Optima Health Provider Manual

Supplemental Information For Facilities and Ancillaries

This supplement of the Optima Health Provider Manual provides information of specific interest to Optima Health contracted Hospitals, Home Health Agencies, Skilled Nursing Facilities, Free Standing Ambulatory Surgery Centers, Sleep Study Centers, and Reference Laboratories. Unless otherwise indicated in this Supplement information in the core Provider Manual applies for Facilities and Ancillaries. Please refer to the core Provider Manual or the program specific Provider Manual Supplements for Optima Family Care, Medicare Advantage, Optima Health Community Care or D-SNP for policies and procedures not addressed in this Supplement.

HOSPITAL AND ANCILLARY KEY CONTACTS

OPTIMA HEALTH CONTRACT MANAGERS

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OPTIMA HEALTH NETWORK EDUCATORS

Hampton Roads
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TABLE OF CONTENTS

Credentialing for Facilities and Ancillaries

All Participating Optima Health 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 Health and a determination has been made by Optima Health that there is a need for the Provider to be added to the Network. At a minimum, the Optima Health Facility Credentialing and Re-Credentialing processes will:

- Be conducted at least every three 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 acceptable accrediting body
- Implement standards of participation for any Provider that has not been approved by an acceptable accrediting body and the process for assuring review of CMS' site audit.

Facilities and Ancillaries must provide Optima Health with copies of current accreditation certificates, Medicare certification survey results and state licensures, as applicable to each contracted Facility or Ancillary. In addition, completion of a Disclosure of Ownership and Control Interest Statement is required.

Facility or Ancillary that does not hold the expected certification may be credentialed only after the Optima Health Quality Improvement department reviews the Certification Survey letter and copy of CMS-2567 (Statement of Deficiencies and Plan of Correction) issued by the applicable State survey organization.

If the Certification Survey letter and CMS-2567 indicate no deficiencies were cited, the contract process will continue. If the Certification Survey letter and CMS-2567 indicate that deficiencies have been cited, these documents and the provider's 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 Provider will resolve all cited deficiencies. If Quality Improvement is not satisfied with the stated action plan, the contract process will stop.

Delegated Credentialing

For Hospital Based Providers and Providers participating through an entity that has been approved and contracted to perform delegated credentialing, credentialing is covered under the agreement with that organization. Please contact the organization's administrator for further information.

Any Facility or Ancillary that has its Medicare certification suspended due to cited deficiencies must notify OPTIMA HEALTH immediately.

Accreditations accepted by Optima Health for each provider type are as follows**:**

Hospitals

- Joint Commission
- DNV Healthcare, Inc.
- HFAP (Healthcare Facilities Accreditation Program)
- CMS-approved accrediting body

The only exception made for Hospital accreditation is when a Facility is newly opening. If the Hospital is initially opening, documentation of patient safety plans and records from a state or federal regulatory body that has reviewed the Hospital must be forwarded to Optima Health. Full accreditation must be acquired within three years to continue the contract with Optima Health.

Home Health Agencies

- Joint Commission
- CHAP (Community Health Accreditation Program)
- ACHC (Accreditation Commission for Health Care)
- Medicare Certification

Skilled Nursing Facilities

- Joint Commission
- Medicare Certification

Free Standing Ambulatory Surgery Centers (ASC)

- Joint Commission
- DNV
- AAAHC (Accreditation Association for Ambulatory Health Care)
- Medicare certification.

Sleep Studies Centers

- American Academy of Sleep Medicine (AASM)
- ACHC

All sleep labs must comply with Medicare guidelines and criteria as referenced in the Medicare Program Integrity for Independent Diagnostic Testing Facilities (IDTFs). Physicians 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.

Optima Health uses the AASM guidelines and credentials physicians who are board certified or eligible. Sleep technicians supervising sleep studies on Optima Health Members must be certified or enrolled in an approved program by the Board of Registered Polysomnographic Technologists (BRPT) or other pre-approved certification body. All sleep labs must maintain an appropriate level of patient to technician ratio of 2:1.

DMAS ARTS Program (Addiction and Recovery Treatment Programs)

Facilities offering intensive outpatient programs, partial hospitalization programs, inpatient detoxification, inpatient and/or residential treatment programs specializing in addiction treatment for managed Medicaid Members (OFC, FAMIS, and Optima Health Community Care) must complete DMAS certification and ARTS attestation documents as well as DMAS credentialing for those services.

Other Provider Types

Please contact your Network Educator for credentialing requirements for any other type of Facility or Ancillary Provider.

Hospital/Ancillary Billing Information

Coding

Optima Health requires the most current procedure and diagnosis codes based on Current Procedural Terminology (CPT) and International Classification of Diseases (ICD) guidelines for inpatient and outpatient claims. The principal diagnosis is the condition established after study to be chiefly responsible for causing the hospitalization or use of other Hospital services. Each inpatient diagnosis code must indicate in the contiguous field whether symptoms warranting the diagnosis were present on admission.

Revenue codes must be valid for the Bill Type and should be listed in ascending numeric order. Revenue codes do not guarantee coverage. Covered Benefits are detailed in the Member's Optima Health Evidence of Coverage documents. CPT or HCPCS codes are required for ambulatory surgery and outpatient services.

Bill Type is a key indicator to determine whether a claim has been previously submitted and processed. The first digit of the Bill Type indicates the type of Facility, the second digit indicates the type of care provided and the third digit indicates the frequency of the bill. Bill Type is important for interim billing or a replacement/resubmission bill. Claims submitted for reconsideration require a "7" as the third digit. "Resubmission" should be indicated in block 80 or any unoccupied block of the UB-04.

Appropriate DRG information is required in Field 71 for all Hospital reimbursement methodology. For Hospital claims based on DRG methodology, the claim will be denied "provider error, submit corrected claim, provider responsible" (D95) if the applicable type of DRG information, based on the Provider Agreement, is not indicated.

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.

Inpatient Billing Information

CCS will assign an authorization for service. **An authorization is issued for Medical Necessity, but it is not a guarantee of payment. The authorization number should be included on the UB claim.**

Copayments, Deductibles, or Coinsurance may apply to inpatient admissions.

Inpatient claim coding must follow "most current" coding based on the date of discharge. If codes become effective on a date after the Member's admission date but before the Member's discharge date, Optima recognizes and processes claims with codes that were valid on the Member's date of discharge. If the Hospital Agreement terms change during the Member's inpatient stay, payment is based on the Hospital Agreement in effect at the date of discharge. If the Member's benefits change during an inpatient stay, payment is

based upon the benefit in effect on the date of discharge. If a Member's coverage ends during the stay, coverage ends on the date of policy termination. Please see the OHCC Provider Manual Supplement for OHCC exceptions for DRG reimbursement methodology.

Inpatient services are billed with revenue codes 10X, 11X, 12X, 13X, 15X, 16X, 17X, 18X, 19X, 20X, 21X, 22X, and 23X. 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, Optima Health will automatically pay the claim at the semi-private room rate.

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.

Optima Health requires Providers to code claims consistent with CMS "Present on Admission" guidelines and follows CMS "Never Events" guidelines.

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.

- Optima Health 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).

Re-Admissions

Members re-admitted to the Hospital for the same or similar diagnosis will be considered as one admission for billing and payment purposes according to the terms of the Facility Agreement. This protects the Members from having to pay multiple cost-share amounts for related readmissions within a short period of time.

Furloughs

Furloughs (revenue code 18X) occur when a Member is admitted for an inpatient stay, discharged for no more than ten days, and 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.

Interim billing

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. The appropriate Bill Type should be indicated for each claim.

Newborn Claims

Coverage for a newborn child or adopted newborn child of a Member will begin at birth if the newborn is added to the plan within thirty-one (31) days of birth. Optima Health does not delineate between sick or well newborns, or whether the care is rendered in an inpatient Facility or Physician's office.

Normal newborn charges for care rendered in the Hospital (while the mother is confined) will be paid whether the newborn is enrolled in Optima Health or not. One claim should be submitted for the mother and a second claim should be submitted for the newborn, if the reimbursement is paid using DRG methodology.

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 prior-authorization under the newborn's own Member 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.

Please see the Optima Family Care and Optima Health Community Care Provider Manual Supplements for newborn enrollment information.

Organ Transplants

Optima Health contracts directly with Optum Health Care Solutions for organ transplantation services. A limited number of direct contracts with local and regional transplant providers are used as part of the Optum Managed Transplant Program. **Prior-authorization is required for transplant services, even if Optima Health is the secondary payer**.

Commercial Plans**:**
Prior-authorization should be obtained at the time the Optima Health Commercial Member is identified and referred for organ transplant evaluation.

Please see the Optima Family Care and Optima Health Community Care Provider Manual Supplements for transplant information specific to these programs.

Skilled Nursing Facility Services

Placement in a Skilled Nursing Facility (SNF) requires prior-authorization. Clinical Care Services will make the necessary arrangements for the Facility admission. Case

Managers will review SNF services concurrently and authorize a continued stay as appropriate and arrange the Member's transition to home. If a Member has exhausted their SNF benefit or has been moved to custodial care, the SNF service is no longer a Covered Benefit. Please see the OFC and OHCC Provider Manual Supplements for information applicable to custodial care.

For Optima Health Commercial products, SNF services are typically reimbursed using all-inclusive per diems. For OHCC and D-SNP, services are reimbursed using Resource Utilization Groups (RUGs).

Inpatient Denials/Adverse Decisions

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 because a test ordered by the attending Physician is not performed due to 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 a family member insists on continued hospitalization (even though both the attending Physician and Optima Health 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 (D75)".

For all medically unnecessary dates of service, both the Provider and Member will receive a letter of denial of payment from Optima Health. The letter will note which dates of service are to be denied, which claims are affected (Hospital and/or attending Physician), and the party having responsibility for the charges.

Facility Outpatient Services

General Information

Members may receive certain outpatient services (i.e., diagnostic tests, chemotherapy, radiation therapy, dialysis, physical therapy, nutritional counseling, etc.) per their benefit plan. Providers must use UB bill type 131 for outpatient services.

Outpatient Facility services typically have a Member cost-share associated with them. Optima Health assigns certain revenue codes to specific plan benefits. For example, revenue codes 450-459 are mapped to Emergency Department services, and further drive the determination of the Member's cost share. The default outpatient benefit is "outpatient diagnostic". Member cost share may be waived if the Member is subsequently admitted.

If no dollar amount is billed on the claim, Optima Health automatically assigns zero dollars as the Billed Amount. If quantity is not reported, Optima Health automatically denies the claim and request additional information from the Provider.

Outpatient Billing Guidelines

Providers must bill with the appropriate revenue code and associated CPT/HCPCS code. The following matrix identifies specific outpatient Facility services (A-Z), how these services should be billed, and related payment information:

Service (A-Z)	Revenue Code	Comments
AICD Implant Checks (Automatic Implantable Cardioverter Defibrillator)	921 with corresponding CPT/HCPCS code	• Associated CPT codes must be billed.
Ambulatory Surgery (Including Outpatient Surgery)	Revenue code 360 or 490 with the associated CPT surgical code	• Use Bill Type 131 when performed in a free-standing Facility or an outpatient Hospital setting. • Prior-authorization is required for each procedure and implant. Authorizations have a 30-day time span. • Each surgical procedure must be billed separately and have a charge amount included • Copayments, deductibles and coinsurance may apply
Blood transfusions, storage, administration and any associated observation room charges	38X,39X with corresponding CPT/HCPCS Code	• Optima Health processes all charges to the 38X/39X procedure charge and pays under the 38X/39X revenue code. • Optima Health does not consider the claim to be an ambulatory surgery claim.

Service (A-Z)	Revenue Code	Comments
Chemotherapy (Drugs to eradicate or minimize cancer)	636 with corresponding CPT/HCPCS code	• Include appropriate J codes for all medications. OFC and OHCC claims require NDC numbers for any drug billed with revenue codes 25x or 63x.
Clinic Charges		• Will be denied "non-allowed expense, Provider responsible" (D21).
Colonoscopy, Endoscopy, Proctoscopy, Sigmoidoscopy	750 with corresponding CPT/HCPCS code	
Dialysis Services		• A valid written or verbal order from the attending nephrologist is required. • Claims must indicate the appropriate revenue, CPT and/or HCPCs codes and be submitted on a UB04 claim form. • Supplies are payable only in the home setting. Documentation and J codes are required to differentiate medication from pharmacy supplies. • Non-routine dialysis lab work must be sent to a Participating Reference Laboratory
Diagnostic procedures (CPT code range between **70000 and 99999** such as **spinal punctures, cardiac cath, etc.** procedures and their associated observation room charges	Varies with corresponding CPT/HCPCS code	• If observation room charges (revenue code 760) are billed with a diagnostic procedure, Optima Health will add the observation room charges to the diagnostic procedure charge. • If a recovery room (revenue code 710) is billed in conjunction with a diagnostic procedure (series 60000 or 90000), Optima Health 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 Optima Health will deny the radiology medical surgery supplies and the recovery room "non-allowed expense, Provider responsible" (D21).
Genetic Testing	30x	• Requires prior-authorization and is performed at a specific Participating specialty laboratory
Hemodialysis		• Add associated CPT//HCPCS (**Q codes**) codes or use revenue codes for each date of service.
IV Therapy (Antibiotics, hydration, etc.)	26X with corresponding CPT/HCPCS code	• **Prior-authorization is required if medications are being administered**. • For medications, add associated J codes
Lab services for OHCC facility residents	30x	• Provider responsible for determining if lab services are included in facility per diems

Service (A-Z)	Revenue Code	Comments
Miscellaneous medical supplies or implants	25x, 27x	• Include HCPCs Level I or Level II code. • OFC and OHCC claims require NDC numbers for any drug billed with revenue codes 25x or 63x. • If no appropriate code is available, include English description • Claims omitting this information may be audited retrospectively to ensure items are Covered Services, and allowed for the Member's condition.
Nerve Blocks	372 with corresponding CPT/HCPCS code	• **Prior-authorization is required.** • An itemized statement is required. • Associated CPT codes must be billed.
Nutritional Counseling	942 with corresponding CPT code 942 with corresponding **HCPCS code (diabetic diagnosis only)**	• Services provided by a participating provider are covered. • Prior-authorization is not required.
Observation Room	760, or 762	• Observation status is allowed for up to 72 hours. Claims for HMO Members billed with revenue codes 760 or 762 utilize the Member Ambulatory Surgery Copayment amount. Deductibles and Copayments may apply for other Plan types. Hospitals must provide oral and written notification (MOON) to Medicare Members who receive observation services as an outpatient for more than 24 hours
Outpatient Physical and Occupational Therapy (Hospital-Based Providers)	Revenue Code 42X for PT and 43X for OT with appropriate CPT code	• Claim must be submitted on UB04 form
Pacemaker Checks (telephone)		• Associated CPT codes must be billed.

Service (A-Z)	Revenue Code	Comments
Pharmacy • Injectable immunization serum & med-surgical supplies • Revenue codes 25X and 27X • Immunizations	**Vaccine**: revenue code 250 or 636 with J code **Administration** revenue code 940 with CPT code (e.g. 90471-90474 or 90782)	• Paid in addition to the procedure payment when billed with a **CPT procedure code**. Payment is subject to referral and authorization requirements. • No prospective denial for claims with insufficient coding butt subject to review after payment is rendered. OFC and OHCC claims require NDC numbers for drugs billed with revenue code 25x • May be provided by Outpatient Facility due to shortages or when vaccine is unavailable to PCP. Only the vaccine and administration of the vaccine should be submitted on the current UB claim form.
Pregnancy-related Observation (non-delivery)	720/721 with corresponding CPT/HCPCS code and appropriate ICD-10 diagnosis code(s) OR 760/762 with corresponding CPT/HCPCS code and appropriate ICD-10 diagnosis code(s)	• Review the diagnosis code to ensure that diagnoses are billed correctly. • Optima Health will pay under revenue code based on contract. • Primary diagnosis codes which report the occurrence of early, late or threatened labor (ICD-10-CM 020, 042, 044, 047, 048, and 060) must use revenue codes 720-721. • Pregnancy-related observation does not require a prior-authorization.
Radiation Therapy	333 with corresponding CPT/HCPCS code	• Claims may be received for a one- month period of time. • Associated CPT codes must be billed.
Radiology or Diagnostic Procedures	25X, 636 and 27X	• Pharmacy and med-surgical supplies are a non-allowed expense and will be denied (D21), Provider responsible when billed with these **revenue** codes for radiology or diagnostic procedures
Sleep Apnea/ Sleep Studies	74X with corresponding CPT/HCPCS code	• **Facilities must be explicitly contracted to provide this service. Prior-authorization is not required**. • Associated CPT/HCPCS codes must be billed.

Laboratory Services

Laboratory services for Optima Health Members may only be performed by Optima Health Participating lab Providers. All laboratories, including physician offices, participating with Optima Health, must have the appropriate CLIA certificate. Optima Health can accept reference lab billing in either a CMS or UB format.

Optima Health Reference Lab Providers are required to provide an electronic report each month. That report includes actual test values for selected tests used by Optima Health in HEDIS® reporting and in disease management. Laboratory Provider service standards and reporting requirements are listed in the Reference Laboratory Provider Agreement.

Emergency Department 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.

Commercial Plans: Emergency services are subject to retrospective review of the dictated treatment sheet. The Facility must bill revenue code 450 for emergency room services. Optima Health 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 as non-emergent **without review of a complete treatment sheet**. Under a commercial 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)".

There are no follow-up days associated with an emergency room visit. Emergency room Providers must **direct the Member to the appropriate Physician for follow up care**.

A Copayment may apply under HMO Plans. Deductible and Coinsurance amounts may be applied under other Plan types. 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 Copayment (only the inpatient or ASC Copayment). If the Member is not directly admitted to the same Hospital, the Emergency Department charges are paid separately from the inpatient charges. In this situation, the Member may visit the Emergency Department, return home, and be admitted later in the day (normally within 24 hours).