OPTIMA HEALTH KEY CONTACTS

OPTIMA HEALTH PROVIDER WEB PORTAL
www.optimahealth.com/ohio

PROVIDER RELATIONS
Provider Relations & Eligibility Verification
Medical
Phone: 1-844-853-4060
Fax: 1-877-822-7503

OPTIMA HEALTH CLINICAL CARE SERVICES
Phone: 1-800-229-5522 (option 0)
Fax: 1-844-202-5034

Behavioral Health Providers
Phone: 1-800-648-8420 Option 1
Fax: 1-844-202-5036

Pharmacy
Phone: 1-800-229-5522
Fax: 1-800-750-9692

After Hours Nurse Advice Line
Phone: 1-844-834-4375

Healthcare Services (Direct)
Phone: 1-866-503-2731
OB Notification Fax 1-844-202-5037

Quality Improvement
Phone: 1-866-425-5257
Fax: 1-866-783-5196

NETWORK EDUCATOR
Phone 1-877-865-9075 (option 4)

OPTIMA HEALTH AND PREVENTIVE SERVICES
Phone: 1-800-736-8272
Fax: 1-844-552-7508
OPTIMA HEALTH KEY CONTACTS (Continued)

FRAUD AND ABUSE
Hotline: 1-866-826-5277
E-mail: compliancealert@sentara.com
U.S. Mail: Optima Health
C/o Special Investigations Unit
4417 Corporation Lane
Virginia Beach, VA 23462

OPTIMA HEALTH ELECTRONIC CLAIM SUBMISSION NOTES
Fax: 757-275-9953

MEDICAL NECESSITY RECONSIDERATIONS
Mail: Clinical Care Services
4417 Corporation Lane
Virginia Beach, VA 23462
Fax: 1-844-398-5419

CLAIM PAYMENT RECONSIDERATIONS
Mail: Claims
P.O. Box 5806
Troy, MI 48007-5806

LATE CLAIM RECONSIDERTIONS AND APPEALS
Mail: Optima Health Claims Department
4417 Corporation Lane
Virginia Beach, VA 23462

OVERPAYMENTS
Phone: (800) 508-0528
Mail: Optima Health Provider Receivables
PO Box 61732
Virginia Beach, VA 23466

PROVIDER APPEALS
Fax: 866-472-3920
Mail: Optima Health
Provider Appeals
P.O. Box 62876
Virginia Beach, VA 23466
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INTRODUCTION

As a Participating Provider, you are an integral member of the team. We thank you for making it possible for Optima Health to promote the maintenance of health and the management of illness and disease by providing access to quality healthcare and the best in customer service to the communities we serve.

Optima Health Resources for Providers

Optima Health provides a number of resources for Providers to obtain information regarding membership, products, policies and procedures:

- Provider Reference Manual:

  This Provider Manual identifies contacts and resources within Optima Health, provides basic information for Member identification, credentialing procedures, requirements for prior-authorization, claim and reimbursement procedures. The Provider Manual also provides directions to locate detailed lists, contact information and policies on the Provider Web Portal. The Manual consists of a core document that includes general policies and procedures and detailed information. It also includes a Supplement that contains information specific to Hospitals and Ancillary Providers.

  The Provider Manual was developed to assist Providers in understanding the administrative requirements associated with managing a Member’s health care. This Provider Manual is amended as our operational policies change. Many of the policies and procedures that are referenced by or incorporated into this Provider Manual will be made available to you on the Provider Web Portal.

  In addition to the Provider Manual being available online, it is also available on CD or paper, by written request. Providers are responsible for complying with updates to the Provider Manual as they are made available from time to time. Optima Health may further notify Providers of updates to this manual by e-mail or by otherwise posting to our Provider Web Portal. For these reasons, keep us updated of changes to your mailing and e-mail addresses, and make sure to check your e-mails and the Provider Web Portal often.

- Online:

  Up-to-date contacts, policies and procedures, forms and reference documents are available to all Providers through the Provider Web Portal.

  Additional information and operational functions are available anytime for Participating Providers who register for Provider Connection. Provider Connection is a free service for Providers, but does require secure access registration. Providers may register for a secure login ID and password to allow secure access to Provider
Connection by going to the Provider Web Portal and completing the online Provider Connection Optima Health Enrollment Form.

Providers with secure access to Provider Connection are able to perform the following functions 24 hours per day, seven days per week:

- Check Member eligibility, copayments and benefits
- View and print Member ID cards
- Check authorization status
- Request prior-authorization
- Create OB notifications
- View claim detail and status
- Pre-adjudicate medical claims using C3-Clear Claims Connection
- View and download remits and Pended Claim Reports
- Submit online reconsiderations for Medical claims

- Mailings and Newsletters:

  Providers may be notified of updates or changes to policies via targeted mailings, e-mail or announcements on the Provider Web Portal.

- Telephone:

  Medical and Behavioral Health Providers may contact Provider Relations by phone. In the event an issue or a dispute under the Provider Agreement cannot be satisfactorily resolved by Provider Relations, Providers should contact their assigned Network Educator.

A complete directory of phone and fax numbers for Optima Health departments (including contacts for after hours) may be found online on the Provider Web Portal under “Contact Us”. A listing is also provided in the “Key Contacts” section of this Manual.

**Optima Health Resources Updates**

Notice of changes, amendments, and updates to this Provider Manual and any sources that are referenced by and incorporated herein, will be communicated to you via the Optima Health website and by e-mail (for Providers that have notified Optima Health of their e-mail address) sixty (60) days before the changes become effective. For this reason, it is critical that you keep your e-mail address with us current so that you can receive electronic communications with new and updated operational information and the Provider Manual. It is your responsibility to ensure that the e-mail address that you have provided to us is correct and current. To update your e-mail address and directory information contact your Network Educator.
HIPAA Privacy Statement


Optima Health maintains compliance with the Privacy Rule and Security Rule under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Health Information Technology for Economic and Clinical Health (HITECH) Act, and American Recovery and Reinvestment Act (ARRA). To ensure the protection of confidential information and patient health information, Optima Health 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.
MEMBER IDENTIFICATION

Member ID Cards

Members receive identification cards that indicate each enrolled member of the family. The card is for identification purposes only and does not verify eligibility or guarantee payment of services. Members should present their identification card at the time of service. The sample card shown is representative of Ohio plan type. ID cards will vary slightly due to specific differences between plans and employer groups.

To access a sample Member Identification Card for Ohio Plans: [http://providers.optimahealth.com/ProviderManualLibrary/ohio-id-cards.pdf](http://providers.optimahealth.com/ProviderManualLibrary/ohio-id-cards.pdf)

Eligibility Verification

Since a Member’s eligibility status may change, Member coverage should be verified at the time of service. Providers may access Provider Connection or call the Optima Health Interactive Voice Response (IVR) System 24 hours a day, seven days a week for the most current eligibility in Optima Health systems. Optima Health 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 online, sign in to Provider Connection using the Provider Web Portal. Choose “View Eligibility”.

To use the IVR System, call Provider Relations and press 2 to verify eligibility. There are three options available to search for a Member:

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

The IVR System provides:
- The Member ID number if a SSN or Medicaid number is used to search for the Member.
- The Member 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 Copayment or benefit information is available 24 hours a day on the Provider Web Portal or by speaking with a Provider service representative during business hours.
OPTIMA HEALTH CLINICAL CARE SERVICES

Clinical Care Services consists of the following departments:

- Quality Improvement
- Health and Prevention
- Healthcare Services (care management services)
- Medical Care Services (for prior-authorization and utilization management)
- Pharmacy
- Clinical Review
- After Hours Nurse Triage
- Appeals and Grievances

Information regarding the Clinical Care Services departments may be found in specific sections of this manual.

For all Members:

- A PCP referral is not required for Members to access health services, including behavioral health services.
- Participating Physicians may not refer to out-of-network providers unless authorized by the Plan. Ohio Health is a PPO plan type with higher Member out-of-pocket expenses for out-of-network services.
- Participating Physicians must obtain a prior-authorization from the Plan prior to recommending the Member obtain care out-of-network.
Purpose

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, and our health improvement community partnerships. Members may contact Health and Preventive Services through the Member Services phone number listed on the back of their Member ID card. Information for Members is available on the Member website.

Member Services

Preventive health services for Members include specific interventions to increase preventive health practices and to decrease identified health risks.

The Patient Identification Manager (PIM) Reminder System is a computer-based direct mail program designed to reach Members and Physicians every month to promote health. These initiatives support HEDIS® improvement requirements. Mailings and communications may include:

- **Birthday cards:** All plan Members age 3 and over receive a birthday card during their birthday month from the plan. Members ages 18 and over receive a bookmarker that serves to remind Members of the preventive health guidelines they should follow to achieve their personal best health; the mailing to Members aged 3-17 years includes a bookmarker with games and puzzles to remind their family to schedule annual checkups. Teen and adult Members who have an e-mail address in their profile will receive an electronic birthday message instead of the paper card that includes health information as well as links to the Optima Health website.

- **Healthy pregnancy mailings:** Once the health plan learns of a Member’s pregnancy, she receives the following as part of the Partners in Pregnancy Program:
  1. The *Planning a Healthy Pregnancy Self-Care Handbook*
  2. A letter and magnet featuring the childhood immunization schedule and our wishes for a healthy delivery (*sent once Member is in her seventh month of pregnancy*)

- **Immunization postcards and letters:** Postcards are mailed to parents for children at 6, 12 and 18 months of age emphasizing the basic immunization schedule.

- **Physician notifications:** Primary Care Physicians receive monthly lists of their patients (our Members) who were reminded through the PIM System and are still non-compliant for their immunizations and preventive screenings.
• **Telephonic reminder system:** Each month noncompliant Members are reminded to get their necessary testing with regard to asthma treatment, medication compliance, well child visits, antibiotic usage, mammography, pap tests, and colorectal screening. Additionally, Members with diabetes receive reminder calls about preventive screenings, eye exams and A1c testing.

**Health and Preventive Services by Optima Health** offers health improvement programs which include health risk identification and risk reduction strategies.

Members may complete an online Personal Health Assessment (PHA) and generate an immediate detailed report with specific risk reduction strategy recommendations and a shorter report that can be taken to their healthcare Provider. Diabetic, asthmatic and pregnant health plan Members are referred to our clinical care services teams.

**Health Coaching Services**

WebMD health coaching is available to Members participating through groups that are fully-insured and to any self-insured groups that purchase the health coaching option. Through a partnership with WebMD, Members are provided health and wellness solutions that are designed and managed by clinical experts, fully integrated with the health plan, with an emphasis on improving the health of all members – not just at-risk members. Optima Health provides this unique resource that includes: a health improvement web site, personalized wellness plans, and access to health coaches.

WebMD’s online and telephonic coaching is a powerful resource to help Members adopt healthy behaviors, reduce health risks and lower their lifetime cost of care. This comprehensive health coaching program has telephone-based coaching with strong internet tools, and educational resources to support the member in their goal to improve their health. Members complete a personal health assessment that is used to develop an individualized wellness plan.

The program is fully integrated with Optima Health. Self-reported and claims data combine for better targeting, permitting outreach and interactions that are well coordinated and “member centric” rather than “disease centric.” This resource promotes total population health management, since members have access to health coaches and receive a personalized wellness plan.

**Resources**

A comprehensive library of prevention literature and information about Optima Health print pieces and community resources for patient education is maintained by Health and Preventive Services and is a resource for Participating Providers. Please contact Health and Preventive Services for specific preventive health educational needs.
Communications

Health and Preventive Services participates with the Optima Health 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.

Community Health

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.

Awards

Optima Health received the National Health Information Award for the “Eating for Life” DVD program and the Wellness in the Workplace Award from WELCOA. Additionally Optima Health was awarded the C. Everett Koop National Health Award Honorable Mention and the Game Changer Award in Employee Health from the Virginia Health Innovation Network for the employee health improvement program, “Mission Health.”
CLINICAL CARE SERVICES
HEALTHCARE SERVICES

Healthcare Service Teams (case management services) 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.

Types of issues which may be referred to Healthcare Services:

- Members with complex medical issues who utilize multiple services
- Members who are non-adherent with treatment plans
- Members who frequently utilize services without consulting PCP or Specialist
- Members who frequently utilize the ER
- Members who could benefit from disease management of heart failure, metabolic cardiovascular disease, asthma, COPD or obesity

Requests for services (written or verbal) may be made by:

- Provider
- Member
- The Health Plan

To refer Members for Healthcare Services you may call Provider Relations and be referred to the appropriate team.

Direct phone numbers for case management services are listed in the Key Contacts section of this Manual.

Members are assigned to the Healthcare 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: Coordination of care and services provided to Members who have experienced a critical event or diagnosis that requires extensive use of resources and who need help navigating the system to facilitate appropriate delivery of care and services.
CLINICAL CARE SERVICES
MEDICAL CARE SERVICES: PRIOR-AUTHORIZATION

Prior-Authorization via Provider Connection

The preferred method to obtain prior-authorization is through the Optima Health secure Provider portal, Provider Connection. Providers must register to access Provider Connection. To submit a request for authorization, sign in to Provider Connection, choose Authorizations, Create Authorization and then complete the authorization request details. Create Authorization, defaults to outpatient service and users must select inpatient if applicable; then Request Type. The system will default to non-urgent and then you may enter the ICD 10 codes and Procedure/Revenue Codes. Ordering Provider and Servicing Provider codes may be looked up by using the NPI search icon. The Document Clinicals section is the clinical criteria used in making the determination for the authorization. This documentation must be completed before submission. You may attach this information or fax it. When the authorization information is completed, the Status of Request field will show Complete – Approved or Complete – Pended.

Prior-Authorization Fax Forms

All prior-authorization forms are available on the Provider Web Portal. The fax number varies based on the service requested. Please use the fax number listed on the Authorization form for the specific service.

Prior-authorization is available by phone for medically emergent requests. However, Providers are encouraged to use the Provider Connection whenever possible to expedite the process.

Medical Care Service Availability

Medical Care Service personnel are available to process faxed requests and medically urgent telephone requests between 8:00 a.m. and 4:30 p.m., Monday through Friday, Eastern Time. A confidential voice mail is available between the hours of 5PM and 8AM Monday through Friday and 24 hours on weekends and holidays.

Prior-authorization Procedures and Requirements

Prior-authorization is based on medical necessity and benefit coverage as supported by medical criteria and standards of care. Optima Health does not provide incentives to influence authorization decisions, promote denials of coverage of care, or encourage under-utilization of services.

*Elective admissions/requests must be submitted for prior-authorization 10 days prior to scheduling an admission or procedure. Treatment by non-participating Providers must receive prior-authorization from Optima Health in the same timeframe as above.*
The requesting provider should receive an authorization for services within five business days if all the necessary clinical information is provided with the initial authorization request and the service is covered under the Member’s benefit plan. Lack of clinical information to support authorization approval will delay processing.

**Failure to pre-authorize services will result in the denial of payment and the Provider may be held responsible for the cost of services rendered.**

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.**

Prior-authorization 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. Prior-authorization may, at the sole discretion of Optima Health, be required for:

- All inpatient hospitalizations
- All partial hospitalizations
- All outpatient surgeries/short stays/observations and IV therapy and drug infusions.
- All skilled nursing facility admissions
- All acute rehabilitation
- All Intensive Outpatient programs
- All out-of-area services or referrals to non-Participating providers (prior to scheduling).

All of the following services require prior-authorization regardless of the place of service:
- Durable Medical Equipment (DME) single purchased items greater than $750 and all rentals
- Home health/hospice/IV infusions
- Orthotics/prosthetics, single purchased items greater than $750 and all rentals, repair, replacement and duplicates
- Plastic surgery
- Ambulance transportation (non-emergent).
- All rehabilitation programs (cardiac, vascular, vestibular, pulmonary, etc.).
- Early intervention services (Part H certification required)
- OB global notification
- Transplant services (also applicable when Optima Health is not the primary payer)
- Oral surgery and related services
- Advanced Imaging Studies: PET, CT, CTA, MRI, MRA, MR-CT
- Hyperbaric therapy
- Electronic bone stimulator
• Any surgical or diagnostic procedure for which anesthesiology or conscious sedation is billed.
• Injectable drugs indicated on the online prior-authorization list, including but not limited to Synvisc/Hyalgen, Synagis, Rabies, Remicaid & IVIG
• Genetic testing (if covered by group/Plan)
• Bone densitometry if less than 24 months since last study
• Clinical trials
• Bariatric Surgery

To authorize admissions:
• **Scheduled inpatient admissions:** Complete the on-line request in Provider connection or Fax the completed request form and supportive clinical information to the fax number on the request form.
• **Emergent inpatient admission for a member that is currently hospitalized:** Complete the on-line form via Provider Connection and indicate that it is an urgent request or call Medical Cares Services.
• **Emergent inpatient admission for a member that has not been admitted:** Complete the on-line form via Provider Connection and indicate that it is an urgent request or call Medical Care Services.

**Forms for Medical admissions should be faxed to the number listed on the prior-authorization Form**

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

• Attending Physician’s name
• Patient’s name and Member ID number
• Name of admitting hospital
• Date of planned admission
• Admitting diagnosis, reason for admission/procedures and any applicable codes
• Procedures and procedure code(s) to be performed and date
• Treatment plan and prior treatment
• Summary of test results (if applicable)

Prior-authorization is NOT required for the following:
• Blood transfusions
• EEG
• Echocardiogram
• EKGs
• PVL
• X-rays
• Lab tests
• Bone density studies (bone densitometry), (A prior-authorization is needed if it is performed more than once in 24 months).
• Gallium scans
• Mammograms
• Spinal tap
• DME or prosthetic purchased items costing less than $750 per single item, and the rendering provider is a contracted DME Provider
• Emergency/UCC care
• Ultrasound
• Colonoscopy
• Upper GI
• Optima Health as a secondary payer (except organ transplant).
• Incontinence Supplies

**Genetic Testing and Counseling**

Physicians must obtain a prior-authorization from the Plan prior to the Member receiving services.

**Optima Behavioral Health Prior-authorization Requirement**

**Routine Outpatient Services**
Optima Behavioral Health (OBH) does not require prior-authorization before routine outpatient services are rendered.

**Psychological and Neuropsychological Testing**
Prior-authorization is not required for up to 7 hours of psychological testing or 8 hours or less of neuropsychological testing.

**Prior-authorization Required**
The following behavioral health services require prior-authorization:
• Inpatient/partial hospitalization
• Intensive Outpatient Program (IOP)
• Electroconvulsive Therapy (ECT)
• Repetitive Transcranial Magnetic Stimulation (rTMS)
• Applied Behavior Analysis
• 8 or more hours of psychological testing

**Clinical Care Policies/Criteria**

Clinical decisions are based on evidenced based medicine, appropriateness of care and service and coverage. Optima Health does not reward denials or provide any financial incentives that could result in underutilization.
Clinical Care Policies are used to determine medical necessity. Clinical Care Services 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 and requirements including LCD and NCD
- Assistance of appropriate network Providers/Specialists
- Benefits Committee review
- Computer medical search
- Local practicing Physicians

The Medical Directors of the Plan review Clinical Care Services policies. Approved policies are distributed to all appropriate departments and all policies are available to Physicians upon request. To request copies of policies and criteria, please call Clinical Care Services.

**Pre-Services Review**

Medical or behavioral health services requiring elective prior-authorization should be submitted as soon as possible or at least 7-10 days prior to scheduling procedure. This enables the Nurse Reviewers and Medical Directors time to review all submitted documentation, request other information or test results to make authorization determinations. These elective decisions will be rendered within 5 business days from receipt of all requested information. Urgent cases will be completed within 72 hours. Emergency requests due to life altering situations will be completed within 24-48 hours.

**Admission Review**

Clinical Care Services Hospital-review case mangers 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 prior-authorization request, the Plan will determine if the admission was Medically Necessary. If the admission was Medically Necessary, Optima Health will pay the claim. PPO/POS Members failing to obtain prior-authorizations within 48 hours may be subject to a $500.00 penalty or may be denied payment.

**Post-Service/Retrospective Review**

Any service or admission that was not authorized may be retrospectively reviewed. Reviews and decisions will be completed within 30 business days of receipt of all requested information.
**Concurrent Review**

Concurrent or continued stay review is performed on a daily basis (Monday-Friday) on all hospitalized Members 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 Medical Necessity for continued hospitalization is uncertain, the Medical Director may discuss the case with the attending Physician (peer to peer).

**Second Opinion**

Optima Health will pay for a second opinion for surgical procedures to determine if the procedure is Medically Necessary or to explore other treatment options. Members have the option of consulting with any Physician at their own expense at any time.

**Pre-Service or Current Request for Reconsideration of an Adverse Decision/Denial for Payment**

When a denial for payment/adverse decision 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/reconsideration 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. To request a reconsideration of a denial/adverse decision for payment please call Clinical Care Services and choose option 9.

A treating Provider may request reconsideration of an adverse decision or may appeal an adverse decision. Any reconsideration of an adverse decision shall only be requested by the treating Provider on behalf of the covered person. A decision on reconsideration shall be made by a Physician advisor, peer of the treating healthcare Provider, or a panel of other appropriate healthcare Providers with at least one Physician advisor or peer of the treating healthcare Provider on the panel.

The treating Provider on behalf of the covered person shall be (i) notified verbally at the time of the determination of the reconsideration of the adverse decision and in writing following the determination of the reconsideration of the adverse decision, (ii) notified verbally at the time of the determination of the reconsideration of the adverse decision of the process for an appeal of the determination and the contact name, address, and telephone number to file and perfect an appeal.

If the treating Provider on behalf of the covered person requests that the adverse decision be reviewed by a peer of the treating Provider at any time during the reconsideration process, the request for reconsideration shall be vacated and considered an appeal. In such cases, the covered person shall be notified that the reconsideration has been vacated and an appeal initiated, all documentation and information provided or relied upon during
the reconsideration process pursuant to this section shall be converted to the appeal process, and no additional actions shall be required of the treating Provider to perfect the appeal.

Any reconsideration shall be rendered and the decision provided to the treating Provider and the covered person in writing within 10 business days of receipt of the request for reconsideration.

The peer-to-peer process outlined above does not apply to claim denials or benefit denials. Please refer to the Claim Payment Reconsideration section and the Appeals sections of this manual for claim denial reconsiderations.

**Inpatient Denials**

The following are examples of 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 the 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”.

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 who is responsible for the charges.
CLINICAL CARE SERVICES
OBSTETRICAL CARE/PARTNERS IN PREGNANCY

Once a Member’s pregnancy is confirmed, the obstetrician (OB) must notify the Health Care Services Department by completing the OB Certification/Psychosocial Screen, and submitting it to Optima Health by fax. The numbers for Partners in Pregnancy are listed on the Contact page in the front of this Manual.

The certification assures the obstetrician may provide care for the Member throughout the entire pregnancy, delivery and for 6 weeks post-partum care. This certification is part of the Member’s incentive program for first trimester office appointments.

**Patient Access Guidelines**

For maternity care, appointments to provide initial prenatal care shall be made as follows:

- Within 14 calendar days of the request for pregnant enrollees in their first trimester.
- Within 7 calendar days of the request for pregnant enrollees in their second trimester.
- Within three 3 business days of the request for pregnant enrollees in their third trimester or for high-risk pregnancies, or immediately if an Emergency exists.

**Home Health Post-Delivery Services**

Home Health Services are available, **if prior-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
- Checking mother’s condition

**High-Risk Pregnancies**

All High-Risk Pregnancies should be managed by a contracted Maternal and Fetal Medicine Specialist (MFM). If you need assistance identifying a contracted MFM specialist please contact the Partners in Pregnancy Case Manager.

**Breast Pumps**

All rental breast pumps require prior-authorization.
GYNECOLOGICAL CARE

Annual Gynecological Exams

Annual GYN exams are covered every 320 days. This allows a 45-day grace period for scheduling appointments. This exam includes routine healthcare services rendered during or as a result of the annual visit. It includes:

- Physical and pelvic exam
- A hematocrit or hemoglobin
- Pap smear
- Urinalysis
- Wet prep
- Depo Provera
- A pregnancy test if medically indicated
- Cholesterol screening
- Mammograms:
  - Covered under Preventive Healthcare services at Participating ACR accredited radiology facilities with a Physician prescription
  - Annual mammograms covered starting at age 40
  - Screening/diagnostic mammograms covered for Members between the ages of 35 and 40

Vasectomies and Tubal Ligations

Most plans require Copayments for vasectomies and tubal ligations. Call Provider Relations for more plan specific information. Not all plans cover these services. Please see the Medicaid section of this Manual for Medicaid specific policies.

Infertility Treatment

Some Members do not have infertility benefits in their core coverage. Please call Provider Relations to verify coverage. In addition, fertility drugs, in-vitro fertilization, services associated with the storage/freezing of sperm, or charges for donor sperm are not covered.

Termination of Pregnancy/Abortions

Most Members have benefits for elective abortions in the first 12 weeks of pregnancy. If the PCP or OB/GYN does not wish to refer the Member; the Member may obtain an authorization by calling the prior-authorization number on her Member ID card. For questions regarding coverage, Members should contact Member Services.
EMERGENCY DEPARTMENT/URGENT CARE CENTERS

Members do not need prior approval from their PCP or the Plan before seeking care at the Emergency Department (ED) or urgent care center (UCC). All Members are encouraged to contact their PCP or the Plan via the After Hours Nurse Advise Line Program for instructions on the type of care to receive.

Optima Health covers any Emergency services necessary to screen and stabilize Members.

All Members seeking care at Emergency facilities will be subject to the ED Copayment (if applicable).

CLINICAL CARE SERVICES
AFTER HOURS NURSE ADVICE LINE PROGRAM

The After Hours Nurse Advice Line provides an avenue of care for Members who need treatment or advice after their Physician’s office is closed. Registered Nurses are available to provide direction and education for patients whose needs range from a sore throat to surgery questions. These nurses follow a set of protocols written and approved by Physicians. Depending on patient’s symptoms, the nurse may give instructions (advice) with approved protocols for self-care and further follow-up if symptoms should worsen or reoccur; she/he may recommend follow up with a Primary Care Physician (PCP) or may refer patients to a Facility for evaluation and treatment of symptoms. Members are informed that the After Hours nurse does not have access to medical records, does not diagnose medical conditions, order lab work; write prescriptions, order home health services, or initiate hospital admissions. If the Member disagrees with the nurse’s advice for self-care and proceeds to the Emergency Department or an urgent care center, Optima Health may retrospectively review the visit for payment determination.

Benefits

Physicians benefit from the program in a number of ways:

- You will appreciate the Member receiving advice after-hours to meet appropriate health-care needs.
- The program reduces the number of after hour’s non-Emergency calls you receive.
- You have the assurance that the After Hours nurse will contact you if the situation requires it.

Telephone Number and Hours

Members may be directed to their Member ID cards or the Member website for telephone contact numbers. The program is available 24 hours a day seven days a week.
ADDITIONAL/ANCILLARY SERVICES (A-Z)

Depending on the plan, covered ancillary/other services such as Home Health, DME, and prosthetic appliances require prior-authorization by the Clinical Care Services (CCS) Department. Details are outlined in the information provided below.

Artificial Limb Benefit

Coverage for artificial limbs varies by product and/or employer. Please call Provider Relations 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 prior-authorization of services. Prior-authorization is required.

Audiology Services

Audiology services are covered when authorized by Medical Care Services.

Hearing aids are covered under some Plans through a Rider. All Members have access to a value added hearing aid discount program if they use the discount program Provider. This value added hearing aid discount program can be accessed when the Member does not have a hearing aid benefit. Please contact Provider Relations for specific coverage.

Chiropractic Services

Some Plans and employer groups have chiropractic benefits. Participating Chiropractic providers may be identified by using the Provider search feature on the Provider Web Portal.

Dental Coverage

Accidental Dental:

Treatment of a dental accident is covered as a medical benefit for some Members and is separate and apart from any dental plan or dental Rider. Specific coverage information and exclusions are available to Providers during business hours by calling Optima Health Provider Relations. A healthcare professional such as a nurse or a physician must document treatment. For injuries that happen on or after the Member’s effective date of coverage, treatment must be sought within 60 days of the accident. Specialist Copayments apply to each visit to a dentist or oral surgeon covered under this benefit.

Dental services performed during an Emergency Department visit immediately after an Accidental Injury in conjunction with the initial stabilization of the injury are covered. Members are responsible for the Emergency Department Copayment or Coinsurance.
**Dialysis Services**

- A valid written or verbal order from the attending nephrologist is required.
- Dialysis claims must be submitted on a UB 04 claim form.
- Dialysis supplies are only payable in the home setting. Appropriate documentation and J codes are required to differentiate the medication from pharmacy supplies.
- 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.

**Disposable Medical Supplies**

- Commercial plans cover ostomy supplies, diabetic supplies, holding chambers (spacer/aerochamber) and peak flow meters. These items do not require authorization.
- 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.

In summary, all **COVERED** disposable supply items (excluding those supplies listed above) that will be separately billed to the Plan must be authorized. Most disposable medical supplies are **NOT** covered. All **COVERED** replacement supply items also require an authorization.

**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.

**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 prior-authorization. Most products have a calendar year benefit maximum. Contact Provider Relations for specific Member benefit information. Clinical Care Services (CCS) will assign authorizations for DME services that require authorization. Authorizations are issued for medical necessity but do not guarantee payment.
**DME Equipment Rental and Purchase Policy**

- Optima Health Clinical 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 percent of the purchased price of the equipment, Optima Health 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.

**Equipment rental payment when a Member becomes disenrolled:**

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

- The line item billed will be changed to indicate the dates the Member was covered.
- A quantity of one will be shown for the covered days and the full month’s rent will be paid.
- A second line item will be added indicating the dates the Member was not covered.
- A quantity of zero 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”.

**DME Copayments/Coinsurance**

Copayments vary by product and employer. Please contact Provider Relations for details.

**DME Authorization**

- Authorization requirements for DME equipment single purchase is any item >$750.00, however, specific authorization requirements may vary by employer. Services must be provided by contracted DME Providers.
- All DME equipment rentals, regardless of dollar amount, require an authorization. Services must be provided by contracted DME Providers.
- All covered disposable supply items (excluding ostomy and diabetic supplies) that will be separately billed to the Plan must be authorized. All covered replacement supply items also require an authorization.
- Providers may fax a completed prior-authorization form to Clinical Care Services (CCS) to request an authorization.
• Requested changes in authorizations must be faxed to Clinical Care Services within 30 days of the original authorization.

**Home Health & IV Therapy**

Home Health and IV Therapy services require prior-authorization for all products. To arrange and obtain prior-authorization for Home Health or IV Therapy Services, fax the completed authorization form to Clinical Care Services. Change requests for authorizations must be faxed to Clinical Care Services within 30 days of the original authorization.

Home Healthcare 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.

For all products, therapy services (physical, occupational or speech) provided in the home setting will have a Copayment applied for each modality provided during the visit as defined by the plan. 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 at contracted rates if specifically authorized by Clinical Care Services (CCS).

**Hospice Services**

Hospice care is available to Members who are diagnosed with a terminal illness and have fewer than six months to live. Hospice care services 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 prior-authored by Medical Care Services.

**Medical Transportation Services/Ambulance**

Ambulance/stretcher 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 on a case by case basis.
• Ambulance/stretcher service is covered from the place where the Member was injured to the nearest hospital where treatment can be furnished when Medically Necessary.

• Ambulance/stretcher transportation from facility to facility must be prior-authorized through CCS. When part of a scheduled transport, ambulance services should be prior-authorized by CCS.

• Members are responsible for Copayments 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. In cases requiring services after routine business hours or other circumstances where services were provided in good faith, Optima Health will not withhold authorization if the patient is a current Optima Health Member, Medical Necessity warrants the services, and the authorization request is made within 30 days of the service.

Oxygen Policy

Members may receive oxygen through a Durable Medical Equipment (DME)/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, oxygen therapy is prior-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 CCS, 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 prior-authorization.

Physical and Occupational Therapy

Outpatient physical and occupational therapy may be performed by Participating therapy Providers meeting the Plan’s therapy participation criteria. The following therapy guidelines are applicable to all therapy Providers:

• Coverage of therapy services varies by plan type and employer. Verification of therapy benefits for a specific Member may be obtained by contacting Provider Relations.

• Re-evaluations are not covered by the Plan

• Work Hardening programs or functional capacity testing is not covered by any plan.
All therapy services must be ordered by a Physician. A Primary Care Physician (PCP) or Specialist may order therapy services by providing the Member with a written prescription for therapy services to a Participating therapy Provider.

Billing and Reimbursement:

- Freestanding therapy Providers should submit claims electronically on a CMS 1500 claim form using the appropriate CPT codes as designated by the current AMA CPT Code book.
- Hospital-based therapy Providers should submit claims on a UB 04 claim form using the revenue code 42X for physical therapy and revenue code 43X for occupational therapy. In addition to the revenue code the appropriate CPT codes, as designated by the current AMA CPT Code book, must be included.
- Procedure code 97750 (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.
- Customized splints provided by the therapy Provider must be specifically prior-authorized by CCS for all plans. The customized splint must be billed using the appropriate HCPCS code.

**Prosthetic and Orthotic**

Prosthetic and orthotics are covered when determined to be Medically Necessary and appropriately pre-authorized by Medical Care Services. Customized and non-customized single orthotics with requested charges equal to or greater than $750.00 must be authorized. Authorization limit amounts may differ for some self-funded groups. Providers should call Provider Services to determine authorization requirements for self-funded groups.

Coverage for non-surgically implanted prosthetic and orthotics 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 and orthotics 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 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.
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.

**Skilled Nursing Facilities (SNF’s)**

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

**Speech Therapy**

- Speech therapy may be performed by Participating Physicians, therapy centers or Hospitals contracted to perform speech therapy.
- Verification of therapy benefits for a specific plan may be obtained by contacting Provider Relations.
- Regardless of place of service Deductibles/Coinsurance or Copayments are required for therapy services, per visit, per therapy type for Commercial plans.

**Vision Coverage**

Please be sure to verify vision benefits prior to providing service. Vision benefits may vary by employer group and benefit plan.
PHARMACY

Prescription drugs are covered. Any guidelines regarding preferred drug use must be followed. Please contact Provider Relations for specific coverage information.

Specialty Drugs are available through the Optima Health specialty mail order pharmacy, BriovaRx.

**Standard Formulary**

- The formulary provides quantity, form, dosage and prior-authorization restrictions for certain drugs;
- The formulary requires generic drug prescription usage whenever possible. These drugs are listed with the generic name on the drug listing. If a Member requests a brand name drug when a generic drug is available, the Member may be responsible for additional charges;
- The formulary provides a framework and relative cost information for the management of drug costs;
- Formulary copies are available on the Provider Web Portal with quarterly updates.

**Marion Bargaining Unit**

The Marion Bargaining Unit has a different pharmacy benefit with a 4-tiered Copayment structure. With a tiered pharmacy plan, all drugs are covered (with the exception of exclusions as listed in the Member’s benefit description). Copayments vary depending on the tier in which the prescription drug falls. Tiers are assigned by the Plan’s Pharmacy and Therapeutics Committee and include:

- **Selected Generic (Tier 1):** Includes commonly prescribed generic drugs. Other drugs may be included in Tier 1 if the Plan recognizes they show documented long-term decreases in illness.
- **Selected Brand & Other Generic (Tier 2):** Includes brand-name drugs, and some generic drugs with higher costs than Tier 1 generics, that are considered by the Plan to be standard therapy.
- **Non-Selected Brand (Tier 3):** Includes brand name drugs not included by the Plan on Tier 1 and Tier 2. These may include single source brand name drugs that do not have a generic equivalent or drugs determined to be no more effective than equivalent drugs on lower tiers.
- **All Other (Tier 4):** Includes those drugs not classified by the Plan as Specialty Drugs. Tier 4 also includes covered compound prescription medications. Specialty Drugs have unique uses and are generally prescribed for people with complex or ongoing medical conditions. Specialty Drugs typically require special dosing, administration, and additional education and
support from a health care professional. Specialty Drugs include the following:
- Medications that treat certain patient populations including those with rare diseases;
- Medications that require close medical and pharmacy management and monitoring
- Medications that require special handling and/or storage;
- Medications derived from biotechnology and/or blood derived drugs or small molecules; and
- Medications that can be delivered via injection, infusion, inhalation, or oral administration.

**Drugs not included on the Formulary**

Based on peer-reviewed medical literature and the input of the appropriate medical specialists, the Pharmacy and Therapeutics Committee may opt to develop criteria for authorization approval of non-formulary drugs. The committee may also recommend alternatives for requested agents. Please refer to Pharmacy section on the Provider Web Portal.

**Prior-authorization**

Prior-authorization is required for a limited number of drugs to ensure appropriate use. For the prior-authorization process:
- Refer to the Prior-Authorization, Step Edit and Quantity Limits Drug List on the Provider Web Portal for a listing of drugs requiring prior-authorization. A prescription authorization is initiated at the Provider’s office. The requesting Provider must present evidence of meeting the criteria.
- Prior-authorization for certain drugs may be obtained by filling out the specific prior-authorization form for the medication. These forms may be completed by an office staff Member, but must contain an original MD signature. Once completed, fax the forms to pharmacy authorizations. For copies of the forms, go to the Provider section of the Provider Web Portal or call Pharmacy Authorizations at Clinical Care Services.
- This authorization should occur prior to filling the prescription, but it is not necessary for refills. If the authorization is not obtained in advance, the pharmacy will have to call the prescribing Provider to request that he/she initiate the prior-authorization process.
- Formulary prior-authorization responses are generally received within 2 working days of Optima Health receiving the completed form and information from the Provider.

**Contraception**

Based on the Affordable Care Act, generic contraceptives are available to female Members at $0 cost share when filled at a participating Pharmacy. After the calendar year
Deductible, brand oral contraceptives are covered; the Member pays 20% of the negotiated charge at a participating Pharmacy. For Marion Bargaining Unit, generic and brand oral contraceptives are covered at $0 cost share.

The following is a list of contraceptives that are covered by Optima Health Plans and whether they are a medical benefit or a pharmacy benefit. If the contraceptive is a medical benefit, it cannot be obtained at the retail pharmacy.

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<thead>
<tr>
<th>CONTRACEPTIVE</th>
<th>PHARMACY</th>
<th>MEDICAL</th>
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<tbody>
<tr>
<td>Birth Control Pill</td>
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<tr>
<td>Diaphragm</td>
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<td>Birth Control Patch</td>
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<td>IUD</td>
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<td>Depo Provera</td>
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<td>Lunelle</td>
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<tr>
<td>Cervical Cap</td>
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**Days Supply Dispensing Limitations**

Members may receive up to a 31-day supply of a non-maintenance prescription at a retail pharmacy or Riverside Medical Building. A 31-day supply shall be interpreted as a consecutive 31-day supply. Members may obtain up to a 90-day supply from Riverside Medical Building (RMB) Pharmacy.

**Dental & Optical Prescriptions**

Prescriptions written by Participating dentists, optometrists and ophthalmologists are covered when the Plan’s guidelines are followed.

**Diabetic Supplies**

Diabetic supplies are covered under the pharmacy benefit.

**Diaphragms**

Members may receive one diaphragm every twelve months.

**Drugs: Self-Injectable Medications**

Self-injectable medications are covered exclusively under the pharmacy benefit. Members must obtain these medications directly from the specialty pharmacy. Self-injectable medications that require Prior-authorization are listed on the Optima Health Prior Authorization, Step Edit and Quantity Limit Drug List on the Provider Web Portal.
Injectable and Infusion Medications Administered in the Physician’s Office

Optima Health has an agreement with BriovaRx to fill and deliver injectable and infusion medication orders for administration in the Physician office. BriovaRx is a mail-order specialty pharmacy that provides certain prescription medications and immunizations directly to Physician offices. Delivery to the Physician office is generally received within 24 hours of submitting the prescription order.

A 20 percent coinsurance may apply. Some drugs require prior-authorization and the prior-authorization requirements also apply when using BriovaRx. Medications that are administered in the Physician’s office that require prior-authorization are listed on the Optima Health Injectable and Infusion Medication List on the Provider Web Portal.

BriovaRx bills Optima Health directly for the medication. The Physician office should only bill for the administration of the medication, and should not collect Copayments or Coinsurance associated with the medications from patients. BriovaRx will bill the Member for the Coinsurance or Copayment amount. BriovaRx may be reached by calling 1-855-427-4682. Specialty forms are available to Providers on the Provider Web Portal.

Providers may also bill Optima Health for pre-authorized injectable and infusion medications obtained from other sources by submitting the appropriate J code. When billing Optima Health directly for the cost of the medication, Providers will be responsible for collecting any Coinsurance amount due from the Member when the remittance is received.

IUDs

Mirena and Skyla IUDs may be ordered through CVS Caremark. CVS Caremark will send the IUD to the Physician’s office and bill Optima Health directly. Alternatively, Providers may provide the Mirena or Skyla IUD and bill Optima Health with the appropriate J code.

Limited Distribution Drugs

Manufacturers are increasingly limiting the distribution of specialty drugs to certain pharmacies. Instructions and ordering forms will be distributed to Providers by Optima Health to facilitate continuity of care when this occurs. Optima Health will notify Providers of limitations by e mail, newsletters and postings on the Provider Web Portal.
**Migraine Quantity Limits**

The Neurology specialty group has recommended that quantity limits be established for certain medications used to treat migraines. If dosages exceed these limits, the Physician is requested to use prophylactic medication for the prevention of migraines. The Prior-Authorization, Step-edit, and Quantity Limits Drug List with the recommended quantity limits is available on the Provider Web Portal under Drug Authorization Policies in the Pharmacy section.

If a Physician feels that it is Medically Necessary to obtain quantities exceeding the recommended limits, he/she will need to submit an authorization request to Pharmacy Services.

**Mail Order Prescription Drug Program**

Members may purchase a 90 day supply of drugs from OptumRx. Members can download and print the OptumRx Mail Service Form from the Member website. Physicians need only to write a prescription for the Member on the appropriate form.

For more information on the mail order program, Members may call OptumRx toll free at 1-866-244-9113.

**Pharmacy Coverage Exclusions**

The following is a list of products or categories that are not covered for reimbursement under the Member pharmacy benefit contract. This list is subject to periodic review by Optima Health and therefore may not be a complete listing of products.

Prescriptions for the following are excluded from coverage:

- Medications that do not meet the Plan’s criteria for Medical Necessity, Pre-Authorization or Step-Therapy
- Medications with no approved FDA indications
- Medications for experimental indications and/or dosage regimens determined by the Plan to be experimental
- Over-the-counter (OTC) medications that do not require a Physician’s authorization by state or federal law
- Prescription medications with an OTC equivalent
  - PPIs with OTC equivalents are excluded (for example, omeprazole 20 mg and Nexium 20 mg)
  - Antihistamines with OTC equivalents are excluded (for example, Zyrtec and Claritin)
- Any prescription drug dispensed for the treatment of erectile dysfunction, impotence or sexual dysfunction or inadequacy. Exception: These drugs are covered for the Marion bargaining Unit.
• Compound prescription medications with ingredients not requiring a Physician’s authorization by state or federal law
• Non-durable disposable medical supplies and items such as bandages, cotton swabs, hypodermic needles, and durable medical equipment
• Immunization agents, biological sera, blood, or blood products
• Injectables (other than those self-administered and insulin)
• Medication taken or administered in the Physician’s office
• Medication taken or administered in whole or in part, while a patient in a licensed Hospital
• Medications for cosmetic purposes only, including but not limited to Retin-A for aging
• Therapeutic devices or appliances, including but not limited to support stockings
• Drug charges exceeding the cost for the same drug in a conventional packaging (i.e., convenience packages, unit doses, blister packs, etc.)
• Ancillary charges which result from a request for a brand name outpatient prescription drug when a generic drug is available are excluded from Coverage and do not count toward any Plan Maximum Out of Pocket Limit.

**Additional Pharmacy Policies**

• Benefits will not be denied for any drug prescribed, on an inpatient or outpatient basis, to treat a covered indication so as long as the drug has been approved by the United States Food and Drug Administration for at least one indication and the drug is recognized for treatment of the covered indication in one of the standard reference compendia or in substantially accepted peer-reviewed medical literature.
• Benefits will not be denied for any drug, prescribed on an inpatient or outpatient basis, approved by the United States Food and Drug Administration for use in the treatment of cancer on the basis that the drug has not been approved by the United States Food and Drug Administration for the treatment of specific type of cancer for which the drug has been prescribed, provided the drug has been recognized as safe and effective for treatment of that specific type of cancer in any of the standard reference compendia.
• Benefits will not be denied for any drug, prescribed on an inpatient or outpatient basis, approved by the United States Food and Drug Administration for use in the treatment of cancer pain for the reason that the dosage is in excess of the recommended dosage of the pain relieving agent, if the prescription has been prescribed for a person with intractable cancer pain.
• At its sole discretion the Optima Health Pharmacy and Therapeutics Committee determines which Tier a covered drug is placed in. The Pharmacy and Therapeutics Committee is composed of Physicians and pharmacists. The committee reviews the medical literature and then evaluates drug tier placement and the addition of any prior authorization or step-edit requirements. Efficacy, safety, cost, and overall disease
cost are factors that are taken into consideration. The Pharmacy and Therapeutics Committee may establish monthly Quantity Limits for selected medications.

1. Amounts the Member pays for any outpatient prescription drug after a benefit limit has been reached, or for any outpatient prescription drug that is excluded from Coverage will not count toward any Plan Maximum Out of Pocket Amount.

2. Prescriptions may be filled at a Plan pharmacy or a non-participating pharmacy that has agreed to accept as payment in full reimbursement from the Plan at the same level as the Plan gives to participating pharmacies.

3. The Plan may approve Coverage of Limited quantities of an OTC drug. You must have a Physician’s prescription for the drug, and the drug must be included on the Plan’s list of covered Preferred drugs.

4. Insulin, syringes, and needles are covered. Diabetic supplies and equipment, in-person outpatient self-management training and education, including medical nutrition therapy, for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes and noninsulin-using diabetes if prescribed by a health care professional legally authorized to prescribe such items under law, other than those listed as covered under the prescription drug Rider are covered under the Plan’s medical benefit. Any Plan maximum benefit does not apply to Physician prescribed diabetic supplies covered under the medical benefit.

5. Intrauterine devices (IUDs), and cervical caps and their insertion are covered under the Plan’s medical benefits.

**Specialty or Biotech Drugs**

BriovaRx is a mail-order pharmacy that is contracted with Optima Health to provide covered specialty or biotech drugs for high-risk diseases requiring a complex pharmaceutical regime directly to Physician offices. Current prior-authorization requirements also apply when using BriovaRx. Delivery to the Physician office is generally received within 24 hours of submitting the prescription order.

BriovaRx bills Optima Health directly for the medication. The Physician office should only bill for the administration of the medication and should not collect Copayments or Coinsurance associated with the medications from patients. BriovaRx may be reached by calling 1-855-577-6512. (See also “Injectable and Infusion Medications Administered in the Physician’s Office”) Specialty forms are available to Providers on the Provider Web Portal.
LABORATORY SERVICES

Laboratory services may only be performed by contracted lab Providers. Any entity providing laboratory services must have the appropriate CLIA certificate.

In-Office Laboratory Services Reimbursement

- The office may bill one venipuncture fee per patient
- Samples obtained by swab or cup are considered to be part of the office visit
- Optima Health will not reimburse CPT codes billed individually when they are considered part of a bundled CPT code

Laboratory Providers

Providers have the option of sending the patient with orders to a Participating reference Laboratory. Members and Providers may locate the nearest Participating Laboratory on the Provider Web Portal or call Provider Relations for information. Since locations and Providers are subject to frequent additions and changes, the most reliable locator for current information is the Provider Web Portal.

HealthReach Preferred Providers should reference the OhioHealth website for the most current listing of participating laboratory locations.

Pre-Operative Lab and X-Ray

Members scheduled for surgery at a Participating Hospital may obtain services through a Participating Provider, a Participating reference lab or may be sent directly to the admitting Participating 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.

Genetic Testing

All genetic testing requires prior-authorization by the ordering Physician prior to initiation of the order for tests.

Medication Compliance Testing

Pain management medication compliance testing must be obtained from contracted laboratory Providers only.
REIMBURSEMENT POLICIES

Optima Health intends to follow American Medical Association (AMA) coding guidelines (e.g. CPT and HCPCS definitions) and Health Plan Policy 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 Optima Health routinely uses Medicare rules as its basis. Optima Health may utilize proprietary purchased software products that incorporate similar coding and compliance rules into Optima Health’s claims processing edits.

Clear Claim Connection (C3) is a web based code auditing reference tool that enables Optima Health to disclose code-auditing rules and associated clinical rationale. Medical Providers are able to enter outpatient claim information using CPT and/or HCPCS codes, obtain audit results, and review recommendations. Clear Claim Connection is available to Medical Providers through Provider Connection on the Provider Web Portal.

Medicare policy and procedural information is available at http://www.cms.gov/. The CMS website can give your practice information regarding Medicare’s National Correct Coding Initiative (CCI) Edits and how to go about obtaining those edits.

Provider Fee Schedule

Provider compensation arrangements and rates are detailed in your Provider Agreement.
BILLING AND PAYMENTS

Contracted Amounts/Billing Covered Persons

By entering into a Provider agreement, you have agreed to accept payment directly from us. This constitutes payment in full for the Covered Services you render to Members, except for Copayments, 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 Copayment 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 Member the difference of the two amounts.

Appropriate Service and Coverage

Optima Health has mechanisms 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.

Medical Necessity

The Plan may deny claims for services deemed medically unnecessary. If the Provider does not agree with the Plan’s determination the Provider may submit medical documentation (chart copies, treatment sheets, consultation reports, etc.) with a request for reconsideration to Optima Health.

See the “**Provider Reconsideration and Appeal Process**” in this manual for more detailed information.

Members may not be billed for services determined to be not Medically Necessary by Optima Health 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.
- 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 Copayments, Coinsurance or Deductibles and file a claim for the service rendered.
Please see “Copayments and Coinsurance” section of this manual for more information.

Never Events

When an inpatient claim is denied as a “Never Event,” all Physician claims associated with that “Never Event” will be denied. In accordance with Centers for Medicare and Medicaid Services (CMS) guidelines, any Provider in the operating room when the error occurs, who could bill individually for their services, are not eligible for payment. All related services provided during the same hospitalization in which the error occurred are not covered. The hospital providing the repair will be paid. All Never Events are reviewed by the Optima Health Medical Director.

Member Cost-Share

You should expect payment of Member Copayments at the time of service. If the Copayment is more than the charges for the service rendered, the allowed charge amount should be billed to the Member instead of the full Copayment.

The Optima Health 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.

Coordination of Benefits (COB)

Group 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 and similar liability insurance claims are not covered by Group health plans.

Access detailed Optima Health Coordination of Benefits Policies:

Pursue Letter

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

If the Provider has not received the EOB from the primary carrier after 30 days of receipt of Optima Health’s pursue letter, Optima Health will retract any claim paid and deny the claim pending receipt of the primary carrier’s EOB.
**Overpayments**

In most cases, when a Provider is paid in error, Optima Health 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 the Optima Health Provider Receivables address in the Contacts section of this Manual.

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

General Information and Filing Requirements

- The preferred method for claim submission to Optima Health is electronic claim submission. Claims can be submitted through a clearinghouse, AllScripts/PayerPath, or can be submitted directly by a Provider or vendor.
- All claims must be submitted within the guidelines of the product (see the “Timely Filing” section in this chapter) or they will be denied as a late claim submission.
- Claims submitted must be for Participating Providers within the practice.
- Submit paper claims on the standard CMS 1500 form for professional Providers or UB-04 form for Facilities. All claims must be “Clean Claims” or “Complete Claims.” These are claims that are properly completed claims for payment for Covered Services that require no further information, documentation, adjustment, or alteration by the Participating Provider in order to be processed or paid.

NPI

All claims submitted to Optima Health must include individual and Group Practice NPI numbers. It is preferred that Providers also submit the taxonomy code on the claim in addition to the NPI numbers.

Completing the CMS 1500 Claim Form

In order to expedite payment and avoid re-submission of claims, it is important to fill out the CMS 1500 claim form as completely and accurately as possible. Submit claims containing all the data elements and industry-standard coding conventions. The National Uniform Claims Committee (NUCC) provides standard instructions for completing the 1500 form on their website at www.nucc.org. The CMS 1500 claim form version 02-12 is required by Optima Health.

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

- Complete all patient identifying information in boxes 1-13. The Member’s (Patient) ID and Group number should be placed in boxes 1a and 11.
- The Member name submitted on the claim must match the Member name in box 12.
- Either the patient’s signature or the words “signature on file” are required.
- ICD-10 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 must be provided.
A “Clean” or “Complete” Claim will be processed and paid by Optima Health within 30 days of its receipt. Processing delays may occur for claims that require coordination of benefits, code review or medical review.

Paper Claims:
All paper claims should be sent to the claim address on the Member’s ID card.

Common Reasons for Claim Rejection

- Errors in Member name. Hyphenated last names must be submitted as they appear on the Member’s ID card.
- The birth date submitted must match the birth date associated with the Member ID number.

Remittance Advice

A Remit is an explanation of reimbursement. The Remittance Advice details claim adjudication. Providers registered with Provider Connection may download their Remittance advice from the Provider Web Portal.

Negative Vendor Status

This term is used for information purposes for 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 Optima Health 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 by Optima Health.

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. 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 30 days from the date of the report, call Provider Relations for Medical or Behavioral Health claim information to resolve its status.

If your claim has not been paid or denied, and is not pending for any reason, please call Provider Relations for information. If the claim is confirmed as not received, a second request must be submitted. These claims are subject to the Optima Health Timely Filing Policy.

**Authorization Search**

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

**Timely Filing Policy**

The filing deadline for all plans is **365 days from the date of service**.

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 member.

**Late Claim Reconsiderations and Appeals**

Requests for waivers to the timely filing requirements due to an exceptional circumstance must be made in writing within the reconsideration filing deadlines and should be submitted to the Optima Health Claims Department.

In situations where a Provider does not agree with the reconsideration decision on a claim, an appeal should be filed according to the “Provider Reconsideration and Appeal Process” section.

**Duplicate Claims and Reconsiderations**

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 view claim status on the Provider Web Portal or call Provider Relations to inquire on the status of your claim. Optima Health checks for duplicate claims by comparing the Member number, vendor identification 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 “Claim Payment Reconsiderations” section of this manual for detailed information.

**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 Optima Health within **90 days** of receipt of the new information.

**Retroactive Disenrollment**

Optima Health 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; the Plan 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.

**Claims Denied in Error**

The Physician’s office must follow-up with Optima Health within **365 days** of the date of denial for claims the Provider suspects have been denied in error. If after researching the claim, Optima Health discovers that the claim was denied in error the Provider is entitled to payment.

**Worker’s Compensation**

Any claim with an injury diagnosis code for a patient over the age of 16 will be reviewed. Optima Health 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 a claim is paid under an Optima Health Benefit Plan prior to determining that it is a Workers’ Compensation claim, Optima Health will reverse the payment. The claim should be submitted through the Member’s employer’s Workers’ Compensation Plan.
ELECTRONIC CLAIMS & ELECTRONIC FUNDS TRANSFER (EFT)

Electronic Funds Transfer (EFT)

EFT is safe, secure, efficient, and less expensive 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 when payment is made through EFT.

Providers are encouraged to enroll for EFT by completing the Electronic Payment/Remittance Authorization Agreement on the Optima Health Provider Web Portal.

Filing Claims Electronically

Providers that submit claims to Optima Health electronically enjoy a number of benefits: documentation of claims transmission, faster reimbursement, reduced claim suspensions and lower administrative costs.

- Claims can be submitted through AllScripts/PayerPath, or any clearinghouse that can connect through All Scripts/PayerPath, or can be submitted directly to Optima Health by a Provider or Vendor via data files in HIPAA compliant format.
- Providers who can receive data files in the HIPAA compliant ANSI 835 format may elect to receive EFT/ERA directly from Optima Health. The 835 transaction contains the remittance information as well as the Electronic Funds Transfer. Inquiries about direct claims submission or EFT/ERA transactions may be submitted by e-mail to EFT_ERA_Inquiry@sentara.com.
- All claims must be submitted within the Timely Filing Policy provisions stated in your Agreement or as dictated by Plan policy. Please see the “Timely Filing Policy” section in the Claims chapter of this manual.
- Claims submitted must have charge amounts. Claims for zero (0) charge amounts will be rejected.
- Claims submitted electronically will be received within 24 hours for processing.

Required Claims Information

All information noted in the claims chapter of this manual is applicable to claims filed electronically. A noted exception is for operative or office notes. Claims requiring additional information may be sent electronically. Providers may submit electronic notes by fax directly to Optima Health within 24 hours of electronic claims submission.
Electronic Operative Notes or Attachments

To submit medical records and faxed notes in conjunction with the submission of an electronic claim, please follow these steps:

1. Ensure that your clearing house is capable of sending an Attachment Control Number (ACN).
   a. ACNs are numbers that link a faxed document with an electronic claim.
   b. ACNs are sent in the PWK segment of loop 2300 of the ANSI 837 5010 professional and institutional claim files.
   c. ACNs used for Optima Health submissions should follow these guidelines:
      i. The first 10 digits should be the NPI of the Provider submitted on the claim.
      ii. The Optima Health Member ID number submitted on the claim should follow the first 10 digits. Optima Health Member ID numbers are either 9 numeric digits or 11 alpha-numeric digits.
      iii. Following the Optima Health Member ID number is the earliest date of service included on the claim, in the format MMDDYYYY.
      iv. Following the date of service is any number assigned by the Provider. This information will be ignored by Optima Health and is strictly for the Provider’s internal use.
      v. An example ACN number would be:
         1234567890123456701010120091234 where 1234567890 is the claim Provider NPI, 123456701 is the Optima Health Member ID number, 01012009 is the claim date of service, and 1234 is the Provider’s internal identification number.

2. Begin submitting claims electronically, including the appropriate ACN number on each claim.

3. Within 24 hours of claim submission, fax the associated notes/medical records to the Optima Health Claims Department. The notes for each Member in a fax submission should include a cover sheet which includes the ACN number for that claim. For example, if there are 5 Members included in a fax, there should be 5 cover sheets separating the Members.

Birth Date

Claims submitted with incorrect birth dates (birth date submitted does not match birth date associated with Member ID number submitted) will be rejected.

Reconsiderations or Second Submissions

Optima Health accepts the following reconsideration and second submissions electronically:

- Patient payment
- Service periods/dates
- Procedure/service codes
• Charges
• Units/visits/studies/procedures
• Hospitalization dates
• Name or ID number of referring Physician
• Provider ID
• Wrong Member ID Number or birth date

Please see the “Claim Payment Reconsiderations” section of this manual for detailed information.

**Coordination of Benefits (COB)**

Optima Health accepts secondary and subsequent claims electronically. Your clearinghouse or software vendor is the best resource for you to determine how to submit the necessary data. Please provide;

1. Full claim allowed amount
2. Patient responsibility at the claim level
3. Any additional line information that is available.

**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.

**Support for Electronic Claims Filing**


Contact your current EDI vendor for:
• Problems with transmission
• Level one or level two errors

Contact Provider Relations for:
• Consistent rejections of claims, although information is correct
• Status of claims received electronically
• Questions concerning the adjudication or payment of claims sent electronically
INFORMATION FOR SPECIFIC CLAIM TYPES (A-Z)

Add-on Codes

The CPT code book identifies add-on codes with + symbol. These are codes that are to be added to a primary procedure. They cannot be billed alone. Optima Health adjudicates add-on codes at 100 percent of the allowable fee-schedule. They are not subject to multiple surgery discounts or reductions.

After Office Hours Codes

- After office hours codes can only be billed when the services extend beyond the posted hours.
- Two codes are used for billing after hours care: the appropriate office visit code and the appropriate after-hours code.
- Specialists are not reimbursed for after hour’s codes.

Allergy Claims

The office visit Copayment applies to allergy injections. The date of each injection must be indicated on the claim. Since allergy benefits vary, please confirm eligibility and specific allergy benefits by calling Provider Relations and choose option 2.

Anesthesia

The most current ASA codes should be used when billing anesthesia codes. The Optima Health claims processing system will automatically add the appropriate base units. Providers should bill for time and modifying unit only and include start and stop times. Providers may also bill with minutes in the unit field. Calculations use the following guidelines:

- 00 – 15 minutes 1 unit
- 16 – 30 minutes 2 units
- 31 – 45 minutes 3 units
- 46 – 60 minutes 4 units

Anesthesia Modifiers

According to ASA guidelines, there are specific units associated with the physical status modifiers.

- All P1 P2, and P6 modifiers will not receive any additional payment
- Claims with modifiers P3, P4 and P5 may require supporting documentation as a prerequisite for payment.
**Code 99211**

CPT code 99211 is used for an evaluation and management visit that may not require the presence of a Physician. Presenting problems are usually minimal and time spent performing or supervising services is typically 5 minutes or less. An appropriate use of this code would include a blood pressure check performed by a nurse, where medications were maintained or changed at the time of the visit. This service includes an exam and decision making.

Code 99211 should **not** be used if **only** the following services are being performed on the date of service:

- Administration of injections (vitamin B-12, Depo-Provera, etc.)
- Administration of medication for an established course of therapy following a protocol that does not require Physician input for dosing (chemotherapy, PUVA) when no other services are performed
- Routine in-person prescription renewal and telephone prescription renewal
- Venipuncture (use code 36415 when no other service is performed)
- Allergy injections

**Conscious Sedation and Monitored Anesthesia Care**

Reimbursement is provided for conscious sedation as part of the non-facility payment when the conscious sedation is administered and monitored by the Provider performing in-office diagnostic procedures and surgeries. Monitored anesthesia care that is provided by a qualified Participating anesthesiologist or CRNA will receive separate reimbursement in accordance with criteria for Medical Necessity.

General anesthesia is excluded from coverage in the office setting.

**Fluoroscopic Guidance and Contrast**

Optima Health allows the reimbursement of fluoroscopic guidance and in general, follows CCI guidelines on payment of this procedure. The policy is available upon request.

Optima Health allows the reimbursement of contrast materials under specific circumstances in accordance with CMS guidelines. The policy is available upon request.

**Immunizations and Injections**

- Provide the name of the injectable and the appropriate CPT code or J code.
- Provide the amount, strength, dosage and when appropriate, and the NDC number.
- Provide the charge.
Incident–to Guidelines

Per the Centers for Medicare and Medicaid Services (CMS) National Coverage Provision for incident-to services, when Non-Physician Practitioners (NPPs) render services that are incident-to a Physician service, they may bill under the Physician when the service is:

- An integral part of the Physician’s professional service;
- Commonly rendered without charge or included in the Physician’s bill;
- Of the type that is commonly furnished in Physician offices or clinics;
- Furnished by the Physician or auxiliary personnel under the Physician’s direct supervision.

CMS defines Incident-to services as those performed by a NPP who is under the supervision of a Physician and who is employed by or contracted with the Physician or the legal entity that employs or contracts with the Physician.

There must have been a direct, professional service furnished by the Physician to initiate the course of treatment of which the service being performed by the non-Physician is an incidental part, which means that the Physician must see the patient first, in order to initiate the plan of care for the patient. The NPP would follow the Physician’s plan of care for subsequent services. The Physician must perform the initial service for the diagnosis and must remain actively involved in the course of treatment. The Physician must perform subsequent services that reflect his or her continued active involvement in the patient’s care.

Example: If a patient informs the NPP of a new problem while being seen in a subsequent visit for an established problem, with an established plan of care, the visit cannot be billed incident-to because the Physician has not seen the patient to establish a new plan of care for the new problem. If the NPP is credentialed and the services are within the NPP’s scope of practice then the NPP should bill the appropriate level of new or established E/M service provided under his or her own Provider number.

Per CMS guidelines, “Direct supervision in the office setting means the Physician must be present in the office suite and immediately available and able to provide assistance and direction throughout the time the service is performed. Direct supervision does not mean that the Physician must be present in the same room with his or her aide.”

The only time a NPP can bill a service under a Physician is when a Physician is in the office suite and directly available to help. The Physician being available by phone is not appropriate and does not constitute direct supervision. More information is available from CMS. Incident to (revised 2016): https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/se0441.pdf

Laboratory Claims

Reference Lab Providers may submit claims using the CMS 1500 format or UB 04 format.
**Modifier 51 Exempt**

The CPT code book identifies modifier 51 exempt codes with an “Ø” symbol. Optima Health adjudicates these exempt codes at 100 percent of the applicable fee schedule and will not apply multiple surgery discounts or reductions.

**Newborn Claims**

Claims for newborn Members may be sent utilizing the subscriber’s Member ID number, the newborn’s date-of-birth and the newborn’s name in field 2 of the CMS form. If the date of service is less than 31 days from the newborn’s date-of-birth, the claim will be accepted for processing pursuant to the rules of the plan. Claims for infants outside of 31 days from the newborn’s date of birth will suspend for review of newborn eligibility and will be processed according to the enrollment status of the newborn.

**Obstetrical Information**

**Reimbursement for Global OB:**

Review your Provider Agreement for reimbursement terms and rates. The OB rate in effect at the time of delivery determines the amount of payment.

**Global case rates should only be billed when the OB has seen the patient in the office at least six (6) times.** No dates of service are required when billing a global case rate.

If the Member was seen in the office fewer than six (6) times, the OB will be paid fee-for-service (FFS). If the Member was seen by the Physician for up to three (3) visits, the Physician should bill the appropriate E&M office visit codes (99201-99215) with the date of service.

If the Member was seen by the Physician four (4) to six (6) visits, the Physician should not bill the E&M codes. The Provider should bill the code 59425 (antepartum care only four (4) to six (6) visits). If the Provider has seen the Member for antepartum care only with seven (7) or more visits, the Provider should bill with the antepartum code 59426.

**Obstetrical Copayments for HMO/POS/PPO:**

Confirmation of pregnancy by the obstetrician should be billed as a Specialist office visit, with the appropriate Copayment taken. This visit and all services performed during the initial visit will be reimbursed outside of the global OB reimbursement. The Member may be responsible for additional Specialist Copayments if she is referred for extra services during the pregnancy (i.e., nutritional counseling, high-risk ultrasounds, genetic counseling/testing, or diabetes management).
When a Member is disenrolled from the plan or suffers a miscarriage, the Member is responsible for a Specialist Copayment for each date of service up to the global Copayment as defined by the Member’s benefit plan. The Physician must bill for individual dates of service and will be paid fee-for-service, depending on the plan, for all visits/lab/diagnostic testing rendered in the office.

If the Member changes to another obstetrician (OB) in the course of the pregnancy, the Member is responsible for the first Specialist Copayment (the initial confirmation of pregnancy Copayment, if warranted by the product) to the first OB. The second OB would receive the global OB Copayment. The first OB must bill for each date of service and will be paid fee-for-service for all visits/lab/diagnostic testing rendered in the office. The first OB should refund the global OB Copayment to the Member. The Member is responsible for the global OB Copayment to the second OB.

**Payment for Multiple Births:**

If a Member has multiple births and all are delivered vaginally or by C-section, the OB will be reimbursed a single global OB fee. If the Member has multiple births and the first delivery is vaginal and the additional deliveries are C-sections the OB will be reimbursed a global OB fee for the first delivery and a separate delivery only fee for the C-section.

**Covering OB Physicians:**

If a covering Physician performs OB services and/or the delivery, then each Physician rendering partial OB care must bill only for the services they provided.

**Pathology Reports**

Pathology reports are required when a skin lesion is excised in the office or an ambulatory surgery facility. Pathology may not be billed as office charges. The Physician may bill for excising the lesion. Either the lab or the pathologist may bill for examination of the specimen and for the written report.

**Subrogation**

Subrogation laws vary by State and some States laws do not permit subrogation for certain products. Optima Health follows the applicable State law.

**Surgical Procedures**

Miscellaneous Surgical Codes require operative notes. Failure to submit operative notes with the claim will delay payment.
**Unlisted Procedure Codes**

“Unlisted” procedure codes are those codes ending in “9”. Additional information must always be provided when these codes are billed. They are “special report” codes and do not have fees assigned. Examples of documentation are: OP reports for unlisted surgical procedures and specific descriptions of lab tests and their methods. If the documentation is not provided with the claim, processing delays or denials may occur due to insufficient information. If the claim is denied, please provide the additional information and submit the claim for reconsideration within 365 days of the date the claim was initially processed.
CLAIMS POLICIES - MODIFIERS

AS Modifier – Surgical Assistants

Optima Heath allows reimbursement for Surgical Assistants under the following conditions:

- A Surgical Assistant is a Physician’s Assistant or Nurse Practitioner who provides diagnosis and treatment of patients under the supervision of a surgeon. A surgical assistant is a Non-Physician, as opposed to an Assistant Surgeon who is a Physician.
- Primary Surgeon should bill with the appropriate procedure code and the Nurse Practitioner or Physician Assistant should bill with the same procedure code with an AS modifier.
- Optima Health does not limit the procedures to which an AS modifier would be allowed.

Surgical Assistant reimbursement is 20 percent of the maximum allowable fee.

24 Modifier – Unrelated Evaluation and Management Service by the Same Physician during a Postoperative Period.

Modifier 24 is required for payment of an Evaluation and Management service that was performed during a post-operative period for a reason unrelated to the original procedure.

25 Modifier – Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of the Procedure or Other Service

Optima Health allows reimbursement for Modifier 25 on the day of a minor procedure or service identified by a CPT code, where the patient’s condition required a significant, separately identifiable E/M service above and beyond the other service provided or beyond the usual preoperative care associated with the minor procedure performed. Modifier 25 should only be used on minor procedures (0 or 10 global days). If the E/M service prompts the initiation of a major surgery (90 global days) use modifier 57 instead (see coding guidance on appropriate use of modifier 57). Notes and/or separate diagnosis codes are not required.

26 Modifier – Professional/Technical Component

Optima Health follows CMS guidelines for coding and reimbursement of professional, technical and global procedures. Modifier 26 is appended to the primary procedure code to report and bill for the provision of the professional component (PC) of a procedure. Modifier TC is appended to the primary procedure code to report and bill for the provision of the technical component (TC) of a procedure. Reimbursement of modifier 26 is provided only for codes designated by the CMS National Physician Fee Schedule Relative Value File as having a separately identifiable and billable technical/professional component.
- **CMS National Physician Fee Schedule Relative Value File, PC/TC Designation of 1 or 6:** Modifier 26 is applicable for the procedure code. If billed by a professional provider with a facility place of service, the procedure must be billed with modifier 26 or the claim will be denied.

- **CMS National Physician Fee Schedule Relative Value File, All Other PC/TC Designations:** A separate professional and technical component is not applicable for the procedure code. If billed with a modifier 26 by a professional provider the claim will be denied regardless of the place of service.

Global procedure codes include reimbursement for technical and global components. Modifiers 26 and TC should not be used for global procedures. Global codes billed by a professional provider with a facility place of service will be denied.

**51 Modifier – Multiple Surgical Procedures**

Multiple procedures are defined as two or more CPT codes (10000-69999) procedures performed at the same time.

A clinical representative will review claims with four or more surgical procedures. However, if all the codes other than the primary code are add-on codes or modifier 51 exempt codes, they will not be sent to clinical for review. Those claims will be paid at 100 percent of the appropriate maximum allowable fee.

Reimbursement will be determined using the following guidelines:

1. The procedure with the highest work Relative Value Unit (RVU) will be paid at 100 percent of the maximum payment amount.
2. The procedure with the second highest work RVU will be paid at 50 percent of the maximum payment amount.
3. The procedure with the third highest work RVU will be paid at 50 percent of the maximum payment amount, as will all other procedures billed for that Member on that date of service. Optima Health does not limit the number of procedures that may be performed.
4. If multiple procedure codes are billed for the same Member on the same date of service, but do not have a modifier 51 attached, the Optima Health Code Review software will determine whether or not the codes should have been billed with 51 modifiers, and will affix the modifier if appropriate. In turn, the multiple surgical discounts will apply (as outlined above).
**57 Modifier – Decision for Surgery**

Modifier 57 should be used only when Evaluation and Management services that result in the initial decision to perform surgery are performed the day before or the day of the surgery.

**59 Modifier/XE/XP/XS/XU – Distinct Procedural Service**

Under certain circumstances, the Physician may need to indicate that a procedure or service was distinct or independent from other services performed on the same day. Optima Health code bundling determinations are generally based upon the most current AMA coding guidelines (e.g. CPT and HCPCS definitions), Medicare policies and procedures, and Correct Coding Initiative (CCI) edits.

Starting with dates of service on January 1, 2015, Providers should utilize the newly created CMS modifiers XE, XP, XS and XU in place of modifier 59 when appropriate. The new modifiers are more specific versions of the 59 modifier and they should not be used on the same line as Modifier 59. Modifier 59 should only be used when the new modifiers are not appropriate for the procedure.

Modifiers XE, XP, XS, XU or 59 do not bypass multiple surgery fee reductions, bilateral fee adjustments, or any other administrative policy other than clinical edits. Documentation should be available in the patient’s record to support the distinct or independent identifiable nature of the service and provided in a timely manner for review upon request.

**62 Modifier – Two Surgeons**

Optima Health allows the reimbursement of two surgeons under the following conditions.

- Both surgeons must be MD’s or DO’s
- Each surgeon must be a Participating Provider and have a separate and distinct Provider number
- Each surgeon is performing a distinct part of a procedure
- Both surgeons bill the same procedure code with a modifier 62
- Operative notes are required

If the procedures are deemed appropriate, payment is determined by taking the Optima Health contracted allowable rate, multiplying it by 125 percent and dividing by 50 percent. This payment is made to each co-surgeon. If there are multiple surgery codes with a 62 modifier then the multiple surgery discount will apply.
80 and 82 Modifier – Assistant Surgeon

Optima Health allows reimbursement for Assistant Surgeons under the following conditions.

- Assistant Surgeon must be an MD or DO
- Assistant Surgeon must be a Participating Provider and bill with a separate and distinct Provider number from the primary surgeon
- The Optima Health list of codes which warrant an assistant surgeon are generally based upon CCI guidelines
- Primary Surgeon should bill with the appropriate procedure code. Assistant Surgeon should bill with the same procedure code with an 80, 81 or 82 modifier.

Assistant Surgeon claims are paid at 20 percent of the fee maximum.

81 Modifier – Minimum Assistant Surgeon

Billing and credentialing requirements are the same for modifier 81 as they are for Modifier 80 and 82. Modifier 81 is reimbursed at 20 percent of the fee maximum.
CLAIM PAYMENT RECONSIDERATIONS

A “Request for Reconsideration” is a re-billed or corrected claim that is resubmitted by the Provider for the same patient, date of service and/or procedures. A “Request for Reconsideration” is required prior to initiation of the appeals process. The reconsideration filing deadline is 365 days from the date that the claim was initially processed.

Registered Providers may electronically submit reconsiderations through Provider Connection on the Provider Web Portal by selecting “View Medical Claim Status”, entering the Members Optima Health Member ID Number, selecting the claim in question and choosing the “Reconsider Claim” option. Providers are able to make changes or corrections online for the following:
- Procedure/service coding
- Diagnosis
- Billed charges
- Quantity
- Place of service

This option is not available for hospital and ancillary claims that would typically use the UB-04 format.

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 attached documentation, such as medical records or operative notes; reconsiderations with more than 50 line items and payment retractions. Selecting “other” will bring up the CMS 1500 form online for preparation of a completed printable form for paper submission.

Electronic Reconsiderations are accepted in an electronic claim file through a clearinghouse or software vendor. Claims sent through a clearinghouse or software vendor must have a 7 frequency code in the CLM05-3 segment of the 2300 loop of the 5010 A1 837 professional guide. If a claim is resubmitted without the resubmit code, the claim will be denied as a duplicate. Contact your software vendor or clearinghouse with questions about how to send this code.

Provider Reconsideration Forms are also available under Billing and Claims Information on the Provider Web Portal or by calling Provider Relations.

Reconsiderations submitted using the CMS 1500 form should indicate the original claim document number with the word “reconsideration” in field 19 of the form to prevent misidentification of the reconsideration as a duplicate claim. All line items submitted on the original claim should be included. Mail the completed form and any attached
documentation to the claim reconsideration address in the Contacts section of this Manual.

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.
PROVIDER/MEMBER APPEALS AND EXPEDITED APPEALS

Claim Appeals

Optima Health 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 Optima Health has determined that the original payment was properly adjudicated and the Provider continues to dispute the payment. Optima Health will not take punitive action against a Provider who requests an expedited resolution or supports a Member’s appeal.

Appealed claims must meet the following criteria:
1. An adverse payment decision was made by Optima Health 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.

Access the Policies for Provider Appeals and Expedited Appeals:

Hold Harmless Policy

For all Optima Health Products, if Optima Health 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.

Adverse Benefit Determination - 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. Access the Policies for Member Appeals: http://providers.optimahealth.com/ProviderManualLibrary/policies-provider-member-expedited-appeals-va.pdf.
FRAUD, WASTE AND ABUSE

Optima Health is responsible to detect and prevent fraud, waste, & abuse (FWA) in accordance with the Deficit Reduction Act and the False Claims Act.

Optima Health, through the Special Investigations Unit (SIU), has implemented policies and procedures to detect and prevent all forms of insurance fraud, including fraud involving employees, providers, employer groups, and contractors or agents of Optima Health.

Optima Health has adopted the Commonwealth of Virginia’s definition of Fraud, Waste and Abuse (FWA) 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. Optima Health 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."

Common types of fraud and/or abuse are as follows:
- Unbundling
- Split billing
- Services not rendered
- Upcoding
- Falsification of records/bills/enrollment applications
- Waiving Copayments/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

The Optima Health 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 and abuse.
- Ensure correct payment of medical, behavioral health, and prescription services, 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 abusing medical and prescription services.
- 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.
• Identify and report illegal activities and assist law enforcement by providing information needed to develop successful prosecutions.

Identification of fraud, waste and abuse is accomplished through:
• Referrals from employees, or Providers
• Use of detection software with claims data
• Participation in anti-fraud forums with government agencies
• Staying current with national industry FWA trends through networking and education

The SIU department may receive referrals through internal communications from employees, the hot line or the compliance e-mail. The hot line and compliance e-mail are published on the Optima Health websites, on the explanation of benefits and included in employee training manual, and can be completely confidential.

If you or someone you know has knowledge of a health insurance claim submitted to Optima Health that may meet the above definition of a "suspicious claims activity," or suspect any Provider, enrollee or employee of Optima Health may be committing fraudulent or abusive practices, please forward all the pertinent information to the Optima Health SIU for further investigation. 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 (CMS, OIG, BOI, etc.) will be notified as required by law.

Upon conclusion of an investigation Optima Health will pursue restitution for financial loss where appropriate.

In cases of waste and abuse, Provider education may be provided to prevent further incidents. If needed a Corrective Action Plan may be issued to a Provider that will require them to sign and agree to a plan to correct any issues identified within a specified time period.

In cases of fraud, waste and abuse that go uncorrected after education, Optima Health reserves the right to terminate a Provider, broker or employer group contract. These cases will be brought to the Compliance Fraud, Waste and Abuse sub-committee for review. This committee is headed by the Director of SIU and includes representatives from legal, clinical, pharmacy, compliance, government relations, claims, underwriting and network management. If a majority vote for rescission or termination is made it will then be brought to the Optima Senior Leadership team for review where a final determination will be made.
When a determination of fraud or abuse is made, the case will be reported to the appropriate government agencies, law enforcement and/or regulatory agency (State Medical Board, State Police, Attorney General’s Office, Office of Personnel Management (OPM)/Office of the Inspector General (OIG), Medicaid Fraud Control Unit (MFCU), CMS, FBI, etc.).

All referrals and cases and supporting documentation is tracked and stored electronically. Supporting documentation may include medical records, letters received and mailed, claims identified, phone call summaries, etc.

Optima Health requires all employees to complete Fraud, Waste and Abuse training within 30 days of hire and annually thereafter.

**Federal False Claims Act**

The Federal False Claims Act’s primary use is to combat fraud and abuse in government healthcare programs. The Act accomplishes this by making it possible for the government to bring civil actions to recover damages and penalties when healthcare Providers submit false claims. Penalties can include up to three times actual damages and an additional $5,500 to $10,000 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 applicable State 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.
Providers contracted with Optima Health will agree to be bound by and comply with all state and federal laws and regulations. Any violation by the practice or by any practice Physician shall be grounds for termination. Providers contracted with Optima Health 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 Optima, 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

**Physician Query Requirements**

A coding query is defined as “a written question, posed by a coder requesting clarification on documentation in the medical record, which requires further specificity for accurate coding”.

Optima Health will accept appropriate, timely, and compliant Physician coding queries submitted as part of the patient medical record to the extent it provides clarification and is consistent with other medical record documentation. Optima Health follows the Centers for Medicare & Medicaid Services’ (CMS) position on query forms as stated by the Director of CMS’ Quality Improvement Group.

Additionally, Optima Health will not accept the practice of assumptive coding and will refer for further action any facility found to be practicing assumptive coding. The Office of Inspector General (OIG) defines assumptive coding as "assuming (and coding) from the clinical evidence on the patient’s record that the patient has certain diagnoses in the absence of the Physician’s explicit documentation of the diagnosis." **Assumptive coding is a forbidden practice among coders.**

**Optima Health will evaluate coding queries as follows:**

Clarity and language:
The Physician query process involves asking a Physician to clarify inconsistent, vague or otherwise unclear documentation about a patient’s diagnosis. The Physician query process should only be triggered when there is a problem with documentation quality and there are clinical triggers that act as "clues" to guide the coder in the query process.
Coders’ queries to Physicians should:
- Be initiated only when there is sufficient supporting documentation within the body of the medical record to warrant a query.
- Present or refer to specific clinical information within the record that prompted the query.
- Be clear, open-ended questions allowing for the Physician to render and document his/her clinical interpretation of the diagnosis, condition, and/or procedure, based on the facts of the case.
- Indicate why the query is required (principal diagnosis is unclear, conflicting documentation, etc.)

Queries which are leading in nature, refer to differences in payment, and/or introduce new information will not be accepted for DRG validation by Optima Health and may be subject to referral for further action.

Examples as to when a Physician query is appropriate:
- Documentation regarding reportable conditions or procedures is conflicting, ambiguous, or is otherwise incomplete.
- Abnormal diagnostic test results indicate the possible addition of a secondary diagnosis or higher specificity of an already documented condition.
- The patient is receiving treatment for a condition that has not been documented.
- Abnormal operative/procedural findings not documented.
- It is unclear as to whether a condition was ruled out.
- The principal diagnosis (the reason, after study, for admission) is not clearly identified.

Examples of when a Physician should not be queried include:
- There is no clinical indication to warrant a query.
- There is a discrepancy between the Physician’s diagnosis and clinical indicators. (Unless hospital policy requires a query in this circumstance, policy must be submitted).

Legibility:
Illegible documentation cannot be assumed or interpreted and may be reason to deny payment for services.

Completeness:
Queries must be maintained as part of the medical record and are subject to the same contemporaneous, permanent professional treatment of records, as the body of the medical record.
Timeliness:
Queries must be submitted to the Physician and returned by the Physician, prior to billing and submitting a UB-04 to Optima Health. Queries which are not timely will not be accepted for reimbursement, or for DRG validation purposes.

Authentication:
Physicians’ must date and sign all query responses. As well, Physicians need to date and co-sign queries documented by other clinicians whose work they are responsible for. This applies, for example, to residents and interns in teaching facilities.

**Physician Self-Treating**

Per the American Medical Association (AMA), “Professional objectivity may be compromised when an immediate family member or the Physician is the patient; the Physician’s personal feelings may unduly influence his or her professional medical judgment, thereby interfering with the care being delivered”. Physicians' professional relationships with their patients are based on fiduciary responsibility. Family relationships and collegial relationships with same practice Physicians, by contrast, are based on familiarity.

As such, Optima Health will not reimburse any services rendered by a Physician to:
1. Self
2. Family Member

**DEFINITIONS:**

The following definitions are important for understanding this policy:

Family Member: For the purpose of this policy, “Family Member” means a Physician’s spouse or partner, parent, child, sibling, grandparent or grandchild; a parent, child, sibling, grandparent or grandchild of the Physician’s spouse or partner; or another individual in relation to whom the Physician has personal or emotional involvement that may render the Physician unable to exercise objective professional judgment in reaching diagnostic or therapeutic decisions.

Treating: “Treating” encompasses the performance of any controlled act, including ordering and performing tests, making and communicating a diagnosis, and prescribing medications.

**Fraud, Waste, and Abuse Training**

*Access Fraud, Waste and Abuse training for providers and office staff: [http://providers.optimahealth.com/Pages/compliance.aspx](http://providers.optimahealth.com/Pages/compliance.aspx)*
Provider Responsibilities for Excluded Entity Screening and Reporting

The Office of Inspector General imposes exclusions from state and federal healthcare programs under the authority of sections 1128 and 1156 of the Social Security Act. The law requires that no payment shall be made by any Federal healthcare program for any items or services furnished, ordered or prescribed by an excluded individual or entity. Federal healthcare programs are administered by the Centers for Medicaid and Medicare Services (CMS). This payment prohibition applies to the excluded person, anyone who employs or contracts with the excluded person, any hospital or other Provider for which the excluded person provides services and anyone else who provides services through or under the direction of an excluded person. The exclusion applies regardless of who submits the claims and applies to all administrative and management services furnished by the excluded person.

Providers are obligated to ensure that Medicaid and Medicare funds are not used to reimburse excluded individuals or entities by taking the following steps:

1. Screen all new and existing employees and contractors to determine whether any of them have been excluded. This includes owners with an interest of 5 percent or more.
2. Search the HHS-OIG website (http://oig.hhs.gov/exclusions/exclusions_list.asp) monthly to capture exclusions and reinstatements that have occurred since the last search.
3. Immediately report any exclusion information to Optima Health in writing.

Civil monetary penalties may be imposed against Providers and managed care entities that employ or enter into contracts with exclude individuals or entities to provide services for Federal healthcare programs.
SUBCONTRACTOR, VENDOR AND AGENT COMPLIANCE PROGRAM

Subcontractors, vendors, agents and consultants who represent the company are expected to adhere to the Optima Health Compliance Program. It is the policy of Optima Health 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 Optima Health 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 healthcare 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

Optima Health 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.

Equal Opportunity Employment

Pursuant to Executive Order 11246, Section 503 of the Rehabilitation Act of 1973, as amended, and the Vietnam Era Veterans Readjustment Assistance Act of 1974, as amended, you are advised that our subcontractors, suppliers and vendors are obligated to take affirmative action to provide equal employment opportunity without regard to race, religion, sex, national origin, age genetic information, disability, and/or veteran status.

Conflict of Interest

Optima Health 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**

Optima Health prohibits giving anything of value to government employees who work for customers or potential customers of Optima Health. 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 and 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 federal Anti-Kickback Statute 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**

Optima Health 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

Optima Health is committed to accurate billing and submitting claims for services that are Medically Necessary, reflecting the services and care provided to Members, and are justified by documentation. Optima Health 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

Federal and state laws and regulations govern billing for services provided to Optima Health Members. Failure to follow claims regulations can lead to exclusion from federal funding including payments from Medicare and Medicaid as well as criminal and civil liability. Submission of claims for reimbursement which are false, fraudulent, inaccurate, incomplete, duplicative, or for Non-Covered Services is prohibited.

The Federal False Claims Act covers fraud involving any federally funded contract, including Medicare and Medicaid. Liability is established for any person who knowingly presents or causes a false or fraudulent claim for payment by the U.S. government. “Knowingly” is defined as a person having actual knowledge of false claim information and acting in deliberate ignorance or reckless disregard of the information. Healthcare Providers violating the Federal False Claims Act can be subject to civil monetary penalties ranging from $5,500 to $10,000 per false claim and three times the amount of the government’s damages.

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 Optima Health 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 Optima Health Compliance Committee or to the Optima Health Fraud, Waste, and Abuse Hotline (1-866-826-5277). All reported violations will be investigated.

Fraud and Abuse

“Fraud” is defined as intentional deception or misrepresentation made by an entity or person with the knowledge that the deception could result in some unauthorized benefit to the entity or persons. 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 healthcare program or other healthcare plan.

The Deficit Reduction Act of 2005 became effective on January 1, 2007 and requires healthcare 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; Copayment 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.

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

**Whistleblowers**

The False Claims Act Whistleblower Employee Protection Act prohibits a company from discharging, demoting, suspending, threatening, harassing, or discriminating against any employee, vendor or agent if the individual reports or assists in the investigation of a false claim. Under no circumstances will Optima Health take any adverse action or retribution of any kind against any employee, contractor, agent, or vendor because he reports a suspected violation of Federal or state laws and regulations.

**Insider Trading**

Agents and vendors who have material non-public ("insider") information obtained through a relationship with Optima Health 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**

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

- Notify Optima Health of any known or suspected violations of law or regulations pertaining to the agent's or vendor's relationship with the Company.
- Disclose to Optima Health any government investigations in which the agent or vendor is, was or may become involved.
- Disclose to Optima Health 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 healthcare program
- Immediately disclose to Optima Health, 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 Optima Health’s business success and reputation for integrity depends on you.