Optima Health Provider Manual

Supplemental Information For Facilities and Ancillaries

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

HOSPITAL AND ANCILLARY KEY CONTACTS

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Phone: 757-552-8892

OPTIMA HEALTH NETWORK EDUCATORS

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Credentialing for Facilities and Ancillaries

Providers interested in participating with Optima Health should contact the Optima Health Network Educator assigned to their geographic region. Optima Health Facilities and Ancillary Providers are required to hold certification and/or licensure appropriate to the services offered. The credentialing process begins after a determination has been made by Optima Health that there is a need for the Provider to be added to the Network. At a minimum, the Optima Health Facility and Ancillary Credentialing and Re-Credentialing processes will:

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

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

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

If the Certification Survey letter and CMS-2567 indicate no deficiencies were cited, the contract process will continue. If the Certification Survey letter and CMS-2567 indicate that deficiencies have been cited, these documents and the provider's action plan of correction will be forwarded to the Quality Improvement Department for clinical review to determine if the action plan of correction is adequate to address the issues identified. Quality Improvement will notify Network Management of their review of the stated action plan in the CMS-2567 form. If Quality Improvement is satisfied with the stated action plan of correction, the contract process will continue with the understanding the Provider will resolve all cited deficiencies. If Quality Improvement is not satisfied with the stated action plan, the contract process will stop.

Delegated Credentialing

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

Notice of Suspension Requirement

Any Facility or Ancillary that has its Medicare certification suspended due to cited deficiencies

must notify their Optima Health Contract Manager immediately.

Accreditations and Certifications

Accreditations or certifications accepted by Optima Health are as follows**:**

Hospitals (Medical and Psychiatric)
- Joint Commission
- DNV Healthcare, Inc.
- HFAP (Healthcare Facilities Accreditation Program)

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

Home Health Agencies
- Joint Commission
- CHAP (Community Health Accreditation Program)
- ACHC (Accreditation Commission for Health Care)
- Medicare Certification (if not accredited)

Skilled Nursing Facilities/Nursing Facilities
- Joint Commission
- Medicare Certification (if not accredited)

Free Standing Ambulatory Surgery Centers (ASC)
- Joint Commission
- DNV
- AAAHC (Accreditation Association for Ambulatory Health Care)
- Medicare certification (if not accredited)

Sleep Studies Centers
- American Academy of Sleep Medicine (AASM)
- ACHC

All sleep labs must comply with Medicare guidelines and criteria as referenced in the Medicare Program Integrity for Independent Diagnostic Testing Facilities (IDTFs). Physicians must show evidence of proficiency which may be documented either by certification or criteria established by the carrier for the service area in which the IDTF is located.

Optima Health uses the AASM guidelines and credentials physicians who are board certified or eligible. Sleep technicians supervising sleep studies on Optima Health Members must be certified or enrolled in an approved program by the Board of

Registered Polysomnographic Technologists (BRPT) or other pre-approved certification body. All sleep labs must maintain an appropriate level of patient to technician ratio of 2:1.

Other Provider Types

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

Department of Medical Assistance Services (DMAS) ARTS Program (Addiction and Recovery Treatment Programs)

Facilities offering intensive outpatient programs, partial hospitalization programs, inpatient detoxification, inpatient and/or residential treatment programs specializing in addiction treatment for Optima Health Medicaid program members must complete DMAS certification and ARTS attestation documents as well as DMAS credentialing for those services.

Hospital/Ancillary Billing Information

Coding

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

Optima Health will group to MS-DRG or APR DRG groupers as appropriate.

Revenue codes must be valid for the Bill Type and should be listed in ascending numeric order. CPT or HCPCS codes are required for ambulatory surgery and outpatient services and NDC numbers are required for drugs.

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

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

Reconsideration of a Previously Billed Claim

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

Inpatient Billing Information

Clinical Care Services (CCS) will assign an authorization number based on Medical Necessity. The authorization number should be included on the UB claim.

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

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

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

Pre-Admission Testing

Pre-admission testing may occur up to ten (10) days prior to the ambulatory surgery or inpatient stay. The testing may include chest x-rays, EKG, urinalysis, CBC, etc. The tests should be performed at the same Facility at which the ambulatory surgery or inpatient stay is ordered. The tests should be billed on the inpatient or ambulatory surgery claim. The admission date for ambulatory surgery must be the actual date of surgery and not the date of the pre-admission testing.

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

Re-Admissions

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

Optima Health follows the DMAS reimbursement policies for readmissions for the Optima Health Medicaid program.

Never Events and Provider Preventable Conditions

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

A Never Event is a clearly identifiable, serious and preventable adverse event that affects the safety or medical condition of a Member and includes Provider Preventable Conditions. Health care services furnished by the Hospital that result in the occurrence and/or from the occurrence of a Never Event are considered Non-Covered Services.

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.

Providers are required to report Never Events and Provider Preventable Conditions associated with claims for payment or member treatments for which payment would otherwise be made.

Critical Incident Reporting

Critical incidents include medication errors, severe injury or fall, theft, suspected physical or mental abuse, neglect, financial exploitation, and death of a member. The Optima Health Medicaid program requires staff and contracted providers to report, respond to, and document critical incidents to Optima Health.

Incidents must be reported within 24 hours. Providers should call the Optima Health Medicaid program Care Coordination Department, complete the Critical Incident Reporting Form found on optimahealth.com and fax the form to Optima Health using the fax number listed on the form.

Furloughs

Furloughs (revenue code 018X) occur when a Member is admitted for an inpatient stay, discharged for no more than ten days, and then re-admitted under the same authorization. Examples include situations in which surgery could not be scheduled immediately, a specific surgical team was not available, or further treatment is indicated following diagnostic tests but cannot begin immediately.

Interim billing

Interim Billing indicates that a series of claims may be received for the same confinement

or course of inpatient treatment that spans more than thirty consecutive days. Interim billing may be based on the month's ending date (Medicare) or based on a 30-day cycle from the date that charges begin. The appropriate Bill Type should be indicated for each claim.

Newborn Claims

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

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

If the newborn must stay in the Hospital after the mother has been discharged (boarder baby), the newborn must be enrolled, and must have an inpatient prior authorization under the newborn's own Member ID number in order for the charges to be covered. The "boarder baby's" date of admission should equal the mother's date of discharge.

Please see the Optima Health Medicaid Program Care Provider Manual for newborn enrollment information.

Organ Transplants

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

Prior authorization should be obtained at the time the Member is identified and referred for organ transplant evaluation for all plans.

Please see the Optima Health Medicaid Program Provider Manual for transplant information specific to the Medicaid program.

Skilled Nursing Facility Services

Placement in a Skilled Nursing Facility (SNF) requires prior authorization. Clinical Care Services will make the necessary arrangements for the Facility admission. Case Managers will review SNF services concurrently and authorize a continued stay as appropriate and arrange the Member's transition to home. If a Member has exhausted their SNF benefit or has been moved to custodial care, the SNF service is no longer a Covered Benefit.

Optima Health Medicaid program Skilled Nursing Facility services follow payment

methodology as published by the Department of Medical Assistance (DMAS).

The Optima Health Medicaid program requires that a valid screening exists for individuals admitted to a certified Nursing Facility. Screenings must be entered into the Electronic preadmission screening (ePAS) system (or approved alternative) prior to an admission to receive reimbursement.

Inpatient Denials/Adverse Decisions

If the attending Physician continues to hospitalize a Member who does not meet the Medical Necessity criteria, or there is Hospital related delays (such as scheduling), 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 a family member insists on continued hospitalization (even though both the attending Physician and Optima Health agree that the hospitalization is no longer Medically Necessary), the claims related to the additional days will be denied. The claims will be denied "continued stay not authorized, Member responsible (D75)".

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

Prior Authorization

Optima Health prior-authorization requirements for Commercial Products, including self-funded plans are shown in the core Provider Manual and provide a general overview of prior-authorization requirements for Optima Health.

Prior-Authorization requirements may vary for government programs based on government contract requirements for certain services in the specific program. Please reference the Provider Manual or Provider Manual Supplement for each government program to confirm the requirements for that program.

Facility Outpatient Services

General Information

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

Outpatient Facility services typically have a Member cost-share associated with them. Optima Health assigns certain revenue codes to specific plan benefits. For example, revenue codes 0450-0459 are mapped to Emergency Department services, and further drive the determination of the Member's cost share. The default outpatient benefit is "outpatient diagnostic". Member cost share may be waived if the Member is subsequently admitted.

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

Outpatient Billing Guidelines

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

Service (A-Z)	Revenue Code	Comments
AICD Implant Checks (Automatic Implantable Cardioverter Defibrillator)	0921 with corresponding CPT/HCPCS code	• Associated CPT codes must be billed.
Ambulatory Surgery (Including Outpatient Surgery)	Revenue code 0360	• Prior authorization is required
Blood transfusions, storage, administration and any associated observation room charges	038X,039X with corresponding CPT/HCPCS Code	• Optima Health processes all charges to the 038X/039X procedure charge and pays under the 038X/039X revenue code. • Optima Health does not consider the claim to be an ambulatory surgery claim.

Service (A-Z)	Revenue Code	Comments
Chemotherapy (Drugs to eradicate or minimize cancer) Chemotherapy, immunotherapy and supportive drugs covered under the medical benefit that require administration by a health care professional (excluding inpatient)	0636 with corresponding CPT/HCPCS code	• Include appropriate J codes for all medications. The Optima Health Medicaid program claims require NDC numbers for any drug billed with revenue codes 025x or 063x. • Prior authorization with Aim Specialty Health is required
Clinic Charges	0510	• Will be denied "non-allowed expense, Provider responsible" (D21).
Colonoscopy, Endoscopy, Proctoscopy, Sigmoidoscopy	0750 with corresponding CPT/HCPCS code	
Dialysis Services	08XX with corresponding CPT/HCPCS code	• A valid written or verbal order from the attending nephrologist is required. • Claims must indicate the appropriate revenue, CPT and/or HCPCs codes and be submitted on a UB04 claim form. • Supplies are payable only in the home setting. Documentation and J codes are required to differentiate medication from pharmacy supplies. • Non-routine dialysis lab work must be sent to a Participating Reference Laboratory

Diagnostic procedures (CPT code range between **70000 and 99999** such as **spinal punctures, cardiac catheterization, etc.** procedures and their associated observation roomcharges	Varies with corresponding CPT/HCPCS code	• If observation roomcharges (revenue code 0760) are billed with a diagnostic procedure, Optima Health will add the observation room charges to the diagnostic procedure charge. • If a recovery room(revenue code 0710) is billed in conjunction with a diagnostic procedure (series 60000 or 90000), Optima Health will deny the recovery room"non-allowed expense, Provider responsible" (D21). This recovery roomis considered as part of the procedure and should not be billed separately. If a radiology procedure (series 70000) and radiology medical surgery supplies (revenue code 0621) and/ or recovery room(revenue code 0710) are billed Optima Health will deny the radiology medical surgery supplies and the recovery room "non-allowed expense, Provider responsible" (D21).
Genetic Testing (except BRCA and NIPT)	030x	• Requires prior-authorization and is performed at Participating specialty laboratories
Hemodialysis		• Add associated CPT//HCPCS (**Q codes**) codes or use revenue codes for each date of service.

Service (A-Z)	Revenue Code	Comments
IV Therapy (Antibiotics, hydration, etc.)	026X with corresponding CPT/HCPCS Code and NDC	• **Prior authorization is required if medications are being administered**. • For medications, add associated J codes
Lab services for Optima Health Medicaid program facility residents	030x	• Provider responsible for determining if lab services are included in facility per diems
Miscellaneous medical supplies or implants	025x, 027x	• Include HCPCs Level I or Level II code. • Optima Health Medicaid program claims require NDC numbers for any drug billed with revenue codes 025x or 063x. • Implants must be prior authorized for ASCs. • If no appropriate code is available, include English description • Claims omitting this information may be audited retrospectively to ensure items are Covered Services, and allowed for the Member's condition.
Nerve Blocks	0372 with corresponding CPT/HCPCS code	• **Prior authorization is required.** • An itemized statement is required. • Associated CPT codes must be billed.

Nutritional Counseling	0942 with corresponding CPT code 0942 with corresponding HCPCS code **(diabetic diagnosis only)**	• Services provided by a participating provider are covered. • Prior authorization is not required, except for the Ornish Program, a specialized cardiac nutritional program.
Observation	0760, or 0762	• Observation requires authorization • Observation status is allowed for up to 72 hours. Claims for HMO Members billed with revenue codes 0760 or 0762 utilize the Member Ambulatory Surgery Copayment amount. Deductibles and Copayments may apply for other Plan types. • Hospitals must provide oral and written notification (MOON) to Medicare Members who receive observation services as an outpatient for more than 24 hours • When both Emergency Department and Observation charges are submitted, the claim will be paid as Observation
Outpatient Physical and Occupational Therapy (Hospital-Based Providers)	Revenue Code 042X for PT and 043X for OT with appropriate CPT code	• Claim must be submitted using UB04 or CMS 1500 formats. Prior authorization is required for Commercial plans.
Pacemaker Checks (telephone)		• Associated CPT codes must be billed.

Service (A-Z)	Revenue Code	Comments
Behavioral Health Partial Hospitalization		• Place of Service (POS) code for outpatient facility is required on HCFA-1500. POS 11 for office will be denied. Prior authorization is required.

Pharmacy • Injectable immunization serum& med-surgical supplies • Revenue codes 025X and 027X • Immunizations • Oral Chemotherapy	**Vaccine**: revenue code 0250 or 0636 with J code **Administration** revenue code 0940 with CPT code (e.g. 90471-90474 or 90782)	• Paid in addition to the procedure payment when billed with a **CPT procedure code**. Payment is subject to referral and authorization requirements. • No prospective denial for claims with insufficient coding but subject to review after payment is rendered. Optima Health Medicaid program claims require NDC numbers for drugs billed with revenue code 025x • May be provided by Outpatient Facility due to shortages or when vaccine is unavailable to PCP. Only the vaccine and administration of the vaccine should be submitted on the current UB claim form. • Must be billed with J code and the NDC number
Pregnancy-related Observation (non-delivery)	0720/0721 with corresponding CPT/HCPCS code and appropriate ICD-10 diagnosis code(s) OR 0760/0762 with corresponding CPT/HCPCS code and appropriate ICD-10 diagnosis code(s)	• Review the diagnosis code to ensure that diagnoses are billed correctly. • Optima Health will pay under revenue code based on contract. • Primary diagnosis codes which report the occurrence of early, late or threatened labor (ICD-10-CM 020, 042, 044, 047, 048, and 060) must use revenue codes 0720-0721. • Pregnancy-related observation does not require a prior-authorization.
Radiation Therapy	0333 with corresponding CPT/HCPCS code	• Prior-authorization by AIM is required • Claims may be received for a one-month period of time. • Associated CPT codes must be billed.
Radiology or Diagnostic Procedures	025X, 0636 and 027X	• Pharmacy and med-surgical supplies are a non-allowed expense and will be denied (D21), Provider responsible when billed with these **revenue** codes for radiology or diagnostic procedures. Prior authorization is required for Advanced Imaging Studies
Service (A-Z)	**Revenue Code**	**Comments**
SleepApnea/ SleepStudies	074X with corresponding CPT/HCPCS code	• **Facilities must be explicitly contracted to provide this service. Prior authorization is not required**. • Associated CPT/HCPCS codes must be billed. Prior authorization is required for all sleep studies.

Treatment Room	Code 0761	• Revenue code 0761 not covered in the hospital setting

Laboratory Services

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

Emergency Department Services

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

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

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

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

A member liability amount may apply under the Member's benefit plan. If the Member is directly **admitted to the same Hospital** where the ER service was performed, the emergency room Facility charges should be added to the inpatient or ambulatory surgery bill submitted by the Facility. The Member is only responsible for the inpatient or ASC copayment, coinsurance or deductible as applicable. If the Member is not directly admitted to the same Hospital, the Emergency Department charges are paid separately from the inpatient charges. In this situation, the Member may visit the Emergency Department, return home, and be admitted later in the day (normally within 24 hours).

Sleep Studies

Home Sleep Studies are the preferred method of testing. Facility-based studies will require proof of a failed Home Sleep Study or a medical reason why Home Sleep Study is contraindicated