Quick-Start Guide for Providers

Member Eligibility
Claim Submission and Payment

Optima Health Ohio Healthy
About the Quick-Start Guide:

This Quick-Start Guide is intended to give you a brief summary of information you may need to get started with Optima Health. The Quick-Start Guide is not intended to replace the full Optima Health Provider Manual available on the Optima Health provider website, optimahealth.com/ohio. The Optima Health Provider Manual contains additional detail on these topics, as well as links to helpful reference materials and national standards, including NUCC guidelines and electronic claim submission companion guides. We encourage you to become familiar with this Quick-Start Guide as well as the material found in the Optima Health Provider Manual. Should you have questions not answered in the Quick-Start Guide or the Optima Health Provider Manual, please contact Provider Services at 1-844-853-4060 or providerservicesOH@optimahealth.com.
Optima Health Member ID Numbers

Optima Health requires a member-specific ID number to identify the individual receiving services. Use of this member-specific ID determines accurate application of benefits and cost-share calculations. Additionally, clear identification of the patient is just one measure we apply to help prevent errors that could contribute to violations of HIPAA regulations concerning PHI.

The member ID is a nine (9) digit number, consisting of the first seven (7) digits of the associate’s member number (located in the middle of the ID card), plus the two-digit member suffix to designate the specific individual for whom the claim or authorization is being submitted. Generally, the two-digit suffix is assigned to the associate (01), spouse (02), and each dependent (03, 04, 05, etc.). Member suffixes can be found at the bottom of the member ID card.

Some member ID numbers will begin with an alpha character. Please be sure to include the alpha character if it appears in the member ID number. Do not include the asterisk (*) when entering the member ID number on your claim. This is only used on the ID card to emphasize separation of the member suffix.
Eligibility Verification

Since a member’s eligibility status may change, member coverage should be verified at the time of service. Optima Health will verify coverage based on the most current data available from the employer/payer. Retroactive changes can alter the member’s status, therefore; verification of eligibility is not a guarantee of payment.

Optima Health provides three ways to verify member eligibility:

• **Provider Connection on** [optimahealth.com/ohio](http://optimahealth.com/ohio) – available 24 hours a day
  • Verify eligibility and benefit information online with secure login to Provider Connection. To request a secure login and password for Provider Connection, complete the registration form online at [optimahealth.com/ohio](http://optimahealth.com/ohio).

• **Interactive Voice Response (IVR) System** – available 24 hours a day
  • To use the IVR System, call Provider Relations at 1-844-853-4060 and press 2 to verify eligibility.
  • To search for a member:
    • Press 1 to enter member ID number (including the appropriate two-digit suffix), or
    • Press 2 to enter member’s Social Security Number
  • The IVR System provides:
    • The member ID number if a SSN is used to search for the member;
    • The member’s “eligible as of” or “terminated as of” date;
    • The member’s group number; and
    • The assigned primary care physician (PCP) name, when applicable.
  • IVR does not provide specific benefit or Copayment amounts. This information is available through Provider Connection or by calling Provider Services.

• **Speak with a Provider Service Representative**
  • Call 1-844-853-4060
  • Representatives are available Monday-Friday from 8:00 a.m. to 5:00 p.m. ET.
Claim Submission

Optima Health encourages submission of electronic claims. Submitting your claims electronically promotes a faster and more efficient end-to-end process.

Optima Health accepts electronic claims through AllScripts (formerly known as PayerPath), or any clearinghouse that connects with AllScripts. AllScripts works with most clearinghouses; please check with your clearinghouse to ensure they submit claims to AllScripts.

Optima Health Payor ID:
Professional - 54154
Institutional - 00453

Paper claims are also accepted. Please mail your claims to the address on the back of the member ID card. Some Optima Health customers have addresses designated specifically for their claims, therefore, using the address shown on the member ID card helps ensure that the claim will arrive at the correct location without delay.

The filing deadline for all claims is 365 days from the date of service.
Common Reasons for Claim Rejections or Denials

Most claim rejections result from submitting a claim with a member ID number that does not match the patient information.

The most common errors are:

• Incorrect member name – the patient name on the claim must match the patient name as listed on the member ID card (hyphenated names must be submitted correctly).
• Incorrect date of birth – the birth date submitted must match the patient birth date.
• Invalid ID number
  • Incorrect/inactive number – may happen when a patient changes plans and the provider has not yet updated their claim/billing system or the patient presents old member ID card
  • Wrong two-digit suffix – the member number on the claim must contain the correct suffix that identifies the patient
  • Absence of a two-digit suffix
• Too few, or too many, characters – a member ID should contain nine (9) total characters
• Typographical errors, such as including symbols or spaces

What to do?
• Correct the member information and resubmit the claim(s).
• Please be sure that any resubmitted claims are marked as “corrected.”

Member information – including full name, date of birth, and member ID number – can be verified in the “View Eligibility” section of Provider Connection on optimaealth.com/ohio. Member ID cards are also available here for download and print.
Optima Health Payment Process

Optima Health will process your clean, complete claim within 30 days of receipt.

A Remittance Advice (remit) will accompany each reimbursement payment. The remit is your explanation of reimbursement and provides information on the processing detail of each claim – including payment, denial, or other adjustments. The remit may be multiple pages and include payment for multiple members.

Providers who receive payments by Electronic Funds Transfer (EFT) will receive their remits electronically through Provider Connection; those receiving paper checks will receive remits by mail. (Providers who submit claims electronically may also receive claim processing information directly from their clearinghouse.)

All providers registered with Provider Connection have access to their remits on optimahealth.com/ohio.

Adjustment codes may be included with claim processing detail. The adjustment code descriptions are included at the end of every remit. Please call Provider Services at 1-844-853-4060 if you have questions about the adjustment codes noted on your remit.
OhioHealthy HSA/HRA Plan Payments

OhioHealth associates have either an OhioHealthy Health Savings Account (HSA) plan or OhioHealthy Health Reimbursement Account (HRA) plan. Provider billing and reimbursement procedures for both plans are the same*. Optima Health partners with HealthEquity (HSA) and Choice Strategies (HRA) for these services. (As a reminder, plan types are identified on the member ID card.)

OhioHealthy Plan Highlights:

• There is a plan deductible. Patients may use any available HSA (or HRA) funds to pay for any out-of-pocket medical expenses.
• In-network preventative care is not subject to the plan Deductible. It is important to accurately code all preventive care services so patients can receive their maximum plan benefits.
• After a claim has been processed and reimbursed by Optima Health, the total remaining patient responsibility can be billed directly to your patient. (The remit you receive with your reimbursement will clearly identify the payment amount processed by Optima Health, and any remaining amount of your patient's responsibility.)
• Associates are issued debit cards for convenient access to HSA (or HRA) funds to pay for their out-of-pocket responsibilities.
• There is an in-network out-of-pocket maximum (OOPM) for medical and prescription drug expenses in a plan year. If the member reaches the plan's OOPM, they are not responsible for any eligible, in-network healthcare expenses incurred for the rest of the plan year. OhioHealthy will pay 100% of the remaining cost.

Please note: If an associate moves from an HRA to an HSA and has any remaining HRA funds from 2016, those funds will apply to claims with dates of service in 2016 that are adjudicated in 2017. Available HRA funds for these claims will be paid by check directly to the provider by Choice Strategies after the claim is processed by Optima Health.

*Marion General Bargaining Unit associates will not have a debit card; any applicable HRA funds will be paid by check directly to the provider by Choice Strategies. These associates are identified by the group number S6500 on their ID card.
Overpayment Retraction Process

In most cases, when a provider is paid in error, Optima Health will issue a retraction to be applied against future payments without any action necessary from the provider. Notice of any pending retractions will be included on your remit forty-five (45) days prior to the scheduled date of the retraction. If retraction is not possible, or if you would prefer to issue a refund check, please submit the check, a copy of the remit, and the reason the claim was paid in error, within 30 days of receiving the notice of retraction.

The member name and member-specific ID can be easily found on your remit.
Electronic Fund Transfer (EFT) and Electronic Remittance Advice (ERA)

Optima Health encourages the use of Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA) for all provider payments.

The EFT/ERA process allows deposit of payments directly into your bank account and provides easy online access to Optima Health remits. ERA’s are securely stored in Provider Connection for 90 days. You can view, download, or print them for your records.

EFT is safe, secure, and more efficient than paper check payments. Funds are typically deposited 24 hours after payments are processed. Clean claims are processed and paid by Optima Health within an average of seven days when submitted electronically and payment made through EFT.

Providers can enroll for EFT by completing the Electronic Payment/Remittance Authorization Agreement in the “Claims and Reimbursement” section of optimahealth.com/ohio.