Medical Equipment/Respiratory Therapy provider. Oxygen services are paid as a **medical benefit** rather than a DME benefit. DME maximum benefit limits do not apply. For all products except Medicare PPO, oxygen therapy is pre-authorized by Medical Care Services based upon diagnosis and medical necessity. For all products, oxygen services require a physician order and oxygen saturation level meeting medical criteria. All supplies are included in the rental reimbursement.

Continuation of oxygen usage by a Member requires the provider to submit yearly oxygen saturation levels to MCS, except for patients with chronic conditions. All oxygen and oxygen equipment must meet the criteria for medical necessity as defined by Medical Care Services. All pulse oximetry tests require pre-authorization.

All requests for liquid oxygen will require medical necessity from the ordering physician and must be approved by SHP's Medical Director.

Initial authorizations will be setup for either 3 months or 1 year depending on the episode of illness.

11.12 Physical and Occupational Therapy

Outpatient physical and occupational therapy are covered services when medically necessary and authorized by Medical Care Services (MCS). Outpatient physical and occupational therapy may be performed by contracted therapy providers meeting SHP's therapy participation criteria. For purposes of this section, the term "therapy provider" includes freestanding and hospital-based therapy centers. The following therapy guidelines are applicable to all therapy providers:

- Coverage of therapy services varies by product and employer. Verification of therapy benefits for a specific Member may be obtained by contacting Provider Relations at 1-800-229-8822 (toll free) or 757-552-7474.
- Optima Family Care covers up to 24 visits per calendar year as long as rehabilitative or therapeutic progress is demonstrated. For children under the age of 21, additional visits may be authorized if deemed medically necessary.
- The Medicare PPO can not utilize chiropractors for any service except treatment of subluxation of the spine.
- Work Hardening programs or functional capacity testing is **not** covered by any plan.

11.12.1. Ordering and Authorization Process:

- Physical and occupational therapy require authorization by Medical Care Services (MCS) for all plans.
- All therapy services must be ordered by a physician. A PCP or Specialist may order therapy services by either providing the Member with a **written prescription for therapy services to a participating therapy provider** or providing the Member with a copy of the Authorization Request Form.
- The participating therapy provider or facility must contact MCS to obtain authorization for the evaluation.
- Upon completion of the evaluation, the therapy provider should proceed as follows: The therapy provider must complete and fax an Authorization for Therapy Worksheet to MCS. The Authorization for Therapy Worksheet will indicate the diagnosis, treatment plan and modalities.

MCS will process and return the Authorization for Therapy Worksheet to the therapy provider indicating the authorization number, the number of visits authorized, the modalities and the time frame. If a treatment was provided in addition to the evaluation during the initial visit, that treatment must be indicated on the Authorization for Therapy Worksheet. MCS will then determine if the treatment performed during the initial visit will be covered.

1. The therapy provider will use the Authorization for Therapy Worksheet approved by MCM as the basis for continued therapy services, for the number of visits and time frame indicated.
2. If the treatment plan changes or additional modalities or visits are needed for a Member, the therapy provider must fax an updated Authorization for Therapy Worksheet to MCS for appropriate authorization.

11.12.2. Billing and Reimbursement:

Freestanding therapy providers and chiropractors should submit claims on a CMS 1500 claim form using the appropriate CPT code as designated by the current AMA CPT code book.

- Hospital-based therapy providers should submit claims on a current UB claim form. In addition to the revenue code, the appropriate CPT codes as designated by the current AMA CPT codebook must be included.
- Therapy providers may bill an initial physical therapy evaluation or an initial occupational therapy evaluation at the initial visit with a quantity of one (1). Billing evaluation codes for subsequent visits will be denied “non-allowed expense, provider responsible” (D21). Re-evaluations are not covered. Billing of the re-evaluation codes will be denied “non-allowed expense, provider responsible” (D21).
- The procedure code for physical performance measurement, with written report, each 15 minutes is covered and may be billed by a therapy provider to render an initial evaluation of the Member at the initial visit. This code is billable in 15-minute increments. The provider may bill this code with a quantity greater than one (1) on the initial visit. For example, if the provider uses one (1) hour on the initial visit to evaluate the Member, the provider would bill with a quantity of four (4). Billing this code for subsequent visits will be denied “non-allowed expense, provider responsible” (D21).
- Customized splints provided by the therapy provider must be pre-authorized by MCM for all plans. The customized splint must be billed using the appropriate HCPCS code. For freestanding and hospital based therapy providers, customized splints that have been authorized will be paid fee-for-service for all plans.

- An itemized bill is necessary.
- Therapy codes apply one (1) co-payment per visit (date of service) for each type of therapy provided.

11.13 Cardiac Pulmonary Vestibular Rehabilitation

Rehabilitation is a covered service and requires pre-authorization by Medical Care Services (MCS) for all plans. The authorization will indicate the number of sessions authorized.

Contracted Physicians, therapy centers or hospitals may perform rehabilitation. A co-payment, deductible or coinsurance will be applied

11.14 Early Intervention Services

Coverage for early intervention services are available for all fully insured commercial groups (including OHP, SHP, POS, PPO, OOA, Individual Conversion,) and Family Care. Early intervention services are defined as medically necessary speech and language therapy, occupational therapy, physical therapy, and assistive technology services and devices for dependents from birth to age three who are certified by the Department of Mental Health, Mental Retardation and Substance Abuse Services as eligible for services under Part H of the Individuals with Disabilities Education Act. In 1991, this act was renamed the Individuals with Disabilities Education Act (IDEA). In Virginia, children are eligible for early intervention services provided that they have

- developmental delay exemplified with functioning 25% or more below their chronological age or adjusted age in one or more areas of development (for example, having a 25% or greater delay in cognitive, physical, communication, social, emotional or adaptive development)
- atypical development. Children who manifest atypical development such as abnormal movement patterns or attachment disorders may be eligible even though they may not display a 25% delay in development
- a diagnosed physical or mental handicapping condition that has a high probability of resulting in delay. Conditions include those such as significant central nervous system anomaly, congenital or acquired hearing loss, chromosomal abnormalities, and inborn errors of the metabolism.

Medically necessary services are those services designed to "correct or ameliorate" the child's medical condition. These are services designed to help an individual attain or retain the capability to function age appropriately within his/her environment, and include

services, which enhance functional ability without effecting a cure. The Member is eligible to receive the following services:

- assistive technology
- audiology
- family training, counseling and home visits
- health services
- medical services (for diagnostic and evaluation purposes only)
- nursing services
- nutrition services
- occupational therapy
- physical therapy
- psychological services
- respite care
- social work services
- special instruction
- speech-language pathology
- transportation
- vision services

This coverage may be limited as follows:

- Family Care - no dollar limit
- All other groups - \$5,000 per Member per calendar year

This benefit is separate and apart from any other PT, OT, ST or DME benefit. The Member is responsible for any applicable deductible, coinsurance or co-payment (dependent upon the product). The Member may be eligible to receive reimbursement for any deductible/ coinsurance/ co-payments from Part H/ IDEA funding.

- Part H certification (available from the state) must be submitted to MCM, which will input the appropriate authorization
- For Medicare PPO Members, SHP utilizes Medicare coding and payment methodologies.

11.15 Prosthetic and Orthotic Appliances

Prosthetic and orthotic appliances are covered when determined to be medically necessary and appropriately pre-authorized by Medical Care Services (MCS). Customized and non-customized single prosthetic appliances with requested charges equal to or greater than the dollar threshold amount set by each group or product must be authorized (including the SHP Medicare PPO).

Coverage for non-surgically implanted prosthetic and orthotic devices combined is limited to the Member's benefit limit per calendar/contract year and to those conditions

resulting from injury or illness while a Member is covered. Please contact Provider Services to determine the Member's coverage.

Prosthetic devices are covered as follows:

- Purchase of the initial device for conditions resulting from illness or injury while a Member is covered.
- Replacement prosthesis for a growing child up to age 18 (age 21 for Family Care) who may or may not have been continuously covered when the illness or injury occurred and the initial prosthesis was fitted. Replacement is covered due to growth and surgical revision of an amputation.
- Breast prosthetics.
- Two (2) prosthetic bras are covered for Members with a cancer diagnosis.

Coverage does not include:

- Repairs to or replacement of a prosthesis that an adult Member received prior to enrollment.
- Replacements due to weight gain or loss, or shrinkage of the appendage.

11.16 Speech Therapy

- Speech therapy services require pre-authorization by Medical Care Services (MCS) for all plans, except the Medicare PPO.
- Speech therapy may be performed by physicians, therapy centers or hospitals.
- Verification of therapy benefits for a specific plan may be obtained by contacting Provider Relations.
- Regardless of place of service deductibles/coinsurance or co-payments are required for therapy services, per visit, per therapy type. No copayments apply for Optima Family Care.
- The Medicare PPO does have co-payments for all therapy services.

12. Billing and Reimbursement:

This section applies to all SHP products, except the Optima Medicare PPO product. The Optima Medicare PPO product reimbursement and claim payment policies are based on those currently used by Medicare.

SHP intends to follow AMA coding guidelines (e.g. CPT and HCPCS definitions) as well as Medicare Policies and Procedures, to include the most current Correct Coding Initiative (CCI) edits, when making claims payment determinations with respect to the following:

- Bundling/Unbundling
- Anesthesia Included in Surgical Procedure
- Separate Procedure Definitions
- Most Extensive Procedure
- Sequential Procedures
- Mutually Exclusive Procedures
- Misuse of Component Codes with Comprehensive Codes
- Standard Preparation/Monitoring Services
- Standards of Medical/Surgical Practice
- Laboratory Panels

The above list is not meant to be all-inclusive, but represents major categories of edits where SHP routinely uses Medicare rules as its basis. SHP may utilize proprietary purchased software products that incorporate similar coding and compliance rules into SHP's claims processing edits.

Clear Claim Connection is a web based code auditing reference tool that enables SHP to disclose code-auditing rules and associated clinical rationale. Providers are able to enter claim information, obtain audit results, review recommendations, receive explanations for any disallowed procedures and bill appropriately. Clear Claim Connection is available to Providers through Provider Connection on www.optimahealth.com.

Medicare policy and procedural information is available from your intermediary or carrier. The CMS web page provides information regarding Medicare's National Correct Coding Initiative (CCI) Edits and how to go about obtaining those edits at <http://cms.hhs.gov/home/medicare.asp>.

12.1 Provider Fee Schedules

Provider compensation arrangements and rates are available in the applicable compensation addendum (Exhibit) attached to the Provider Agreement. Information and current policies for developing fee tables and gap filling fees for existing codes or

assigning fees to new codes may be obtained by contacting your SHP Network Management Contract Manager.

12.2 Contracted Amounts/ Members' Cost Share

By entering into a provider agreement with SHP, you have agreed to accept payment directly from us. This constitutes payment in full for the covered services you render to Members, except for co-pays, coinsurance, deductibles and any other monies listed in the "Patient Responsibility" portion of the remittance advice. *You may not bill Members for covered services rendered or balance bill Members for the difference between your actual charge and the contracted amount. In cases where the copay is greater than the allowed amount for services rendered, only the allowed amount for the services should be collected. Should you collect more than the allowed amount, you will be expected to refund the number the difference of the two amounts.*

In general, providers should expect payment of Member cost-shares at the time of service. However, since deductibles affect many kinds of health care services, it is often more reasonable to collect deductibles after claims have been processed.

12.2.1 Co-payments and Coinsurance

12.2.1.1 Co-pays

- Check the Member's ID card to determine if there is a co-payment due for the specific service rendered. Collect the appropriate co-payment from the Member.
- The Member should not pay more than the contracted rate of the service rendered. If the co-pay amount is more than the contracted rate for the service, the Member pays the lesser amount of the contracted rate and not the co-pay amount.
- A co-payment should only be collected for services that are reimbursable under the Member's Plan.
- Co-payments will vary among services and plans.

12.2.1.2 Co-insurance

- Members are responsible for the full plan-contracted allowable amount for indemnity care until their deductible is met. It is recommended that providers submit the claim to SHP first and utilize the SHP remittance to determine the amount due from the Member.
- Once the deductible is met, Members using indemnity benefits are responsible for the appropriate coinsurance (percentage of the contracted allowable charge for the care).
- When SHP is the secondary insurance carrier:
 - Do not collect the co-payment
 - If the primary payer does not have a deductible
 - If the Member has met the deductible of the primary payer
 - Collect the co-payment if the primary plan has a deductible that the Member has met.

The SHP Remittance Advice will indicate the “Patient Responsibility” amount. After receipt of the Remittance you will be able to calculate and bill the Member for the amount due for any coinsurance or deductible.

Co-insurance amounts are determined as a percentage of the allowed amount. Although you may collect the co-insurance at the time of service, you must adjust any amount you collect to agree with the amount reported on the SHP Remittance Advice “Patient Responsibility.”

12.3 Appropriate Service and Coverage

SHP has processes in place to detect and correct potential under and over utilization of services. As such:

- Utilization Management (UM) decision-making is based only on appropriateness of care and service.
- The managed care organization does not compensate practitioners or others individuals conducting utilization review for denials of coverage or service.
- Financial incentives for UM decision-makers do not encourage denials of coverage or service.

12.4 Medical Necessity

SHP may deny claims for services deemed medically unnecessary. If the provider does not agree with SHP’s determination the provider may submit medical documentation (chart copies, treatment sheets, consultation reports, etc.) with a letter requesting reconsideration to:

Director of Medical Care Services
SHP
4417 Corporation Lane
Virginia Beach, VA 23462

See **Section 14 Appeals** below, for more detailed information.

Members may not be billed for services determined to be not medically necessary by SHP unless the Member has:

- Been informed prior to receiving the services that those services may not be covered under the Member’s benefit plan.
- Agreed in writing to pay for the services at the time or before services are rendered. This is extremely important with the Medicare PPO Member. In order to bill a Medicare PPO Member, the Member must have prior written notice stating the

specific service was not covered and a Member must sign a waiver with Medicare approved language stating they were willing to pay for the service.

- A patient should be billed directly if it cannot be proven that a patient is a Member at the time of service. If it is later determined that the patient is indeed a Member, you must refund the Member any payments he/she made **in excess** of applicable co-pays, coinsurance or deductibles and file a claim for the service rendered. Please see “**Co-payments and Coinsurance**” Section 12.2.1, for more information.

13. Coordination of Benefits (COB)

Group and individual health plans coordinate benefits with various other payers on either primary or secondary basis to avoid duplication of coverage among payers that have partial liability for the same bill. Work-related claims are **not** covered by group health plans.

13.1 Optima Family Care/FAMIS COB Policy

Medicaid/FAMIS Members who are covered by employer sponsored health plans should not be enrolled in a Medicaid HMO. It is important that if an Optima Family Care Member is identified as having SHP or another commercial product, that initial claim should be sent to the commercial plan for payment. Medicaid is always a secondary payer. Please notify Optima Family Care so the Member can be removed from the Medicaid HMO. Until the Member is disenrolled by DMAS, Optima Family Care will coordinate benefits.

13.2 Other Plan's COB Policy

When SHP is the **primary** plan, its benefits are determined before those of the other plan and without considering the other plan's benefits.

When SHP is the **secondary** carrier:

- SHP waives the co-payment during the claims adjudication process. The provider should not collect a co-payment.
- Claims must be submitted with EOB's attached and must show exactly the same information as the original claim. Providers may not bill one insurance carrier for one charge amount and SHP for another charge amount.
- SHP will not coordinate in cases where services are not covered under the Member's SHP plan.
- If a claim is filed for a Member whose primary insurance is not an SHP plan, the provider must submit an EOB with the claim within 18 months of the date of service. If an EOB is not submitted, the claim will be denied pending receipt of primary's EOB. The name of the primary carrier and the policy number will be recorded in the "Comments" field of the remittance. This indicates that the claim must have an EOB from the primary insurer before it can be resubmitted.
- Please keep your records updated so they reflect current COB information.

13.3 COB Exceptions

Certain insurance plans or policies are exceptions and are always considered secondary payers (by law) regardless of the primary payer. All SHP products would be considered primary payers for a Member with two plans (an SHP product and a secondary product). The following is a listing of Secondary Payers:

- AARP
- CHAMPUS. IF CHAMPUS and Medicaid/Optima Family Care cover the Member, CHAMPUS assumes the position of primary carrier.
- CHAMPVA
- Courtesy or Courtesy Adjustment (not an insurance)
- Medicaid
- Medical Assistance
- Virginia Medical Assistance Program (VMAP)
- FAMIS Members will not have any other insurance since FAMIS is a program for uninsured children

13.4 National Association of Insurance Commissioners (NAIC) Guidelines to Determine Payment Order

The National Association of Insurance Commissioners (NAIC) provides guidelines to determine the order in which benefits will be paid when an individual is covered under more than one group health plan:

No COB:

The plan that does not include a Coordination of Benefits (COB) provision will always be considered the primary payer.

Employee:

The plan, which covers the individual as an employee, Member or subscriber other than a dependent, is considered primary.

Children of Parents who are not divorced or separated:

- The gender rule states that the benefits of the plan covering the child as a dependent of a male are primary before those of the plan that covers the child as a dependent of a female.
- Under the birthday rule, the benefits of the plan of the parent whose birthday falls earlier in the year will be primary before those of the parent whose birthday falls later in the year. The term “birthday” only refers to the month and day rather than the year of birth.
- If both parents have the same date of birth, the benefits of the plan that has covered the child as a dependent for the longer period of time is considered primary.
- When one plan contains the gender rule and the other plan contains the birthday rule, and the two plans differ on the order of benefit payment, the gender rule is used to determine the order of payment.

Children of Parents who are Divorced or Separated:

- The order is as follows:
 1. The plan of the parent with custody
 2. The plan of the spouse of the parent with custody
 3. The plan of the parent without custody
 4. The plan of the spouse of the parent without custody
- If the terms of the court decree specify that one parent is responsible for the health care expenses of a child then that plan is primary.
- If the terms of the court decree that the parents share joint custody and neither parent is specified as responsible for the health care expenses of the child, the rules which apply to parents who are not separated or divorced will be used to determine which plan pays first (birthday rule).

Retired or Laid-Off Member:

- If the order of benefits is being determined for an individual with coverage under one plan as a laid-off or retired employee, the benefits provided by the plan which covered the individual as an active employee or as a dependent of that employee are determined before those of the plan that covers the individual as a laid-off or retired employee. This is referred to as the active/inactive provision.
- For determining the benefits for a retiree who is also covered as a dependent of an active employee, the plan that covered the person as a non-dependent pays before the plan that covers the person as a dependent. This rule is referred to as the non-dependent/dependent rule (which supersedes the active/inactive rule).

- **Active Duty Military:**

Tricare is always primary for active duty military.

Medicare Eligible Member:

- If the Member is over age 65 and is not actively employed, Medicare may be primary for the subscriber and spouse. Member may be enrolled in the Medicare PPO product.
- If the Member is over age 65 and is actively employed by an employer with less than 20 employees, Medicare is primary for the subscriber and spouse.
- If the Member is over age 65 and is actively employed by an employer with more than 20 employees, the employer group health carrier is primary for the subscriber and family.
- If the Member is under age 65, disabled, and is not actively employed, Medicare is primary for the subscriber.

- If the Member is under age 65, disabled, and is actively employed by an employer with less than 100 employees, Medicare is primary for the subscriber.
- If the Member is under age 65, disabled, and is actively employed by an employer with more than 100 employees, the employer group health carrier is primary for the subscriber.
- If the Member has End Stage Renal Disease (ESRD) and is not covered by an employer group health carrier, Medicare is primary.
- If the Member has End Stage Renal Disease (ESRD) and is covered by an employer group health carrier, the employer group health carrier is primary for the first 30 months. At the 31st month, Medicare is primary.
- If the Member has Optima Medicare PPO and Medicaid (“dual eligible”), Medicare is primary and should be billed first. Medicaid should be billed after the Remittance is received indicating the Member responsibility.

Default:

If none of the above rules apply to the situation, the plan that has covered the individual for the longest continuous period of time will be considered primary. The length of time an individual is covered under a plan is determined from the individual’s first date of coverage under the plan. If that date is not available, the date that the individual first became a Member of the group is used to measure the length of time that the individual has been covered under the present plan.

13.5 Continuation of Coverage

- The benefits of the plan covering the person as an employee will pay first.
- The benefits of the plan providing continuation of coverage will pay second.

13.6 Pursues

On occasion, SHP may be identified as the Member’s primary insurance in error. If SHP has paid as the primary carrier instead of the secondary carrier, SHP will send a “pursue” letter to the provider stating the Member has other primary insurance. If the provider files with the primary insurer, SHP will coordinate as the secondary carrier.

If the provider has not received the EOB from the primary carrier after thirty days of receipt of SHP’s pursue letter, SHP will retract any claim paid and deny the claim pending receipt of the primary carrier’s EOB.

13.7 Overpayments

In most cases, when a provider is paid in error, SHP automatically executes a retraction with 30 days advance notice to the provider. If retraction is not reasonable or possible and the provider would prefer to send a refund, please send a copy of the remit, the reason the claim was paid in error and the payment check within 30 days to:

SHP Recovery Unit
PO Box 61732
Virginia Beach, VA 23466

If the remit is not available, please send a check with the Member's name, ID number, the reason the claim was paid in error and the date of service to the above address. Please be sure to make the check payable to the company that sent you the check

14. Appeals

14.1 Provider Appeals

SHP attempts to resolve issues presented by Providers informally whenever possible. If an issue cannot be resolved informally, an internal Provider Appeals process is available to reconcile issues. An appeal is a formal request to reconsider and change a previous adverse decision when SHP has determined that the original payment was properly adjudicated and the Provider continues to dispute the payment. SHP will not take punitive action against a provider who requests an expedited resolution or supports a Member's appeal.

14.1.1. Criteria for Appeals

Appealed claims must meet the following criteria:

1. An adverse payment decision was made by SHP **after the service was delivered.**
2. The **Provider** has been held **responsible** for reasons such as:
 - Disputes regarding coding, capitation, contractual payments and rates, and/or usual and customary (UCR) charges, etc.
 - Denials based upon the Provider's failure to obtain prior authorization of services, timely filing, delayed treatment, length of stay and level of care, etc.
3. The claim has already **completed the reconsideration process.**

14.1.2 Provider Appeals on Behalf of a Member

Providers may appeal adverse benefit determinations on behalf of the Member; however, they must indicate that they are appealing on behalf of the Member. These Member appeals may be filed pre-service, concurrent to or following services being rendered. Appeals on behalf of the Member are processed according to the Member Appeal process and must include a completed *Authorized Designation Form* signed by the Member. Expedited Appeals do not require the Authorized Designation Form. For more information please see Section 14.4, Member Appeals, below.

14.1.3 Provider Appeals Procedure

1. The Provider or his/her designee may request an appeal in writing within 365 days from the date of service
2. Detailed information and supporting written documentation should accompany the appeal
3. Providers may obtain assistance in filing an appeal by contacting the SHP Appeals Department at 757-687-6404.
4. The appeal may be submitted by:
 - Facsimile: 757-687-6232
 - Mail: SHP

Provider Appeals Department
P.O. Box 62876
Virginia Beach, VA 23466-2876

- Hand Delivery:
SHP
Provider Appeals Department
4417 Corporation Lane, 3rd Floor
Virginia Beach, VA 23462

5. The Provider Appeals Coordinator will thoroughly research and gather all relevant documentation including, but not limited to, claims processing history, scanned documents from the I-Max database, denial codes, medical records, operative notes, etc.
6. The following individuals may review each case: the Provider Appeals Coordinator, Appeals Manager or Team Coordinator, Medical Director, Network Management Contract Manager, and a Certified Professional Coder.
7. A decision will be rendered within forty-five (45) business days of receipt of the appeal request.
8. If the decision is made to reverse the payment decision, the Provider Appeals Coordinator will forward the information to the Claims Department for processing as appropriate (for Specialty claim types) or reprocessed within the Appeals Department (Provider Appeals Coordinator-non specialty claim types only).
9. Written notification of SHP's final decision will be sent to the Provider within ten (10) business days from the date of the decision.

Hold Harmless Policy

For all SHP Products, if SHP denies a claim for service due to failure of the contracted providers to follow any rule or procedure, or based on retrospective review that the service was not medically necessary, the provider must hold the Member harmless and not bill the Member.

14.2 Provider Appeal Process for Optima Family Care

For Optima Family Care provider appeals where SHP does not reverse its decision, the written notice of SHP's final decision will also include a reference to the specific plan provision on which SHP based its determination and a notification of the Provider's right to request a State fair hearing and how to do so.

14.3 Expedited Appeals Procedure

An expedited appeal process may be requested by providers or Members for urgent care claims and concurrent care decision/claims. A treating physician with knowledge of the Member's medical condition will be permitted to act as the Member's Authorized

Representative without the completion of an Authorized Designation Form for Expedited Appeals.

An urgent care claim is a claim for medical care treatment where using the standard SHP appeal procedure for making a decision would:

- (a) Seriously jeopardize the life or health of the Member or the ability of the Member to regain maximum function; or
- (b) In the opinion of a physician with knowledge of the Member's medical condition would subject the Member to severe pain that cannot be adequately managed without the care or treatment in question.

A prudent layperson standard applies when making a determination on an urgent care claim, except where a physician with knowledge of the Member's medical condition determines that the claim is urgent. Prudent layperson refers to a person that possesses an average knowledge of health and medicine and is without medical training.

A concurrent care decision/claim means a claim regarding a decision by SHP during the course of treatment to terminate or reduce benefits that it previously approved, or a request to extend the course of treatment already approved. When SHP has approved an ongoing course of treatment to be provided over a period of time or number of treatments, the Expedited Appeal process will be followed to allow sufficient time for the Member to appeal and obtain a determination before the benefit is reduced or terminated.

A request for an Expedited Appeal must explicitly state "**Expedited Appeal**". The process may be initiated by:

- Telephone: Call the Member Services Number on the ID card
- Facsimile: 757-687-6232 or 1-800-472-3920

- Letter:

SHP

Appeals Department

P.O. Box 62876

Virginia Beach, VA 23466-2876

14.3.1 Expedited Appeal Process

- If a physician with knowledge of a Member's medical condition contacts an SHP Representative and requests an Expedited Appeal the call will be transferred immediately to the Medical Care Services or Appeals Department.
- When a Member contacts SHP with a request to initiate an Expedited Appeal, the Member Services Representative will clarify the criteria for Expedited Appeal. If the Member agrees that the appeal does not involve an Urgent or Concurrent Care Claim, the Member Services Representative will direct the Member to follow the standard appeals process.

- If the Member verifies that the criteria for Expedited Appeal has been met or has questions regarding the criteria, the Member Services Representative will transfer the Member to the SHP Appeals Department.
- The Member or Member's physician will have the opportunity to provide additional comments, documents, records or other information relevant to the appeal. The Appeals Coordinator will gather and present all information to ensure a full investigation of the substance of the appeal, including all the aspects of clinical care involved, to an SHP Medical Director who was not involved in the initial or reconsideration of the Adverse Benefit Determination.
- The decision on an Expedited Appeal shall be made by the SHP Medical Director, a peer of the treating provider or a panel of other health care providers with at least one physician on the panel.
- An Expedited Appeal will be considered and notification of the decision by SHP will be made to the Member as soon as possible, but not later than 1 business day after all necessary information is received and not later than 72 hours from receipt of the request. Expedited appeals relating to a prescription to alleviate cancer pain shall be decided no later than 24 hours from receipt of the request.
- If an expedited appeal is approved, notification will be made to the Member and treating physician immediately either orally or electronically if urgent and will be followed by written notice within three days.

14.3.2. Denied Expedited Appeals

If an Expedited Appeal is denied, notification to the Member or treating physician will be made electronically or written and will include information for requesting an External Review with the Bureau of Insurance (BOI). The Appeals Coordinator will provide the Member with the appropriate forms for filing an external review with the BOI. This information will be provided to eligible Members, which excludes self-funded ERISA plans, Medicaid and FEHB plans.

If the BOI accepts an appeal for expedited review, the BOI will contact SHP and the Member by the most expeditious means available, including telephone, facsimile or electronic mail, of their rights to submit information and supporting documentation.

If the BOI determines that a request for an expedited review does not meet the criteria for an expedited review, the Member will be notified in writing by the BOI within 2 business days from the time such a determination is made. The notice will instruct the Member wishing to pursue the appeal to contact SHP and request a review through the standard appeal process of the issues for which the expedited review was sought.

14.3.3. Optima Family Care Expedited Appeals

The Department of Medical Assistance Services (DMAS) will be notified of the receipt of an expedited appeal request within 48 hours. DMAS will be notified of OFC 's Expedited Appeal determination within 48 hours of the decision.

14.4 Member Appeals

14.4.1. Member Appeals Procedure

When SHP makes an Adverse Benefit Determination, the Member has the right to a full and fair review of SHP's determination in accordance with SHP's appeal procedure. Time frames for initiating a Member appeal vary by the Member's Plan. No Member who exercises the right to file an appeal with SHP shall be subject to disenrollment or otherwise penalized due to the filing of an appeal.

With the exception of Expedited Appeals, all requests for Member Appeals must be submitted in writing. Members will be advised to submit their requests to:

Written Complaints:

SHP Appeals Department
P. O. Box 62876
Virginia Beach, VA 23466-2876

Faxed Complaints:

757-687-6232
Toll Free: 866-472-3970

In Person:

SHP
4417 Corporation Lane
Virginia Beach, VA 23462

The Member may request an Expedited Appeal. The procedures for Expedited Appeals are the same for Members and Providers. See section 14.3, Expedited Appeals, for detailed information.

14.4.2. Member Appeal Initiation Procedure

When a Member contacts SHP to initiate an appeal, the Customer Service Representative will inform the Member that:

The Member Appeal Procedure is outlined in their Member materials and at www.optimahealth.com. The Member has the right to designate a healthcare professional as an authorized representative to act on his or her behalf in filing an appeal. SHP

requires that a Designation Authorization Form be completed by the Member identifying the person authorized to act on his or her behalf with the exception of an Urgent Care Claim. In such instances, SHP will permit a health care professional to pursue a claim on behalf of the Member without the completion of the Designation Authorization Form.

A Member Appeals Packet is available to assist the Member with SHP's appeal process. The Appeals Packet may be downloaded from www.optimahealth.com. The Member or their representative has the right to submit written comments, documents, records or any other information relevant to the case.

Relevant information includes:

- The Appeal Request Form describing the services or procedures requested and an explanation of why the Member feels SHP's decision was incorrect
- Office notes from physicians that the Member has seen regarding the services or procedures in question
- Medical records from hospitals and other healthcare providers
- Physician correspondence
- Physical, occupational, or rehabilitative therapy notes
- Copies of bills the Member has received
- Any additional information the Member would like SHP to consider in reviewing their appeal

Upon SHP's receipt of the written request, additional medical information must be submitted within ten days. Any documentation received after the tenth day may not be considered in the appeal review.

14.4.3 Optima Family Care /FAMIS Member Complaint Procedure

An Optima Family Care or FAMIS Member has the right to express a complaint in a positive manner about service or clinical issues. Members may register complaints by calling 1-800-881-2166 or 757-552-8975 during business hours or by submitting a complaint in writing to:

Optima Family Care
Appeals Department
P.O. Box 62876
Virginia Beach, VA 23466-2876

Providers must respond to requests from SHP for information regarding a Member's complaint within 3 days. Depending on the issue, Member Services or Provider Relations will respond to the Member within 7 days.

14.4.4 Optima Family Care Member Appeal Procedure

The formal member appeal process for Optima Family Care Members is as follows:

- Optima Family Care Members must contact Customer Service by telephone or in writing within 30 days of the original notification of a reduced, terminated, or denied claim or request for service, unless good cause is indicated for a delay.
- Members must respond to SHP requests for written information within the 30-day time frame for the appeal file to remain open.
- Optima Family Care Members should be informed that they may appeal in writing directly and immediately to the Department of Medical Assistance Services (DMAS) before, during or after appealing to SHP .
- Written requests for appeal to DMAS by Optima Family Care Members should be sent to:

Appeals Division
 Department of Medical Assistance Services
 Suite 1300
 600 East Broad Street
 Richmond, VA 23219

- A decision to uphold or reverse the decision of SHP will be issued within 30 days.
- If the Optima Family Care Member is not in agreement with the resolution by DMAS, they may appeal such a decision to the Circuit Court.

14.4.5.FAMIS Member Appeal Procedure

- Appeals from FAMIS Members must be submitted first to the SHP Appeals Department for resolution through the SHP Appeals Process.
- If the FAMIS Member is not in agreement with the SHP resolution, the Member may file an appeal within 30 days of receipt of SHP 's final appeal decision.
- An external review will be conducted by an independent external quality review organization. External review requests from FAMIS Members should be sent to:

FAMIS External Review
 Department of Medical Assistance Services
 Managed Care
 600 E. Broad Street
 Richmond, VA 23219
 FAX 804-786-5799

- A decision to uphold or reverse the decision of SHP will be issued within 14 days.

14.4.6 Optima Medicare Preferred Appeals

A detailed description of the Optima Medicare Preferred Grievance and Appeal Process is contained in the Member's Evidence of Coverage document, sections 10, 11, and 12, which is available to providers for viewing at www.optimahealth.com.

14.4.7 Provider Appeals

SHP attempts to resolve issues presented by Providers informally whenever possible. If an issue cannot be resolved informally, an internal Provider Reconsideration and Appeal process is available to reconcile issues.

To be eligible for **Appeal**, claims must meet the following criteria:

1. **Post-service** adverse payment decisions made by SHP
2. **Provider Responsible**. Examples include:
 - Disputes regarding coding, capitation, contractual payments and rates, and/or usual, reasonable and customary (UCR) charges.
 - Denials based upon the Provider's failure to obtain prior authorization of services, timely filing, delayed treatment, length of stay and level of care.
3. Have already gone through the **reconsideration** process.

LIMITATIONS:

Provider Appeals on Behalf of a Member:

Regulatory and accrediting agencies permit Providers to appeal adverse benefit determinations on behalf of the Member if the Provider indicates they are appealing on behalf of the Member. SHP requires that these appeals, filed pre-service, concurrent to or following services being rendered, accompany an **Authorized Designation Form** signed by the Member and will be processed through the Member Appeal process. The Authorized Designation Form is not required for Expedited Appeals.

PROCEDURES:

1. If the Provider is not satisfied with the initial reconsideration outcome, they may request an appeal.
2. The Provider or his/her designee may request an appeal in writing within 365 days from the date of service.
3. Detailed information and supporting written documentation should accompany the appeal.
4. The appeal may be submitted by:
 - Facsimile: 757-687-6232
 - Mail: SHP
Provider Appeals Department
P.O. Box 62876
Virginia Beach, VA 23466-2876
 - Delivery: SHP
Provider Appeals Department
4417 Corporation Lane, 3rd Floor
Virginia Beach, VA 23462
5. The Provider Appeals Coordinator will thoroughly research and gather all relevant documentation including, but not limited to, claims processing history, scanned documents from SHP's database, denial codes, medical records, operative notes, etc.
6. The following individuals may review each case: the Provider Appeals Coordinator, Appeals Manager or Team Coordinator, Medical Director, Provider Contract Manager, and a Certified Professional Coder.

7. A decision will be rendered within forty-five (45) business days of receipt of the appeal request.
8. If the decision is made to reverse the payment decision, the Provider Appeals Coordinator will forward the information to the Claims Department for processing as appropriate (for Specialty claim types) or reprocessed within the Appeals Department (Provider Appeals Coordinator-non specialty claim types only).
9. Written notification of the SHP's **final** decision will be sent to the Provider within ten (10) business days from the date of the decision.

15. Fraud, Waste and Abuse

Note: To avoid having duplicative information in this Guide, information in this section that duplicates information in Section 16, Subcontractor, Vendor, Agent and Consultants Compliance Program may have been modified.

Sentara Health Plans, Inc. (SHP) has adopted the Commonwealth of Virginia's definition of fraud waste & abuse as any "Suspicious Claims Activity," which is any claim that an insurance company has reason to believe, based upon evidence, may contain one or more material misrepresentations. SHP further defines fraud and abuse as "Intentional deception or misrepresentation made by a person or entity with the knowledge that the deception could result in payment of an unauthorized benefit." It may relate to providers, Members, employers, brokers, or employees. Common types of fraud and/or abuse are as follows:

- Unbundling
- Split-billing
- Services not rendered
- Upcoding
- Falsification of records/bills/enrollment applications
- Waiving copays/deductibles
- Duplicate claims submissions
- Prescription drug switching or shorting
- Dispensing expired or adulterated prescription drugs
- Prescription drug seeking behavior, theft, forging or altering of prescriptions
- Identity theft
- Improper COB
- Over/underutilization

SHP's Anti-Fraud Plan is carried out through the efforts of its SIU (Special Investigations Unit). The SIU is an internal investigative unit, separate from the Compliance Department, whose responsibility it is to:

- Detect and prevent fraud, waste, & abuse in accordance with the False Claims Act.
- Ensure proper value of medical, behavioral health, and prescription drugs, including correct coding, reimbursement, quantity and quality.
- Utilize real-time systems that ensure accurate eligibility, benefits, and reimbursement.
- Reduce or eliminate fraudulent or abusive claims paid.
- Identify Members with drug addiction problems.
- Identify and recommend providers for exclusion from the network as a result of fraudulent or abusive practices.
- Identify fraud on employer group enrollment applications.
- Refer potential FWA cases to the appropriate authorities (CMS, MEDIC, MFCU, law enforcement, etc.) and conduct case development and support activities for those investigations.

- Prevent illegal activities and assist law enforcement by providing information needed to develop successful prosecutions.

Federal False Claims Act

The Federal False Claims Act's primary purpose is to combat fraud & abuse in government health care programs. The Act accomplishes this by making it possible for the government to bring civil actions to recover damages and penalties from healthcare providers who have submitted false claims. Penalties can include up to three times actual damages and an additional \$5,500 to \$11,000 per false claim.

The False Claims Act prohibits, among other things:

- Knowingly presenting or causing to be presented to the federal government a false or fraudulent claim for payment or approval
- Knowingly making or using, or causing to be made or used, a false record or statement in order to have a false or fraudulent claim paid or approved by the government
- Conspiring to defraud the government by getting a false or fraudulent claim allowed or paid
- Knowingly making or using, or causing to be made or used, a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the government

"Knowingly" means that a person, with respect to information: 1) has actual knowledge of the information; 2) acts in deliberate ignorance of the truth or falsity of the information; 3) acts in reckless disregard of the truth or falsity of the information.

The False Claims Act also contains a qui tam or "whistleblower" provision. This provision allows a private person with knowledge of a false claim to bring a civil action on behalf of the Commonwealth or Federal Government. The qui tam provision also protects a whistleblower from retaliation by his employer. This applies to any employee who is discharged, demoted, suspended, threatened, harassed, or discriminated against in his employment as a result of the employee's lawful acts in furtherance of a false claims action.

Virginia also has a False Claims Act that mirrors the federal False Claims Act called the Virginia Fraud Against Taxpayers Act, VA Code § 8.01-216.1 through 8.01-216.19. [Click here for more information.](#)

Providers contracted with SHP will agree to be bound by and comply with all applicable Virginia and federal laws and regulations. Any violation by the practice or by any practice physician shall be grounds for termination. Providers contracted with SHP will also comply as follows:

- Provider agrees to comply with all non-discrimination requirements set forth in the contract
- Practice agrees to provide access to its premises and to its contracts and/or medical records, to representatives of SHP, as well as duly authorized agents or representatives of the Department of Health and Human Services, the Centers for Medicare and Medicaid Services, and the State Medicaid Fraud Unit in accordance with their contract
- Practice agrees otherwise to preserve the full confidentiality of medical records in accordance with their contract
- Practice agrees to ensure confidentiality of family planning services in accordance with the contract

If you or someone you know has knowledge of a health insurance claim submitted to SHP that may meet the above definition of a "suspicious claims activity," or suspect any provider, enrollee or employee of SHP may be committing fraudulent or abusive practices, please forward all the pertinent information to SHP's SIU for further investigation at the address below. Your complaint will be investigated and a thorough follow-up will be undertaken, including possible follow-up with you if additional questions arise. All referrals made to the SIU may remain anonymous. Please be sure to leave your name and number if you wish to be contacted for follow up. If appropriate, the necessary governmental agency (DMAS, CMS, OIG, BOI, etc.) will be notified as required by law.

SHP's Fraud & Abuse Hotline: (757) 687-6326 or 1-866-826-5277 or

E-mail: compliancealert@sentara.com, or

U.S. Mail, to:

SHP c/o Special Investigations Unit

4417 Corporation Lane

Virginia Beach, VA 23462

16. Subcontractor, Vendor, Agent and Consultants Compliance Program

Note: To avoid having duplicative information in this Guide, information in this section that duplicates information in Section 15, Fraud, Waste, and Abuse may have been modified.

Subcontractors, vendors, agents and consultants who represent the company are expected to adhere to the SHP Compliance Program. It is the policy of SHP to comply with all local, state, and federal laws governing its operations; to conduct its affairs in keeping with the moral, legal and ethical standards of our industry; and to support the government's efforts to reduce healthcare fraud and abuse. The SHP Compliance Program establishes a culture within the organization that promotes prevention, detection, and resolution of instances of conduct that do not conform to federal and state law, and federal, state, and private payor health care program requirements.

Confidentiality

Information designated as confidential should not be discussed with anyone other than on a “need to know” basis. In addition, agents and vendors have a responsibility to avoid disclosure of non-confidential internal information about the company, its employees, its clients and its business associates unless specifically authorized by the company.

Business Information

SHP considers its pricing information, pricing policies, terms, market studies, business or strategic plans, and any other similar information to be confidential. The sharing of information with competitors is a highly sensitive matter, particularly where that information could form the basis of a pricing agreement.

All bids or proposals should be accurate, complete and directly responsive to the prospective customer’s request, and may not contain any information that is false or intentionally misleading.

Conflict of Interest

SHP employees may not accept:

- Money or gifts (regardless of monetary value) from customers;
- Money from vendors or gifts having a monetary value of \$25 or more.

"Gifts" include any item, favor, discount, entertainment, meal, hospitality, loan, forbearance, personal service, transportation, travel, and lodging, whether provided in-kind, by purchase of a ticket, payment in advance, or reimbursement after the expense has been incurred.

Gifts and Improper Use of Funds

SHP prohibits giving anything of value to government employees who work for customers or potential customers of SHP. There are four permissible exceptions to this rule:

- Promotional items of nominal value (\$20.00 or less), such as a calendar or coffee mug displaying the company logo;
- Modest refreshments, such as coffee and donuts in connection with a business discussion;
- A meal on-site to accommodate continuing business meeting with government employees;
- Food, refreshments, entertainment, instructional materials at a widely attended event provided the government employee's agency has properly authorized his/her attendance.

Non-governmental personal may be provided with meals, refreshments, and entertainment with reasonable value, less than \$25, in connection with business discussions, provided this does not violate the policies of the recipient's organization. Gifts or other considerations of more than a nominal value (\$20.00 or less) or money of any amount may not be given to a physician or anyone in a position to influence client referrals.

Anti-Kickback Act

The Anti-Kickback Act of 1986 requires each prime contractor or subcontractor to promptly report a violation of the kickback laws to the appropriate Federal agency, Inspector General, or the Department of Justice if the contractor has reasonable grounds to believe that a violation exists.

Business Records

SHP's records are maintained in a manner that provides for an accurate and auditable account of all financial transactions in conformity with generally accepted accounting principles. No false or deceptive entries may be made, and all entries must contain an appropriate description of the underlying transaction. All reports, vouchers, bills, invoices, payroll and service records, time worked, Member records, and other essential data must be prepared with care and honesty.

Billing Practices

SHP is committed to accurate billing and submitting claims for services that are medically necessary, reflect the services and care provided to Members, and are justified by documentation. SHP agents and vendors are required to report any potential or suspected improper billing practices or violations of standard billing practices or of company policies and procedures.

False Claims – see description in Section 15, above

The Criminal Penalties for Acts Involving Federal Health Care Programs provides for felonious criminal penalties and a fine of not more than \$25,000 and/or imprisonment for not more than five years for whomever makes false statements or submits false claims.

Any SHP contractor, agent, or vendor who is aware of or suspects any false report or document, false claim, improper billing practices, or violations of company policies and procedures must report their concern to the SHP Compliance Committee or to the SHP Fraud, Waste, and Abuse Hotline (1-866-826-5277). All reported violations will be investigated.

Fraud and Abuse- see definition of Fraud in Section 15, above

Abuse is defined as practices that are inconsistent with sound fiscal, business, or medical practices and that result in an unnecessary cost to a government health care program or other health care plan.

The Deficit Reduction Act of 2005 became effective on January 1, 2007 and requires health care organizations receiving five million dollars or more in annual Medicaid reimbursement to educate employees, contractors, and agents about fraud and abuse, false claims, and whistleblower protection laws and regulations. The Deficit Reduction Act requires investigation of all potential false claims and fraud/abuse; payment coordination; claims payment only for US citizens or qualified aliens; co-payment limits compliance; and electronic claims submission by large providers.

Administrative Remedies for False Claims and Statements states any person who makes, presents, or submits a claim that is false or fraudulent is subject to a civil penalty of not more than \$5,000 for each claim and an assessment of not more than twice the amount of the claim.

SHP will investigate all potential fraud and abuse violations and will initiate actions to resolve the identified problem.

Whistleblowers- see discussion in Section 15, above

Insider Trading

Agents and vendors who have material non-public ("insider") information obtained through a relationship with SHP are prohibited from purchasing or selling the security. Agents and vendors may not use insider information for the purpose of communicating such information ("tipping") to those who trade.

Government Sanctioning

SHP does not contract with individuals or companies sanctioned under government programs. All agents and vendors must:

- ◆ Notify SHP of any known or suspected violations of law or regulations pertaining to the agent's or vendor's relationship with the Company.
- ◆ Disclose to SHP any government investigations in which the agent or vendor is, was or may become involved.
- ◆ Disclose to SHP any persons affiliated with the agent or vendor, including any officer, director, owner, employee, or contractor who has been disbarred or excluded from participation in any federal or state funded health care program.
- ◆ Immediately disclose to SHP , any persons affiliated with the agent or vendor, including any officer, director, owner, employee or contractor of the agent or vendor, who has been convicted of or pleaded guilty to a felony or other serious offense and who remains in affiliation or employment relationship with the agent or vendor after the conviction or guilty plea.

Maintaining Your Position of Trust

Each agent, vendor, subcontractor, and consultant has an obligation to act at all times with honesty and decorum because such behavior is morally and legally right and because SHP's business success and reputation for integrity depends on you.

Agents and Vendors with Contracts Providing Services to Medicare Recipients

- (1) All agents and vendors with contracts to provide services to Medicare recipients agree to comply with the following requirements:
 - (a) Must adopt and maintain arrangements satisfactory to CMS and SHP to protect enrollees from incurring liability for payment of any fees that are the legal obligation of SHP.
 - (b) Shall not hold any beneficiary enrollee liable for payment of any such fees; and
 - (c) Shall indemnify the beneficiary enrollee for payment of any fees that are the legal obligation of SHP.
- (2) All such agents and vendors agree that HHS, the Comptroller General, or their designees have the right to inspect, evaluate, and audit any pertinent contracts, books, documents, papers, and records of involving transactions related to CMS' contract with SHP.
- (3) All such agents and vendors agree that HHS', the Comptroller General's, or their designee's right to inspect, evaluate, and audit any pertinent information for any particular contract period exists through 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later.
- (4) All such agents and vendors agree that any services or other activity performed by the company shall be consistent and comply with SHP's contractual obligations under its contract with CMS.

- (5) All such agents and vendors understand and agree that SHP shall monitor the company's performance on an ongoing basis and may terminate this Agreement if SHP or CMS determines that the company is not satisfactorily performing its delegated activities and reporting responsibilities under this Agreement.
- (6) All such agents shall comply with all applicable Federal laws, regulations, and CMS instructions in performing its obligations under this Agreement.
- (7) All such agents and vendors agree to provide appropriate training to its staff concerning its provision of services to Medicare recipients. All such agents and vendors further agree to provide Optima with any training logs and copies of attestations upon request concerning such training.
- (8) After conducting a reasonable inquiry and determination of potential fraud, waste, or abuse in providing services to Medicare recipients, all such agents and vendors agree to promptly report such fraud, waste, or abuse to Optima for further investigation.
- (9) All such agents and vendors agree that this Agreement may be amended to include other terms and conditions as CMS may find necessary and appropriate.