OptimaHealth

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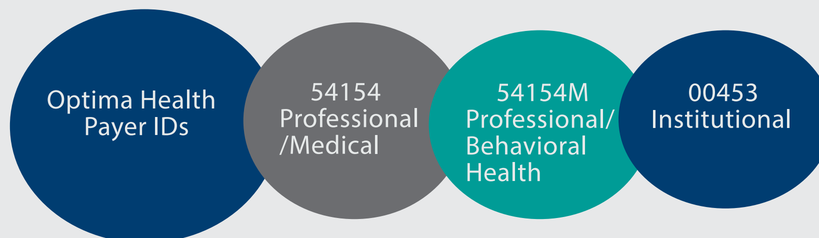
Electronic Funds Transfer (EFT)

Our preferred method of billing and payment is electronic. We accept claims through any clearinghouse that can connect through Payerpath/Allscripts or Availity. Providers can use Payerpath/Allscripts or Availity for EDI.



Benefits of EFT

- Safer, more secure, and efficient method of claims payment
- Funds are deposited within 24 hours after payments are processed
- Clean claims are processed and paid with an average of 7 days when submitted electronically and payment made through EFT
- You will be notified via email when a deposit is made to your bank account.
- This notice is sent to the email address supplied on the EFT enrollment form.
- Sign up for EFT/ERA with the Electronic Payment/Remittance Authorization Agreement in the "Billing & Claims" section of: https://www.optimahealth.com/providers/
- If you have any questions, please email EFT_ERA_Inquiry@sentara.com

Important Note: Optima Health is currently (temporarily) handling all Electronic Funds Transfers (EFT) and Electronic Remittance Advice (ERA) changes manually. Please follow the procedure on the next page until further notice.

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New EFT/ERA Setup

1. Must complete in its entirety the **EFT/ERA Authorization Agreement PDF form** https://www.optimahealth.com/providers/billing-and-claims/
2. Obtain a letter from your bank on the bank's letterhead, including the physical bank address, account number, the bank employee's name, title, email, and phone number. Letter must not be dated more than 90 days prior.
3. The form must be signed by the provider or an authorized representative of the provider.
4. Submit all the documents by email to EFT_ERA_Inquiry@sentara.com
5. Optima Health will validate the provider's relationship with the banking institution.
6. Tax ID information will be validated in the payment System.
6. Once the process is complete, the EFT information will be input into the payment system and the Provider will be notified that the set-up has been completed.

Bank Account Changes

1. Must complete in its entirety the **EFT/ERA Authorization Agreement PDF form** https://www.optimahealth.com/providers/billing-and-claims/
2. Include the current banking institution name, routing number, and last 4 digits of the account on file with Optima Health.
3. Submit all documents by email to EFT_ERA_Inquiry@sentara.com
4. Validation of all information will be completed before changes will be made. Banking information will not be changed in the payment system until validation is completed.
5. Once the process is complete the Provider will be notified of the set-up.

Timely Filing and Payment

Our timely filing deadline on all claims is 365 days from the service date. This includes any corrections, reconsiderations, and/or appeals. Turnaround time for clean (correctly submitted) claims:

- Electronic 14 days
- LTSS/CMHRS/NF claims are processed within 14 days
- Early Intervention 14 days
- Paper 25 days

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Reconsiderations and Corrected Claims

Corrected Claims To resubmit claims that have been denied due to a billing error (incorrect diagnosis, member, or provider information, etc.), **you must mark "Corrected Claim" in box 19 of the claim form.**

Reconsiderations

- A request for reconsideration is a re-billed or corrected claim for the same patient, date of service(s) and/or procedure(s), you must mark "**Reconsideration" in box 19 of the claim form.**
- Electronic Reconsiderations can be done on https://www.optimahealth.com/ to change CPT, diagnosis, on place of service, quantity & correct charges. Behavioral health reconsiderations must be submitted on paper and mailed to the address below.
- **Be sure to reconsider the ENTIRE claim**
- Paper requests for consideration of a claim denial must include the claim or copy of the remit, any supporting documentation, and the **Provider Reconsideration Form or Behavioral Health Provider Reconsideration Form** and mail to:

Medical Claims
Optima Health
PO Box 5028
Troy, MI 48007-5028

Behavioral Health Claims
Optima Health
PO Box 1440
Troy, MI 48099-1440

Medical Records: It is critical to submit the **Provider Reconsideration Form** or the Behavioral Health **Provider Reconsideration Form** with any requested clinical records to avoid processing delays.

Appeals and Refunds

Appeals Process if your claim denial is upheld after the reconsideration process, you have the option to file an appeal. Appeals may be submitted in writing within 365 days from the date of service. Detailed information and supporting written documentation should accompany the appeal. A decision will be rendered within 45 days of receipt of the appeal request. Appeals should be sent to:

Optima Health Appeals Dept.
P.O. Box 62876
Virginia Beach, VA 23466-2876

Refund Process When sending a refund please send a copy of the remit, reason claim was paid in error, and check to :

Optima Health Recovery Unit
PO Box 61732
Virginia Beach, VA 23466

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Paper Claims

Paper claims must be mailed to Optima Health:

Medical Claims
PO Box 5028
Troy, MI 48007-5028

Behavioral Health Claims
PO Box 1440
Troy, MI 48099-1440

Provider Changes and Updates

Submit changes to Optima Health by completing the Provider Update Form on https://www.optimahealth.com/providers/ Sixty (60) day notice is required for all changes, Including:

- Panel Status/Accepting new patients
- Contact information (address, phone, email, etc. - for all locations)
- Provider relocating or joining additional practice
- Tax ID change (need a new/current W-9)
- Name change (new license required)
- Practitioner leaving practice/deceased

Coordination of Benefits

Optima Family Care Members who are covered by employer sponsored health plans may be enrolled in a Medicaid managed care plan. It is important that if an Optima Family Care Member is identified as having a commercial product, that initial claim should be sent to the commercial plan for payment. Medicaid is always a secondary payer.

Optima Family Care will coordinate benefits:

- For children with commercial insurance coverage, Providers must bill the Commercial insurance plan first for covered early intervention services except for the following services that are federally required to be provided at public expense:
- Assessment/EI evaluation,
- Development or review of the Individual Family Service Plan (IFSP); and,
- Targeted case management/services coordination;
- Developmental services; and.
- Any covered early intervention services where the family has declined access to their private health/medical insurance

Optima Family Care as a secondary carrier: Claims must be submitted with EOB's attached and must show exactly the same information as the original claim. Providers may not bill one insurance carrier for once charge amount and OFC for another charge amount. If a claim is filed for a member whose primary insurance is not OFC, the provider must submit an EOB with the claims within 18 months of the date of service. If an EOB is not submitted, the claim will be denied pending receipt of the primary's EOB.

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Appointment Access

Timely appointment access standards are mandated by NCQA, CMS and DMAS.

Product	Appointment type		Scheduling Standard (time between member request and appointment availability
Commercial, QHP, Optima Medicare, and Optima Family Care	Emergency (Medical and Behavioral Health)		Immediately upon request
	Urgent (Medical and Behavioral Health)		24 hours
	Symptomatic (Medical Health only)		1 week
	Routine Medical Care/Well care		30 days
	Routine Behavioral Health		10 business days
	Prenatal Care	First Trimester	7 days
		Second Trimester	7 days
		Third Trimester	3 days
		High-Risk Pregnancy	3 days or immediately if emergency
Optima CCC Plus	Emergency		Immediately upon request
	Urgent		24 hours or as quickly as symptoms demand
	Routine Primary Care*		30 days
	Prenatal Care	First Trimester	7 days
		Second Trimester	7 days
		Third Trimester	3 days
		High-Risk Pregnancy	3 days or immediately if emergency