

PROVIDER MANUAL



A SERVICE OF SENTARA

A PUBLICATION OF THE OPTIMA HEALTH
NETWORK MANAGEMENT DEPARTMENT

Updates to the Provider Manual may occur due to the introduction of new programs, changes in contractual and regulatory obligations, and updates to existing policies. The most current information is available on the Optima Health Provider Website: optimahealth.com/provider

OPTIMA HEALTH KEY CONTACTS

Please see the Optima Health Medicaid Program Manual and Medicare (HMO and OCC (D-SNP) Supplements for contact numbers specific to those programs.

OPTIMA HEALTH PROVIDER WEB PORTAL

optimahealth.com/provider

PROVIDER RELATIONS

Provider Relations & Eligibility Verification

Medical

Phone: 1-800-229-8822

Fax: 1-855-687-6270

Behavioral Health

Phone: 1-800-648-8420

Fax: 1-888-576-9675

CLINICAL CARE SERVICES

Medical Authorizations and Medical Benefit Drugs for Commercial Members

Phone: 1-800-229-5522

Fax: Fax number is indicated on each authorization form

Medical Authorizations and Medical Benefit Drugs for Optima Medicare and Medicaid Products

Phone: 1-888-946-1167

Fax: Fax number is indicated on each authorization form

Behavioral Health Providers

Phone: 1-800-648-8420

Fax: 1-866-466-1452

After Hours Nurse Advice Line

Phone: 1-800-394-2237

Optima Health Case Management Services (Direct)

Phone: 1-866-379-5191 – Commercial Product Case Management

Phone: 1-757-687-6318 – Medicare Product Case Management

Phone: 1-888-946-1167 or 1-757-552-7560 – Optima Health Medicaid

Program Care Case Management Phone: 1-866-503-2731 – Care Management (Population Health)

Partners in Pregnancy: 1-866-239-0618 (Option 1)

Quality Improvement

Phone: 1-844-620-1015

Fax: 1-866-783-5196

PHARMACY SERVICES

Pharmacy Provider Services -Non-Medical Benefits

Phone 1-800-229-5522

Fax: 1-800-750-9692

Mail Order Pharmacy (Express Scripts)

Phone: 1-877-728-0179

Specialty Pharmacy (Proprium Pharmacy)

Phone: 1-855-553-3568

Web: <https://propriumpharmacy.com/for-prescribers/>

TELEPHONE FOR DEAF AND DISABLED (TDD)

Phone (Virginia Relay): 711

HEALTH AND PREVENTIVE SERVICES

Phone: 1-800-736-8272

Fax: 1-844-552-7508

FRAUD AND ABUSE

Hotline: 1-866-826-5277

E-mail: compliancealert@sentara.com

U.S. Mail: Optima Health
C/o Special Investigations Unit
P.O. Box 66189
Virginia Beach, VA 23466

NETWORK MANAGEMENT DEPARTMENT NOTIFICATIONS

Fax: 1-866-751-7645

Mail: Contract Manager

E-Mail: Send to Assigned

P.O. Box 66189

Network Educator

Virginia Beach, VA 23466

MEDICAL NECESSITY RECONSIDERATIONS

Mail: Clinical Care Services
P.O. Box 66189
Virginia Beach, VA 23466

CLAIM PAYMENT RECONSIDERATIONS

Mail: Medical Claims
P.O. Box 5028
Troy, MI 48007-5028

Mail: Behavioral Health Claims
P.O. Box 1440
Troy, MI 48099-1440

OVERPAYMENTS

Phone: (800) 508-0528
Mail: Optima Health Provider Receivables
P.O. 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

TABLE OF CONTENTS

	PAGE
Optima Health Key Contacts	2
Introduction	
Optima Health Resources	10
Optima Health Updates	12
HIPAA Privacy Statement	12
Product Overview	13
Member Identification	
Optima Health Member ID Cards	17
Eligibility Verification	17
Credentialing/Re-Credentialing	18
Disciplinary Action	23
Quality Improvement Program	
NCQA Accreditation	25
HEDIS®	25
Clinical Guidelines	26
Provider Directory Information	26
Patient Appointment Access Guidelines	26
Continuity and Coordination of Care	27
Culturally Competent Care	28
Office Site Reviews	28
Medical Record Documentation Standards	28
Behavioral Health Medical Record Documentation Standards	29
ARTS Medical Record Policies	30
Medical Record Policies	30
Advance Directives	31
Office Visit Procedures and Member Resources	
Visit Procedure	32
Copayments, Coinsurance and Deductibles	32
Member Rights and Responsibilities	33
Special Needs Members	35
Essential Community Providers	36
Primary Care Physicians (PCP)	
Primary Care Physician Provider Panels	37
Guidelines for Removing a Member from a PCP Panel	37
Health and Preventive Services	39
Healthcare Services	42
Clinical Care Services	
Behavioral Health Services Access	43
Physician to Physician Communication	43
Second Opinion	43

Medical Clinical Care Services - Prior-Authorization	
Prior Authorization via Provider Connection	44
Fax Forms	44
Clinical Care Service Availability	44
Optima Health Medicaid program and Medicare Prior Authorization	44
Prior-authorization Procedures and Requirements	43
Genetic Testing and Counseling	48
Behavioral Health Services Prior-authorization Requirement	48
Clinical Care Policies/Criteria	49
Pre-Services Review	49
Admission Review	49
Post-Service/Retrospective Review	49
Concurrent Review	50
Pre-service or Current Request for Reconsideration	50
Inpatient Denials	51
Obstetrical Care/Partners in Pregnancy	
Patient Access Guidelines	52
Home Health Post-Delivery Services	53
High-Risk Pregnancies	53
Dependent OB Coverage	53
Gynecological Care	
Annual Gynecological Exams	54
Vasectomies and Tubal Ligations	54
Infertility Treatment	54
Terminated Pregnancy/Abortions	54
Emergency Department/Urgent Care Centers	55
After Hours Nurse Advice Line Program	55
MDLIVE	56
Additional/Ancillary Services	
Artificial Limb Benefit	57
Audiology Services	57
Chiropractic Services	57
Dental Coverage	57
Dialysis Services	58
Disposable Medical Supplies	58
Durable Medical Equipment (DME)	59
Employee Assistance Services (EAP)	60
Home Health and IV Therapy	61
Hospice Services	61
Medical Transportation Services/Ambulances	62
Nutritional Counseling/ Dietician	62
Oxygen Policy	62
Physical and Occupational Therapy	63
Prosthetic and Orthotics	64
Skilled Nursing Facilities	65

Sleep Studies	65
Speech Therapy	65
Vision Coverage	66
Pharmacy	
Optima Health Formularies	68
Tier Formulary Copayment Structure for Commercial Plans	69
Utilization Management Program	69
Mail Order Prescription Drug Program	70
Diabetic Supplies	70
Injectable Drugs Administered in the Physician’s Office	70
Limited Distribution Drugs	71
Specialty Drugs	71
Pharmacy Coverage Exclusions	72
Laboratory Services	
In Office Lab	75
In-Office Laboratory Services Reimbursement	75
Reference Lab Providers	76
Laboratory Draw Sites	76
Pre-Operative Lab and X-Ray	76
Genetic Testing	76
Toxicology Lab Services and Medication Compliance Testing	76
Reimbursement	
Reimbursement Policies	77
Provider Fee Schedules	77
Billing and Payment	
Contracted Amounts/Billing Covered Persons	78
Appropriate Service and Coverage	78
Medical Necessity	78
Never Events and Provider Preventable Conditions	79
Member Cost-Share	79
Coordination of Benefits (COB)	79
Dual Eligible Members with Both Medicare and Medicaid	80
Pursue Letter	80
Overpayments	80
Claims	
General Information and Filing Requirements	81
NPI Number	81
Completing the CMS 1500 Claim Form	81
Common Reasons for Claim Rejection	82
Remittance Advice	82
Negative Vendor Status	82
Interim Reports	82
Pending Claims	82
Authorization Search	83
Timely Filing Policy	83

Late Claim Appeals	83
Duplicate Claims and Reconsiderations	83
Changes in Insurance Information	84
Retroactive Disenrollment	84
Health Insurance Marketplace Grace Period	84
Claims Denied in Error	84
Worker’s Compensation	85
Electronic Claims and Electronic Funds Transfer (EFT)	
Electronic Funds Transfer (EFT)	86
Filing Claims Electronically	86
Required Claims Information	87
Electronic Operative Notes or Attachments	87
Birth Date	87
Reconsiderations or Second Submissions	88
Coordination of Benefits (COB)	88
Status Reports	88
Support	88
Information for Specific Claim Types	
Add-on Codes	90
After Hours Codes	90
Allergy Claims	90
Anesthesia	90
Anesthesia Modifiers	90
Code 99211	91
Conscious Sedation and Monitored Anesthesia Care	91
Fluoroscopic Guidance and Contrast	91
Immunizations and Injections	92
Incident-To Guidelines	92
Laboratory Claims	93
Modifier 51 Exempt	93
Newborn Claims	93
Obstetrical Claims	
Reimbursement for Global OB	93
Obstetrical Copayments for HMO/POS/PPO	94
Special Fee for Service Billing Arrangements	94
Payment for Multiple Births	94
Covering OB Physicians	94
Pathology Reports	94
Subrogation	95
Surgical Procedures	95
Unlisted Procedure Codes	95
Claim Policies - Modifiers	
AS Modifier - Surgical Assistants	96
24 Modifier - Unrelated E & M Service during Post-Operative Period	96
25 Modifier - Separately Identifiable E & M Service by the Same Physician on the Same Day of Procedure or Other Service	96

26 Modifier - Professional/Technical Component	97
51 Modifier - Multiple Surgical Procedures	97
57 Modifier - Decision for Surgery	98
59/XE/XP/XS/XU Modifiers - Distinct Procedural Service	98
62 Modifier - Two Surgeons	98
80 and 82 Modifier - Assistant Surgeon	99
81 Modifier - Minimum Assistant Surgeon	99
Commercial Product Claim Payment Reconsiderations	100
Provider/Member Appeals and Expedited Appeal Procedure	102
Fraud, Waste and Abuse	103
Provider Responsibilities Regarding Excluded Entities	109
Disclosure of Ownership and Control Interest Statement	109
Subcontractor, Vendor and Agent Compliance Program	110
Fair Business Practices Act	114

INTRODUCTION

As a Participating Provider, you are an integral member of our 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 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 website. The Provider Manual consists of a core document that includes general policies and procedures for all Plan Types and specific information for Optima Health Commercial Plans. It also includes Supplements containing information specific to: 1) Hospitals and Ancillary Providers; 2) Providers participating in the Optima Health Medicaid Program ; 3) Providers participating in the Medicare Advantage HMO; 4) Providers participating in Optima Community Complete(OCC), the Dual Eligible Special Need Plan (D-SNP); 5) an ARTS Supplement for Behavioral Health Providers that participate in the Optima Health Medicaid program.

The Provider Manual was developed to assist Providers in understanding the administrative requirements associated with managing a Member's health care. This Provider Manual, including all sources that are referenced by and incorporated herein, via web-link or otherwise, is a binding extension of your Provider Agreement and is amended as our operational policies change. Many of the policies and procedures that are referenced by or incorporated into this Provider Manual are available on the Provider Web Portal.

All Capitalized terms used but not otherwise defined in this Provider Manual have the same meaning as defined in the Sentara Health Plans Provider Agreement. Should the terms of the body of the Provider Agreement or its exhibits (excluding the Provider Manual exhibit) be in conflict with this Provider Manual, then the body of the Provider Agreement and its exhibits (excluding the Provider Manual exhibit) controls.

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 notifies Providers of updates to this manual via e-mail. 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 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 requires 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 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
- Access real-time deductible and out-of-pocket maximum information
- Request prior-authorization
- Create OB notifications
- Check authorization status and effective/expiration dates
- View claim detail and status
- View, download and print PCP Membership Reports
- Pre-adjudicate medical claims using C3-Clear Claims Connection
- View and download remits and Pended Claim Reports
- Submit online reconsiderations for Medical claims

In addition, Providers can access required and supplemental trainings at [Optimahealth.com](https://www.optimahealth.com) on the Providers tab under Provider Support. Model of Care Training is required annually for providers participating in Medicare. Providers are encouraged to take Fraud, Waste, and Abuse, Trauma Informed Care and Cultural Competency trainings during onboarding and as ongoing training.

- Quarterly Webinars:

Online educational webinars are held quarterly and allow Providers to ask questions, provide Optima Health updates, and provide refreshers on how to successfully do business with Optima Health. Providers must register on the Optima Health Provider website by the day before each event. The schedule is listed on the [optimahealth.com/providers](https://www.optimahealth.com/providers) education page and in the Provider Newsletter, along with other educational opportunities.

- Mailings and Newsletters:

Providers may be notified of updates or changes to policies via targeted mailings or e-mail. We notify Providers of news, updates or changes to our policies via our quarterly Provider newsletter, with an e-mail notification when the Newsletter is available 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 in the front 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, are 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, including amendments to your Provider Agreement 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

As affiliates of Sentara Healthcare, Optima Health entities follow the Sentara Healthcare *Notice of Privacy Practices available at*

<http://www.optimahealth.com/policies/Pages/SentaraHealthcareNoticeofPrivacyPractices.aspx>

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.

PRODUCT OVERVIEW

Optima Health offers a number of health plans designed to meet the needs of most large and small employer groups as well as individuals and families. In addition, Optima Health offers plans for Medicare Advantage and managed Medicaid, including plans for dual eligible Members. Product offerings and designs are subject to change and often vary by geographic area.

Plans Sold on the Health Insurance Marketplace

As a Qualified Health Plan (QHP), Optima Health sells several HMO plans on the Federally Facilitated Health Insurance Marketplace (FFM). The front of the Optima Health Member ID cards indicates FFM in the lower left corner of the card.

Product Funding Types

When the bottom of the Member ID card shows “Administered by Sentara Health Plans, Inc.” on the front or back of the card, it is an indicator that the plan is self-funded. These Plans may also have employer specific logos as well as the Optima Health name. Because medical costs are funded directly by the employer; employer directed exceptions are common to these plans. Please check benefits on the Provider Web Portal or call Optima Health Provider Relations to obtain plan specifics.

Commercial Product Information

The following tables show general information for Commercial plan types currently offered by Optima Health. For Plans with a Deductible, the annual Deductible does not apply to preventive care. Plan type offerings may vary by geographic location. Specific benefit information is available via Provider Connection or by calling Provider Relations.

HMO PLAN TYPES
Underwritten by Optima Health Plan

All HMO Plan Types:

- No referrals required
- Primary Care Physician (PCP) selection required
- No out-of-network coverage except Emergency care
- Some services require prior-authorization

Product Name	Description	Features
Optima Vantage	<ul style="list-style-type: none"> • Standard HMO type plan 	<ul style="list-style-type: none"> • Includes Copayments with some services requiring Coinsurance • May have Deductibles
Optima Equity Vantage (HSA)	<ul style="list-style-type: none"> • High Deductible Health Plan (HDHP) • Includes a Health Savings Account (HSA) with most plans. Health Savings Accounts are administered by HealthEquity. • Health Savings Accounts (HSA) are funded and owned by the employee to help pay patient out-of-pocket expenses • Debit card or HSA remit may indicate HealthEquity 	<ul style="list-style-type: none"> • Includes Copayments • May have Coinsurance • Annual Deductible
Optima Design Vantage (HRA)	<ul style="list-style-type: none"> • A high deductible health plan • A Health Reimbursement Account (HRA) funded by the employer and administered by HealthEquity to help pay patient out-of-pocket expenses 	<ul style="list-style-type: none"> • Includes Coinsurance • Some services may require Copayments • Annual Deductible does not apply to preventive care
Optima FourSight Vantage	<ul style="list-style-type: none"> • Benefits for specific services are paid before the Deductible applies 	<ul style="list-style-type: none"> • Includes Copayments • Includes Coinsurance • Annual Deductible

PPO PLAN TYPES
Underwritten by Optima Health Insurance Company

All PPO Plan Types:

- In-network and out-of-network coverage
- Primary Care Physician (PCP) selection encouraged but not required
- No referrals required
- Some services require prior-authorization

Product Name	Description	Features
Optima Plus	<ul style="list-style-type: none"> Standard PPO 	<ul style="list-style-type: none"> Includes Copayments with some services requiring Coinsurance May have Deductible
Optima Design Plus (HRA)	<ul style="list-style-type: none"> High Deductible Health Plan A Health Reimbursement Account (HRA) is funded and owned by the employer and administered by HealthEquity to help pay patient out-of-pocket expenses 	<ul style="list-style-type: none"> Includes Coinsurance Some services may require Copayments Annual Deductible
Optima FourSight Plus	<ul style="list-style-type: none"> Benefits for specific services are paid before the Deductible applies 	<ul style="list-style-type: none"> Includes Copayments Includes Coinsurance Annual Deductible
Optima Equity Plus (HSA)	<ul style="list-style-type: none"> High Deductible Health Plan (HDHP). A Health Savings Account (HSA) with most accounts administered by HealthEquity. Accounts are funded and owned by the employee to help pay patient out-of-pocket expenses. Debit card or HSA remit may indicate HealthEquity 	<ul style="list-style-type: none"> Includes Copayments May have Coinsurance Annual Deductible
POS (Point of Service) PLAN TYPES Underwritten by Optima Health Plan		
<u>All POS Plan Types:</u>		
<ul style="list-style-type: none"> No referrals required Primary Care Physician (PCP) selection required Includes an out-of-network benefit Some services require prior-authorization 		
Optima POS	<ul style="list-style-type: none"> Operates similar to HMO Plans except includes out-of-network coverage at reduced benefit level similar to PPO. POS plans also offer high deductible options with a Health Savings Account (HSA) or a Health Reimbursement Account (HRA) similar to HMO plans. 	<ul style="list-style-type: none"> Includes Copayments with some services requiring Coinsurance May have Deductibles
INDIVIDUAL AND FAMILY PLANS		
OptimaFit Individual and Family Plans	<ul style="list-style-type: none"> Individuals purchase healthcare directly or through the Health Insurance Marketplace Plans are HMO: <ul style="list-style-type: none"> OptimaFit Gold OptimaFit Silver OptimaFit Bronze OptimaFit Catastrophic 	<ul style="list-style-type: none"> Refer to the information for the Plan purchased

	<ul style="list-style-type: none"> Individuals may also purchase Cost Share Reduction Plans through the Health Insurance Marketplace 	
STRUCTURED NETWORKS		
Select Plans	<ul style="list-style-type: none"> A plan for individuals and families who live in the Charlottesville and Rockingham areas. Members receive services from a narrow network of facilities and physicians consisting of SQCN, VCU, Riverside, CHKD, TPMG, EVMS and a few other select providers. 	<ul style="list-style-type: none"> Services received outside the network are not covered except for emergency services.
Direct Plans	<ul style="list-style-type: none"> A 2-tiered network of doctors and providers for Richmond Metropolitan Statistical Area, Charlottesville, Halifax, Hampton Roads, Harrisonburg, Mecklenburg and Rockingham area residents 	<ul style="list-style-type: none"> Members pay a lower cost share when choosing a provider in Tier 1 for a specific set of benefits

For plan information regarding Optima Health Medicaid program Medicare HMO, or Optima Community Complete , please reference the appropriate Provider Manual or Provider Manual Supplement.

MEMBER IDENTIFICATION

Member ID Cards

Members receive identification cards for 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 cards shown are representative of each Optima Health plan type. ID cards vary slightly due to specific differences between plans and employer groups.

To access sample Member Identification Cards for Optima Health Plans:

<https://www.optimahealth.com/documents/provider-orientation/015-mbrsvcs-samples-all.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 verifies 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

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.

PRACTITIONER CREDENTIALING AND RE-CREDENTIALING

The information below is a summary of the standard Optima Health credentialing process. *Access the complete Credentialing and Re-credentialing Policy and Procedures:*

<https://www.optimahealth.com/documents/provider-manuals/credentialing-policies-procedures-from-exhibit-b-provider-agreement.pdf>

The goals of the Optima Health Credentialing/Re-Credentialing policy are to promote professional competency and to protect:

- The public from professional incompetence
- The organizations for which professionals work from liability
- The professionals from unfair or arbitrary limits on their professional practices
- The professionals at large from damage to their reputations and from loss of public respect
- The long tradition of the profession with regard to self-governance

Scope

Practitioners that require credentialing as a condition of participation with Optima Health are: Physicians, Optometrists, Podiatrists, Nurse Practitioners, Dentists, Physician Assistants, Licensed Midwives, Psychologists, Professional Counselors, Social Workers, Licensed Behavior Analysts, Licensed Assistant Behavior Analysts, Licensed Psychological Associates (NC), Licensed Clinical Addictions Specialists (NC) and Opioid-Based Treatment Providers as applicable by specialty.

Delegated Credentialing

If you are participating through an organization that has been approved and contracted to perform delegated credentialing, your credentialing process may differ somewhat from the process described in this manual. Please contact your Group Practice administrator for further information.

ARTS and CMHRS Organizations Contracting Approval

ARTS and CMHRS Organizations that bill under a Type 2 NPI utilize a specific Licensures, Corrective Action Plans and Prior Audit Review (LCAR) contracting approval process. These Organizations do not utilize the Practitioner Credentialing Policy.

Initiating the Optima Health Credentialing Process

Providers should notify Optima Health directly of their intent to participate by contacting the assigned Network Educator. The Optima Health Network Management department determines if the Provider meets minimum participation and/credentialing criteria. Applicants with a felony conviction, Office of Inspector General (OIG sanction(s) or Excluded Parties List System (EPLS) sanctions will not be accepted.

Access the Optima Health Credentialing Packet:

Medical: <https://www.optimahealth.com/documents/provider-manuals/credentialing-documents.pdf>

Behavioral Health: <https://www.optimahealth.com/documents/provider-manuals/behavioral-health-credentialing-packet.pdf>

LTSS

Contracting and Credentialing for LTSS are handled by Centipede/HEOPS. Centipede may be contacted by e-mail them at joincentipede@heops.com.

CAQH

The Optima Health Credentialing process uses the Council for Affordable Quality Healthcare (CAQH) application exclusively for Provider credentialing. Providers who do not currently have a CAQH application can complete the CAQH ID Request form on the Provider Web Portal. CAQH has designated a limited number of fields on their application as required information. Optima Health requires **all** of the fields applicable to the Provider be completed. Many of the supporting documents requested by Optima Health may be faxed to CAQH for scanning into the CAQH file.

Contact Information for CAQH:

Website: <https://proview.caqh.org/Login/Index?ReturnUrl=%2f>

CAQH Provider Help Desk: (888) 599-1771 or providerhelp@proview.caqh.org

Supporting Documents

In addition to the completed CAQH application, all Providers must submit the following supporting documents to Optima Health or CAQH:

- Copy of all current state medical licenses
- Copy of DEA certificate
- Copy of current malpractice insurance face sheet indicating amount of coverage:
 - In all states except Virginia, the coverage amount required under the applicable state law governing minimum medical malpractice coverage for Providers. If the state does not have a requirement for minimum medical malpractice coverage, the Provider must maintain coverage in an amount not less than \$1 million per occurrence and \$3 million in the aggregate per year.
 - Virginia Providers must maintain coverage in amounts not less than the medical malpractice caps currently in effect under **section 8.01-581 of the Virginia Code** <https://law.lis.virginia.gov/vacode/title8.01/chapter21.1/section8.01-581.15/>
 - Non-prescribing Optima Behavioral Health (OBH) Providers must maintain coverage in an amount not less than \$1 million per occurrence and \$3 million in the aggregate per year.
- Copy of Curriculum Vitae (resume) that includes work history for the past 5 years

- Copy of the Sentara Healthcare Authorization and Release Form. The Provider signature/date must be current within 180 days (6 months) of submission to Optima Health
- Copy of completed Disclosure of Ownership and Control Interest Statement at the time of contracting/credentialing.
- Where applicable Providers should also submit:
 - Letter of explanation for any gaps in malpractice insurance
 - Letter of explanation for any gaps in work history of 6 months or longer in the past 5 years
 - Psychological Testing Application for Licensed Professional Counselors
 - Neuropsychological Testing Application for Licensed Clinical Psychologists
 - Copy of ECFMG certificate if foreign medical school graduate with ECFMG number noted in CAQH.
 - Completed Cross Coverage Form from covering Physician if not within Provider's practice
 - Copy of completed W-9 form if Provider is not in an existing Optima Health contracted practice
 - Licensed Assistant Behavioral Analysts (ABAs) that bill via a Type 2 Organizational NPI must submit a CMHRS application as well as submitting an application through the Behavioral Health Credentialing process.

Credentialing Process

The Optima Health Credentials Analyst reviews all applications for completion. Incomplete applications will not be processed.

Verifications

The Optima Health Credentialing Department verifies with the primary source that the Provider meets the Optima Health credentialing requirements for the following:

- Verification of completion at the highest level of education: internship, residency, or fellowships for Physicians, and other degrees as applicable, for Non-Physicians
- Verification of specialty board certification/eligibility. Accepted boards are as follows: American Board of Medical Specialties, American Osteopathic Association, American Board of Oral & Maxillofacial Surgery, American Board of Podiatric Surgery, American Board of Podiatric Medicine, the American Board of Dentistry and the National Chiropractic Board.
- Optima Health may, at its sole discretion, waive the specialty board certification/eligibility requirement for applicants practicing in an area that is under-served in the applicant's specialty
- Verification of current professional liability insurance in amounts required by contracts for the past five years for Physicians and two years for ancillary Providers.
- Verification of all current state licensures and past state licensures
- Verification of hospital privilege status at a Participating Hospital if applicable or proof of acceptable coverage arrangements with a Participating Physician

- Verification of Medicaid participation in good standing, if applicable
- Verification of Medicare participation in good standing, if applicable
- Review of the OIG Sanction Report, HIPDB and EPLS for sanctions

After primary source verifications are complete, the application is presented to the Optima Health Medical Director for review and submission to the Credentialing Committee.

The Medical Director may request additional information or documentation prior to submission of the application to the Credentialing Committee for discussion and final committee decision. All Committee approvals and denials are communicated in writing.

No Provider will be denied network participation based upon gender, race, creed, ethnic origin, sexual orientation, age, disability, type of patients treated or clinical specialization. Providers will not be denied network participation based on their practice serving high-risk populations or specializing in the treatment of costly conditions.

After an application is approved for participation, Providers are contacted by their Network Educator to inform them of the participation effective date. Optima Health complies with Virginia law §38.2-3407.10:1 regarding payments to Providers during the credentialing process.

Providers should not begin scheduling or treating Optima Health Members on an In Network basis until their Network Educator notifies them of their Optima Health participation effective date.

Re-Credentialing

Practitioners are re-credentialed no less than every 36 months and no more frequently than every 12 months unless an issue is identified by the Credentials Committee that necessitates an earlier review. Optima Health contacts Providers at the time of re-credentialing to initiate the process.

Confidentiality and Provider Rights

All credentialing information is maintained in a confidential manner. All parties involved in the Optima Health credentialing process sign a Confidentiality Agreement on an annual basis. The Confidentiality Agreement includes all credentialing documents, reports, and communications relating to practitioners. All credentialing documents are maintained by the Credentialing Department in a secure, locked environment.

An applicant has the right to review the information submitted in support of their application. The right to review information shall not require Optima Health to allow the applicant to review references, recommendations or other information that is peer review protected under the Health Care Quality Improvement Act.

An applicant has the right to correct erroneous information submitted by another party. In the event that information obtained from other sources varies substantially from that submitted by

the applicant, the applicant will be notified of the discrepancies by the Credentials Analyst within 10 days of receipt of the conflicting information.

The applicant has five business days from the date of notice of the erroneous information to correct such information. Corrections must be submitted (in writing) to the Optima Health Credentials Analyst.

DISCIPLINARY ACTION

The Optima Health Credentialing Committee is responsible for reviewing potential areas of corrective action and recommending disciplinary or corrective action for practitioners who fail to comply with their practitioner's Agreement with Optima Health and Optima Health's policies and procedures.

Grounds for corrective action include:

- Quality of care below the applicable standards
- A pattern of over/under utilization of services which is significantly higher/lower than other practitioners
- Failure to comply with Utilization Management and Quality Improvement Programs
- Violation of the terms of the practitioner's agreement
- Disruptive behavior, including but not limited to: failure to establish a cooperative working relationship with Optima Health, making false statements to Members or the public which discredit Optima Health, or abusive or abrasive behavior toward Members of Optima Health or other Participating Practitioners' office staff
- Falsification of information on documents submitted to the Plan
- Conviction of a felony
- Licensure sanctions (including probation, suspension, supervision, monitoring)
- Loss of DEA certification
- Sanction or exclusion from government health programs, including Medicare and Medicaid
- Failure to maintain required malpractice insurance coverage

The Optima Health Credentialing Committee may recommend the following actions as applicable:

- Summary suspension
- Termination of participation
- Probationary participation status
- Mandatory attendance at continuing education courses if the quality of care is deficient, but not deficient enough to warrant immediate termination
- Concurrent review by the Optima Health Medical Director or designee of the care rendered by the disciplined Practitioner
- Other actions as determined by the Committee
- Summary suspension of the practitioner's clinical privileges may occur without prior investigation or hearing whenever:
 - Immediate action is deemed necessary in the interest of patient care or safety or the orderly operation of the Plan
 - Practitioner is convicted of a felony

The National Practitioner Data Bank (NPDB) and the State Board of Medicine or Nursing will be notified in accordance with legal requirements regarding any quality issues, limitation in participation or termination when determined by the Plan.

Access the Right to a Fair Hearing and Appellate Review Policies and Procedures:
<https://www.optimahealth.com/documents/provider-manuals/right-fair-hearing-appellate-review-policies-procedures-exhibit-b-agreement.pdf>

QUALITY IMPROVEMENT PROGRAM

Purpose

The purpose of the Quality Improvement Program is to provide a foundation for the development of programs and activities directed towards improving the health of our Members. It is designed to implement, monitor, evaluate, and improve processes that are within the scope of the Plan. Several committees within the organization work on Quality Improvement (QI) issues. Membership includes Optima Health staff and participating Providers and may include representatives from other organizations.

Each year, Optima Health develops a QI Program and Work Plan that outlines our efforts to improve clinical care and service to our Members. Providers may request a copy of the current QI Program and Work Plan by calling Quality Improvement Department. Information related to QI initiatives is also available on the Provider Web Portal and in Provider newsletters.

NCQA Accreditation

As part of our commitment to quality, Optima Health voluntarily participates in the Accreditation process administered by the National Committee for Quality Assurance (NCQA).

NCQA is a private, non-profit organization dedicated to improving health care quality. NCQA accredits and certifies a wide range of healthcare organizations. It also recognizes clinicians and practices in key areas of performance. NCQA is committed to providing healthcare quality information for consumers, purchasers, healthcare Providers and researchers.

HEDIS^{®1}

Healthcare Effectiveness Data and Information Set (HEDIS[®]) is the measurement tool used by the nation's health plans to evaluate their performance in terms of clinical quality and customer service. HEDIS[®] is a set of standardized performance measures designed to ensure that purchasers and consumers have the information they need to reliably compare healthcare quality.

HEDIS[®] performance measures are a part of the NCQA Accreditation process. Some of the major areas of performance measured by HEDIS[®] are:

- Effectiveness of Care
- Access/Availability of Care
- Experience of Care
- Utilization and Risk Adjusted Utilization
- Health Plan Descriptive Information
- Measures Reported Using Electronic Clinical Data Systems

¹ HEDIS is a registered trademark of the National Committee for Quality Assurance (NCQA).

Clinical Guidelines

Clinical Guidelines offer the most current recommendations in disease management techniques. They are based on published national guidelines, literature review, and clinical experience. Clinical Guidelines are updated on an annual/biannual basis. They are not meant to replace clinical judgment in dealing with individual patient care decisions, but are intended to facilitate a collaborative approach between Primary Care Physicians, Specialists and other Providers in the management of patient care. Clinical Guidelines are available to Providers on the Provider Web Portal.

Provider Directory Information

Provider contact and availability information in the Optima Health on-line and print directories is the primary source for Members to access medical care. It is important to notify Optima Health of any changes to maintain Member access. CMS audits Optima Health information to confirm that only practice locations where Providers routinely see patients and only specialties in which physicians are currently taking appointments are listed. Except for emergencies, Providers must notify Optima Health in advance of closing their practice to new patients. Prior notice of termination is required in writing for Member notification and in accordance with terms of the Provider Agreement. Participation in CMS mandated directory information audits performed by Optima Health is required.

Patient Appointment Access Guidelines

Access to care is recognized as a key component of quality care. As a condition of participation, all Providers agree to provide necessary Covered Services to Members on a 24-hour per day, 7-day per week basis, or arrange with Physician(s) to cover patients in their absence. For all Optima Health plan types:

- Participating Primary Care Physicians (PCPs) or their Participating partners should provide at least 24 office hours available for patient appointments per week.
- PCP and OB/GYN appointment bookings should average no more than five per hour (six for Pediatrics). Additional time should be allowed for patients with disabilities.
- All Providers must arrange with another Participating Physician to provide coverage for Members in their absence.
- When a PCP is unable to meet access criteria due to schedule conflicts and the Member's condition warrants immediate attention, the PCP should make provisions for that Member to be seen by another Participating Physician.

Appointment access standards for Commercial (HMO/POS/PPO) and Medicare plans:

- Emergency: Immediately upon request
- Urgent: 24 hours
- Symptomatic: 1 week
- Routine/Well Care: 30 days
- Initial PrenatalCare:
 - First Trimester: 7 days

- Second Trimester: 7 days
- Third Trimester: 3 days
- High-Risk: 3 days or immediately if Emergency
- Behavioral Health services:
 - Emergency: 6 hours
 - Urgent: 48 hours
 - Routine: 10 days

Please see the Optima Health Medicaid Program Provider Manual for the Medicaid program appointment access standards.

Continuity and Coordination of Care

Optima Health strives to ensure that all Members receive the highest quality of care. Ongoing collaboration between Primary Care Physicians (PCPs) and Specialists, and Behavioral Health Providers, as well as between PCPs and other types of Providers promotes a continuous plan of care that benefits the Member. Other types of Providers include hospitals, home health agencies, skilled nursing facilities, nursing homes, ambulatory surgical centers, and may include Providers for ARTs, Community Mental Health and Rehabilitation Services (CMHRS) Providers, and Long Term Services and Supports (LTSS) Providers.

The Optima Health policy monitors and identifies potential problems with continuity and coordination of care for all of our Members. Information on continuity and coordination of care is collected at the time of HEDIS[®] chart reviews. Optima Health also monitors continuity and coordination through transitions in care (changes in management of care between Providers, changes in settings or other changes in which different Providers become active or inactive in providing ongoing care for a patient).

If a Provider leaves the Provider Network, except for cause, the Member may have continued access to that Provider under the following circumstances:

- Members undergoing active treatment for a chronic or acute medical condition have access to their discontinued Provider through the current period of active treatment or up to 90 calendar days, whichever is shorter.
- Members in their second or third trimester of pregnancy have access to their discontinued Provider through the post-partum period.
- Members who are receiving care directly related to the treatment of a terminal illness have access to their discontinued Provider for the remainder of their life.

If the PCP terminates in a plan that requires a PCP, notice is sent to the Member by Optima Health at least 30 days prior to the PCP termination with the assignment of a new PCP stated in the letter. Members have the option of changing to another PCP if they desire.

Within 15 days of receiving notice that a specialist practice is terminating, Optima Health sends notification of the pending termination to all Members that have been seen by the Specialist practice within the past 12 months.

Culturally Competent Care

Delivery of culturally competent care allows healthcare Providers to appropriately care for and address healthcare concerns, to include belief and value systems, of patients with diverse cultural and linguistic needs.

Providers are encouraged to:

- Build rapport by providing respectful care
- Determine if the Member needs an interpreter or translation services
- Remember that some cultures have specific beliefs surrounding health and wellness
- Ensure that the Member understands diagnosis, procedures, and follow-up requirements
- Offer health education materials in languages that are common to your patient population
- Be aware of the tendency to unknowingly stereotype certain cultures
- Ensure staff is receiving continued education in providing culturally competent care

Providers are encouraged to complete cultural competency training. ***Online training is available in the Education section of the Optima Health website at <https://www.optimahealth.com/providers/provider-support/education/>.***

CME credits are available. Upon completion of the training, Providers should complete the Provider Acknowledgement Form for Cultural Competency to receive credit.

The Optima Health Provider directory displays Cultural Competence as a feature on all Provider profiles, informing Members which Providers have completed the training.

Office Site Reviews

Any complaint regarding physical accessibility, physical appearance, and/or adequacy of waiting and/or examining room space that is received about an Optima Health Participating Provider is reviewed by the Optima Health Medical Director. The Network Educator schedules a site visit with the office within 60 days of the complaint when the Medical Director determines that a site visit is appropriate. The Office Site Review Tool will be utilized for the review and a letter with the results of the review will be sent to the Provider within 10 calendar days of the site visit. If issues are found during the site visit, a corrective action plan may be initiated, per the Optima Health Site Visit Policy.

Medical Record Documentation Standards

Optima Health may request medical records for review. Listed below are the current Medical record standards:

- Current active problem list must be maintained for each Member. It should be legible and updated as appropriate. Significant illnesses and chronic medical conditions must be documented on the problem list. If there are no identified significant problems, there must be some notation in the progress notes stating that this is a well-child/adult visit.

- Allergies and adverse reactions must be prominently displayed. If the Member has no known allergies or history of adverse reactions, this is appropriately noted in the record. A sticker or stamp noting allergies/NKA on the cover of the medical record is acceptable.
- Past medical history (for patients seen three or more times) must be easily identified and includes family history, serious accidents, operations, and illnesses. For children and adolescents (18 years and younger), past medical history relates to prenatal care, birth, operations, immunizations, and childhood illnesses.
- Each page of the medical record contains patient name or ID number. All entries are dated. Working diagnoses and treatment plans are consistent with medical findings.
- All requested consults must have return reports from the requested consultant or a phone call follow-up must be noted by the PCP in the progress note. Any further follow-up needed or altered treatment plans, should be noted in progress notes. Consults filed in the chart must be initialed by the PCP to signify review. Consults submitted electronically need to show representation of PCP review.
- Continuity and coordination of care among all Providers involved in an episode of care, including PCP and Specialty Physicians, Hospitals, Home Health, Skilled Nursing Facilities, and Free-Standing Surgical Centers, etc. must be documented when applicable.
- There should be documentation present in the records of all adult patients (emancipated minors included) that advance directives have been discussed. If the patient does have an advance directive, it should be noted in the medical record. A copy of the advance directive should be present in the record.
- Confidentiality of clinical information relevant to the patient under review is contained in the record or in a secure computer system, stored and accessible in a non-public area, and available upon identification by an approved person. All office staff must comply with HIPAA privacy practices.
- An assessment of smoking, alcohol, or substance abuse should be documented in the record for patients 12 years old and older. Referrals to a Behavioral Health Specialist should be documented as appropriate.
- Records should indicate that preventive screening services are offered in accordance with Optima Health's Preventive Health Guidelines. This should be documented in the progress notes for adults 21 years and older.

Behavioral Health Medical Record Documentation Standards

Medical records may be audited according to Optima Behavioral Health Treatment Record Documentation Guidelines that incorporate accepted standards for medical record documentation as shown below.

- History of present illness
- Psychiatric history
- Substance use assessment
- Mental status examination
- Diagnosis (all five axes)
- Medical history, including allergies and adverse reactions (physicians only)
- Medication Management (physicians only)

- Allergies and adverse reactions to medications
- Treatment planning
- Risk assessment
- Evidence of continuity of care – Documentation of collaboration with the Member’s Primary Care Physician (PCP) in the area of medication and treatment rendered, or documentation of the Member’s refusal to consent to same. After obtaining the patient’s informed consent prior to the release of information, the Provider is expected to notify the PCP when the Member presents for an initial behavioral health evaluation and continued treatment, including significant changes in the patient’s condition, changes in medication and termination of treatment.

Confidentiality of clinical information relevant to the patient under review should be contained in the record or in a secure computer system, stored and accessible in a non-public area, and available upon identification by an approved person. All office staff must comply with HIPAA privacy. Patient information should be in chronological or reverse chronological order and in a consistent, logical format.

ARTs Medical Record Policies

Please see the ARTs Supplement to this Provider Manual for specific Medical Record documentation required for ARTs.

Medical Record Policies

Participating Providers must treat all communications and records pertaining to the Member’s healthcare as confidential and no records may be released without the written consent of the Member or as otherwise permitted by state or federal law. In the case of an unemancipated minor, the release of information requires the authorization of the legal guardian unless otherwise permitted by law. Healthcare Providers are required to accept a photocopy, facsimile, or other copy of the original document signed by the patient providing authority for the requester to obtain the records, as if the copy were an original document. Participating Providers must obtain a separate Release of Information, or waiver, from those Members with certain conditions, such as sexually transmitted diseases.

Charging for Copies of Records:

Providers **may not** charge the Plan for copies of medical records or for the completion of forms.

Retention of Medical Records:

- Providers must maintain records as required by applicable state or federal law.
- Subject to applicable law, if a Provider practice or facility is sold, the medical records go with the sale but the selling Provider must notify its patients in writing that it is selling its facility or practice and must state where the records will be located. Providers must also ask patients if they wish to receive their records.

- If the practice or facility is being closed, medical records must be maintained in accordance with the applicable state statute.
- Providers are advised to contact their malpractice insurance carrier to see if they have any additional stipulations regarding medical record retention.

Advance Directives

Optima Health provides Members with information related to Advance Directives, Living Wills, Appointment of a Healthcare Agent, and Organ Donation and Anatomical Gift Designation in compliance with the Patient Self-Determination Act and the applicable state law requiring any service provider to inform adult patients about the laws concerning the patient's rights to accept or refuse care and the right to make advance directives about their care.

Access Advance Care Planning information for Virginia and North Carolina Providers from the Sentara Center for Ethics: <https://www.sentara.com/hampton-roads-virginia/patientguide/advance-care-planning.aspx>

Additional QI Information

To request a copy of HEDIS® Performance Measures for Optima Health, request a hard copy of our clinical guidelines or ask questions concerning the QI process please contact the Quality Improvement Department. Current information on HEDIS® measures, clinical guidelines, and preventative health guidelines is available to Providers online on the Provider Web Portal.

OFFICE VISIT/ENCOUNTER PROCEDURES AND MEMBER RESOURCES

Member Visit/Encounter Procedure

- Members should present their Member I.D. card and another form of identity verification (e.g. driver's license).
- The Provider's staff should check the card for eligibility, benefits, and make a copy of the card for the Member's record.
- In an Emergency, treatment should proceed without question of eligibility or coverage. Eligibility verification can be obtained as soon as appropriate after treatment.
- Provider's staff should confirm that an authorization has been received if necessary.
- Provider's staff may access Provider Connection on the Provider Web Portal anytime or call Provider Relations during business hours for verification if a Member's status is in question.

Copayments, Coinsurance and Deductibles

- Check the Member's ID card to determine if there is a Copayment due for the specific service rendered. Copayments vary depending on services provided and the Member's plan benefits. Some plans do not have Copayments. Collect the appropriate Copayment from the Member.
- The suggested best practice is for Providers to submit the claim to Optima Health first and utilize the Optima Health remittance to determine the amount due from the Member. This process avoids over collecting from Members and the additional paperwork and cost of refunding overpayments.
- The Member should not pay more than the contracted rate of the service rendered. If the Copayment amount is more than the contracted rate for the service, the Member pays the lesser amount of the contracted rate and not the Copayment amount.
- A Copayment should only be collected for services that are reimbursable under the Member's Plan.
- Copayments vary depending on services provided and the Member's plan benefits. Some plans do not have Copayments.
- Members are responsible for the full plan contracted allowable amount for applicable visits until their Deductible is met if their plan has a Deductible.
- Once the Deductible is met, Members that have plans with Coinsurance are responsible for the appropriate Coinsurance (percentage of the contracted allowable charge for the visit) unless the Member's plan has a reimbursement account funded by the employer to help pay out-of-pocket expenses directly to the Provider.
- Providers may elect to collect at the time of service when the Member has not yet met their Deductible. The amount of the Deductible and whether or not the Member has met a portion or all of the Deductible is available through Provider Connection on the Provider Web Portal under View Eligibility or by calling Optima Health Provider Relations. Member responsibility information will be correct as of the time of an inquiry but if other claims are received and processed before your claim is received and processed, Member responsibility could change.

- Providers must reimburse the Member any amount collected more than the Member's responsibility within 30 days.
- When Optima Health is the secondary insurance carrier:
 - If the primary payer does not have a Deductible, do not collect the Copayment
 - Do not collect the Copayment if the Member has met the Deductible of the primary payer
 - Collect the Copayment if the Member has not met the primary payer's Deductible
- Members are notified when they reach their Max Out-of-Pocket (MOOP) and Providers should not collect a Copayment or Coinsurance. It is the responsibility of the Provider to refund the Member any Coinsurance or Copayment paid while the Member is in the MOOP. Providers agree to assist Optima Health to document refunds as part of Optima Health internal audits, or any audit by a state or federal regulatory body.

Members Rights and Responsibilities

The Member Rights and Responsibilities document assures that all Optima Health Members are treated in a manner consistent with the mission, goals, and objectives of Optima Health and assures that Members are aware of their obligations and responsibilities upon joining the Plan and throughout their membership with the Plan.

Each type of Optima Health Product has a specific Member Rights and Responsibilities document that is provided to Members at the time of enrollment. The Member Rights and Responsibilities are very similar for all Optima Health Products but have slight variations based on variations in the Product and the Members served by that Product. The Member Rights and Responsibilities listed below apply to Optima Health Commercial Product Members (HMO/POS/PPO/Individual). The specific lists of Member Rights and Responsibilities for the other Optima Health Products (Optima Health Medicaid program, Optima Health Medicare HMO) are provided in the specific Provider Manual or Provider Manual Supplement for each Product.

Commercial Members

Optima Health Plan Members have the right to:

Timely and Quality of Care:

- Access to Protected Health Information (PHI), medical records, physicians, and other healthcare professionals; and referrals to specialists when medically necessary.
- Continuity of care and to know in advance the time and location of an appointment, as well as the physicians and other health care professionals providing care.
- Receive the medical care that is necessary for the proper diagnosis and treatment of any covered illness or injury.
- Participate with physicians and healthcare professionals in:
 - Discussing their diagnosis, the prognosis of the condition, and instructions required for follow-up care;

- Understanding the health problems and assisting to develop mutually agreed-upon goals for treatment;
- Decision-making regarding their healthcare and treatment planning; and
- A candid discussion of appropriate or medically necessary treatment options for their condition regardless of cost or benefit coverage.
- The right to affirm that all practitioners, Providers, and employees who make utilization management (UM) decisions:
 - Base decisions on appropriateness of care, services and existence of coverage;
 - Are not rewarded for issuing medical denials of coverage; and
 - Do not encourage decisions that result in underutilization through financial incentives.

Treatment with Dignity and Respect — Members will:

- Be treated with respect, dignity, compassion, and the right to privacy.
- Exercise these rights regardless of race, physical or mental ability, ethnicity, gender, sexual orientation, creed, age, religion or their national origin, cultural or educational background, economic or health status, English proficiency, reading skills, or source of payment for their care. Expect this right by both Plan and contracting physicians.
- Expect protection of all oral, written, and electronic information across the Plan, and information to plan sponsors and employers.
- Extend their rights to any person who may have legal responsibility to make decisions on the Member's behalf regarding medical care.
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.
- Be able to refuse treatment or to sign a consent form if the Member feels they do not clearly understand its purpose, or cross out any part of the form they do not want applied to their care, or change their mind about any treatment for which they have previously given consent and be informed of the medical consequences of this action.

Receive Health Plan Information — Members will:

- Receive information about their health plan, its services, its physicians, other health care professionals, facilities, clinical guidelines and Member rights and responsibilities statements; and collection, use, and disclosure of PHI.
- Know by name, title, and organization the physicians, nurses, or other health care professionals providing care.
- Receive information about medications (what they are, how to take them and possible side effects) and pharmacy benefit information (effective date of formulary change, new drugs available, or recalled medications).
- Receive clear information regarding benefits and exclusions of their policy, how medical treatment decisions are made/authorized by the health plan or contracted medical groups, payment structure, and the right to approve the release of information.
- Be advised if a Provider proposes to engage in experimentation affecting care or treatment. The Member may have the right to refuse to participate in such research.
- Be informed of policies regarding Advance Directives (living wills) as required by state and federal laws.

Members Solve Problems in a Timely Manner by:

- Presenting questions, concerns or complaints to a customer service specialist without discrimination and expect problems to be fairly examined and appropriately addressed.

- Voicing concerns or complaints to Optima Health about their health plan, if the care provided was inadequate, or feel their rights have been compromised. This includes the right to appeal an action or denial and the process involved.
- Making recommendations regarding the health plan Members rights and responsibilities policies.

Member Responsibilities

Optima Health Plan Members, in addition to their rights, subscribers and their enrolled dependents have the responsibility:

- To identify themselves, and their family members as an Optima Health enrollee and present their identification card(s) when requesting healthcare services.
- To be on time for appointments and contact the physician or other healthcare personnel at once if there is a need to cancel or if they are going to be late for an appointment. If the physician, other healthcare personnel or facility, has a policy assessing charges regarding late cancellations or "no shows", the Member will be responsible for such charges.
- To provide information about their health to physicians and other health care professionals so they may provide appropriate medical care.
- To actively participate and understand improving their health condition(s) by following the plans and instructions for care and treatment goals that they agreed upon with the physician or healthcare professional.
- To act in a manner that supports the care provided to other patients and the general functioning of the office or facility.
- To review the employee handbook and Plan documentation:
 - To make sure the services are covered under the plan,
 - To approve release of information and have services properly authorized before receiving medical attention,
 - To follow proper procedures for illness before and after business hours, and
 - For materials concerning health benefits (e.g. UM issues) and educate other covered family members.
- To accept financial responsibility for any co-payment or coinsurance associated with services received while under the care of a physician or other healthcare professional or while a patient at a facility.
- To contact Optima Health if they have concerns, or if they feel their rights have been compromised.

Special Needs Members

Optima Health will use all reasonable means to facilitate healthcare services for Members with physical, mental, language and cultural barriers. To ensure the needs of Members with physical, mental, language, and/or cultural barriers are properly accommodated; Members with special needs should be instructed to call Member Services at the number on the back of their Member ID card. Members are notified of these services in their Member materials (handbook). In the event that a Member Services representative needs assistance in accommodating the Member,

the representative may contact Clinical Care Services (CCS) for additional resources and assistance.

Optima Health contracts with a vendor to provide communication services for Optima Health Members, Potential Members and their Companions/Family Members.

Providers should handle interpreter services as follows:

Optima Health Commercial and Medicare Advantage Members:

Providers are responsible for coordination and payment of interpreter services for their patients, if necessary, as directed by the Americans with Disabilities Act (ADA) and the Civil Rights Act of 1964. Providers can contact Optima Health Provider Services for assistance to coordinate (but not reimburse for) interpreter services.

Optima Health Medicaid Program Members:

Providers are to contact Optima Health Provider Services for interpreter services. Interpreter services for the Optima Health Medicaid program Members are coordinated and reimbursed by Optima Health as required by the Virginia Department of Medical Assistance (DMAS).

Providers are required to notify Optima Health of their office(s) ADA accessibility status for every office location in order for Optima Health to meet requirements for display of ADA access in Provider directories.

Members who require special services (e.g. substance abuse, childbirth classes, smoking cessation) may have these services arranged by the Plan to ensure access to such services.

Essential Community Providers

Optima Health contracts with available Essential Community Providers (ECPs) such as Federally Qualified Health Centers, Rural Health Centers, Community Health Centers, and Indian Health Care Providers.

PRIMARY CARE PHYSICIANS

Primary Care Physician Provider Panels

Primary Care Physicians (PCPs) are required to accept an average of 350 Members per Physician across all Optima Health plan types with which they participate before closing their panels to new Members. In addition, Providers are required to accept current patients that convert to Optima Health coverage even if they have reached the 350-Member average.

Written notice or email from the Physician practice is required for any network panel status change. All changes will become effective 60 days after the receipt of the written notice. Any Member that selects the PCP prior to the effective date of the panel limitation will be paneled to that PCP.

The Physician's office will receive a written response by e-mail or letter acknowledging receipt of the notification, confirming the Physician's intentions, and informing the Physician of the effective date of the panel status change.

PCP Panel Status Options:

- Open and accepting new Members
- Not accepting new patients; Provider will continue to provide services for established patients, siblings and spouses switching plans
- (Pediatrics) Provider is not accepting new patients; Provider will accept established patients, newborns and their siblings
- Age restriction
- Covering Provider only

Patients who have seen the Physician within the past two years are considered established patients by Optima Health.

Guidelines for Removing a Member from a PCP Panel

Physicians may request that Optima Health assist Members in selection of another PCP when the Members demonstrate any of the following behaviors:

- Failure to pay required Copayments
- Abusive behavior
- Non-compliance with Physician treatment plan
- Failure to establish a Physician-patient relationship

Upon notification of these behaviors, Member Services will counsel the Member and assist with the selection of a new PCP.

The procedure for removing a Member from a Physician's panel is as follows:

1. Send a certified letter to the Member and state the reason for asking him/her to be re-paneled to another Physician. State in the letter that the Member has 30 days to select a new Physician. Inform the Member that his/her medical care will continue to be rendered for the next 30 days on an Emergency basis only.
2. Send a copy of the letter to your Contract Manager in the Network Management Department at Optima Health by mail or Fax.

Physicians may not seek or request to have a Member terminated from the Plan or transferred to another Provider due to the Member's medical condition, or due to the amount, variety, or cost of Covered Services required by the Member.

HEALTH & PREVENTIVE SERVICES

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 a letter, a voucher for a healthy parenting magazine subscription and a magnet featuring the childhood immunization schedule and our wishes for a healthy delivery (sent once Member is in her seventh month of pregnancy). Additional mailings are sent throughout the course of her pregnancy and include messages related to pre-term labor, stress management and post-partum check-up reminders.
- **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:** 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.

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. A shorter report that can be taken to their healthcare Provider is also available diabetic, asthmatic and pregnant health plan Members are referred to our clinical care services teams.

Health Risk Reduction Programs: A number of health risk reduction programs are available free of charge to health plan Members on a regular basis throughout the year. A current list of programs is available to Members on the Member website.

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.

In partnership with Omada Health, Optima Health offers members who qualify, a digital, life-style change program focused on reducing the risk of obesity-related chronic disease. This program combines the latest technology with ongoing support so participants can make changes that matter most to improving their health. The program includes a wireless smart scale, weekly online lessons, professional health coaching and small online peer groups that offer real-time support. *Members can determine if they qualify for the program by visiting www.omadahealth.com/optima and by completing the online screening tool.*

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.

Health and Preventive Services contributes news and current preventive health initiatives to the Optima Health Provider newsletter, and other Optima Health and Sentara publications.

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.”

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
- Neonatal care for premature and medically complex newborns (partnership with ProgenyHealth)

Requests for services (written or verbal) may be initiated 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/care 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

For all Members the following apply:

- A PCP referral is not required for Members to access health services
- Physicians may not refer to out-of-network Providers unless authorized by the Plan
- Physicians must obtain a prior-authorization from the Plan **prior** to recommending the Member obtain care out-of-network
- HMO Plans will not pay if the services are provided to the Member by a non-Participating Provider
- Physicians/Providers must receive prior-authorization before services are rendered for any services requiring authorization.

Primary Care Physicians (PCPs) or Specialists **may not** authorize non-covered benefits or out of network services unless Medically Necessary and prior-authorized by the plan.

Exceptions may apply for emergencies and network accessibility.

Behavioral Health Services Access

A PCP referral is not required for Members to access behavioral health services.

Physician to Physician Communication

To ensure continuity of care, the Specialist is **required** to report medical findings to the PCP. The written report must include:

- Diagnosis.
- Treatment plan.
- Answers to specific questions as the reason for the referral.

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.

MEDICAL CLINICAL 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 and attached before submission. When the authorization information is completed, the Status of Request field will show Complete – Approved or Complete – Pended for Further Review.

Prior-Authorization Fax Forms

All prior-authorization forms are available on the Provider Web Portal. The fax number varies based on the service requested and the Member's Optima Health product type. Please use the fax number listed on the Authorization form for the specific requested service for Commercial, Medicare or Medicaid programs.

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

Clinical Care Service Availability

Clinical Care Service personnel are available to process faxed requests and medically urgent telephone requests between 8:00 a.m. and 5:00 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.

Medicaid Program and Medicare Prior-Authorization

Optima Health Medicaid program, Medicare Advantage HMO and Optima Community Complete (OCC) have a dedicated phone number for Government Programs prior-authorization. Please reference the Optima Medicaid Program Provider Manual, Medicare HMO, or OCC Provider Manual Supplements for information specific to the Optima Health Medicaid program, Medicare HMO, and OCC policies, procedures and contacts.

Prior-authorization Procedures and Requirements

Prior-authorization is based on medical necessity 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. Optima Health follows the National Committee for Quality Assurance guidelines for Timeliness of UM Decisions.

Requests for Elective admissions must be submitted for prior-authorization 14 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 fourteen 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 is urgent and requires expedited review. The definition for an expedited review is the following:

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. Except in the case of emergency treatment, 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:

- Commercial Plan Durable Medical Equipment (DME) single purchased items greater than \$750 and all rentals. For Medicaid and Medicare guidance, please reference the appropriate Provider Manual or Provider Manual Supplement.
- Home health/hospice/IV infusions
- Commercial Plan Orthotics/prosthetics, single purchased items greater than \$750 and all rentals, repair, replacement, and duplicates. For Medicaid and Medicare guidance, please reference the appropriate Provider Manual or Provider Manual Supplement.
- Plastic surgery
- All rehabilitation programs (cardiac, vascular, vestibular, pulmonary, etc.).
- Therapies (PT, OT, ST). Optima Health Medicaid program does not require prior-authorization unless they are part of home health services.

- Applied Behavioral Analysis
- Early intervention services (Part H certification required)
- OB global notification
- Transplant services (also applicable when Optima Health is not the primary payer)
- Human and synthetic tissue
- Oral surgery and related services
- Advanced Imaging Studies: PET, CT, CTA, MRI, MRA, MR-CT
- Sleep studies performed by an Optima Health accredited/contracted sleep study Provider (requirements may vary for some self-funded groups)
- 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 forms
- Genetic testing (if covered by group/Plan)
- Bone densitometry if less than 24 months since last study

Please reference the Optima Health Medicaid program Provider Manual for information specific to prior authorization requirements and contact numbers for Optima Health Medicaid program.

Optima Health Oncology Program:

The Optima Health Oncology Program promotes evidence-based, high-value care for Members receiving drug regimens and/or radiation therapy for the treatment of cancer. This program is administered through AIM Specialty Health® (AIM). Radiation oncology performed as part of an inpatient admission is not part of this program.

Providers of radiation or medical oncology services are required to contact AIM for pre-review for all cancer treatment and supportive drugs, and radiation services listed below:

- 2D conventional and 3D conformal radiation therapy
- Brachytherapy
- Proton beam therapy
- Intensity-modulated radiation therapy (IMRT)
- Intraoperative radiation therapy (IORT)
- Selective internal radiation therapy (SIRT)
- Stereotactic body radiotherapy (SBRT)
- Stereotactic radiosurgery (SRS)
- Fractionation in bone metastases, non-small cell lung cancer, and breast cancer when requesting external beam radiation therapy (EBRT) and intensity-modulated radiation therapy (IMRT)
- Image-guided radiation therapy (IGRT)
- Special procedures and consultations associated with treatment planning (CPT® codes 73370 and 77470)

The Oncology Program applies to all Medicaid program, Medicare and Fully-Insured Members. Self- Insured commercial groups may elect to join the program at the time of their benefit renewal. Medical Oncology Providers should attempt to obtain an authorization for services on all Optima Health Commercial Members. If a self-insured Member has not yet been enrolled in the program, a message indicating the Member's enrollment status will be transmitted at the time of authorization entry.

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 Clinical 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 Clinical Care Services.

Forms for inpatient admissions should be completed on-line via Provider Connection or 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
- Biopsies

- 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
- Commercial plan 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
- Incontinence supplies
- Upper GI
- Optima Health as a secondary payer (except organ transplant).

Genetic Testing and Counseling

Physicians must obtain a prior-authorization from the Plan **prior** to the Member receiving services for all Genetic Testing except BRCA and NIPT. Testing must be performed at participating specialty laboratories.

Behavioral Health Prior-authorization Requirement

Routine Outpatient Services

Prior-authorization is not required 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. All Optima Health Participating Providers, except Licensed Clinical Psychologists, are required to complete a supplemental application in addition to the CAQH application at the time of credentialing and be approved for testing privileges by the Optima Behavioral Health Credentialing Committee prior to testing. Psychological and Neuropsychological Testing Privileges applications are available on the Provider Web Portal.

Prior-authorization Required

Except in the case of emergency treatment, 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 MCG
- HAYES Medical Technology Directory
- Uptodate
- 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 coverage 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 14 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 14 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 managers 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.

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).

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

When a denial of authorization for payment/adverse decision is issued by the Plan, both the Provider and their patient will receive written notification that includes an explanation of the medical necessity or benefits decision and information on the appeal/reconsideration process. In the event that a Provider would like to have the request reconsidered, Medical Directors are available to discuss the criteria the decision was based on. To request a reconsideration of a denial/adverse decision for payment utilize the Reconsideration of a Denied Pre-Authorization Form. This form with the fax number for submission is available on the Provider website in the Medical Authorizations & Policies section. Government program requirements frequently require program-specific forms and processes for Medicare and Medicaid program. Please see the specific program Provider Manual or Provider Manual Supplement for this information.

A treating Provider may request reconsideration of an adverse decision or may appeal an adverse decision. Any reconsideration of an adverse decision may only be requested by the treating Provider on behalf of the covered person. A decision on reconsideration will 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 Member shall be:

- 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
- 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 Member 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 will be vacated and considered an appeal. In such cases, the Member will 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 will be converted to the appeal process, and no additional actions will be required of the treating Provider to perfect the appeal.

Any reconsideration will be rendered and the decision provided to the treating Provider and the Member 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. 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.

OBSTETRICAL CARE/PARTNERS IN PREGNANCY

Once a Member's pregnancy is confirmed, the obstetrician (OB) must notify Partners in Pregnancy by completing the OB Certification/Psychosocial Screen, and submitting it to Optima Health or the Provider may complete the screening and certification process on the Provider Web Portal.

The certification assures the obstetrician may provide care for the Member throughout the entire pregnancy, delivery and for 6 weeks post-partum care.

Partners in Pregnancy Program

The Partners in Pregnancy Program is available to Members enrolled in all Optima Health Products. Partners in Pregnancy Program referrals come from Provider offices and Member self-referrals as well as administrative data, to ensure as many Members can be reached as possible.

Once a referral has been received, the team reaches out to the Member by phone to explain the program. When a Member elects to participate in the Program, a comprehensive assessment, including an obstetrical assessment, is completed in order to tailor the program to suit the Member's individual needs. Risk stratification is conducted using the assessments to allow Members to be assigned to the appropriate Partners in Pregnancy team member. Members who stratify as high risk are assigned to a Registered Nurse and Members who stratify as low risk are assigned to Care Coordinators. Moderate risk Members may have a combination of team member types. The team contacts Members at regular intervals during their pregnancy to provide prenatal education, mental health screenings and to answer questions regarding benefits and other available services. The team also includes a Licensed Clinical Social Worker who can assist with community resources such as housing, food, etc.

The Partners in Pregnancy team can communicate a Member or Case Manager concern to a designated person within the Provider office to expedite coordination of care. After 60 days postpartum, Members who require additional assistance will be referred to other appropriate Optima Health Case Management teams for further assistance. The number for Partners in Pregnancy is listed on the Contact page in the front of this Manual.

Patient Access Guidelines

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

- Within 7 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
- Providing breast feeding education and information for the mother
- 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.

Dependent OB Coverage

Not all dependents will have OB coverage. Please call Provider Relations to confirm OB coverage for dependents.

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 Optima Health Medicaid Program Manual for Medicaid program 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. Please call the Clinical Care Services Medical or Government Programs phone number for a list of Providers contracted to provide this service. Medicaid pregnancy termination policies are listed in the Optima Health Medicaid Program Provider Manual.

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 Advice Line Program for instructions on the type of care to receive.

Optima Health covers any Emergency services rendered at a hospital necessary to screen and stabilize Members.

All Members seeking care at Emergency facilities will be subject to the Member cost share.

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.

Information

Information about the After Hours program and how to use it is available from Provider Relations for offices to distribute to patients.

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.

MDLIVE

When the Member's physician office is closed and the After Hours Nurse recommends seeking care other than the physician's office when it re-opens, Optima Health Fully-insured Members, some Self-Funded Groups, Medicare Advantage and Medicaid program Members have access to Board-Certified physicians through ***MDLIVE 24 hours a day, seven days a week by calling 1-866-648-3638 or online at www.mdlive.com/optima***. Members with this benefit can access MDLIVE through online video, by phone or with secure e-mail for a specific listing of complaints. Optima Health Member ID numbers are required for Members to register for MDLIVE.

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 and in product specific Provider Manuals or Provider Manual Supplements for the Optima Health Medicaid program and Medicare Advantage.

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 Clinical Care Services (CCS).

Hearing aids are covered under some Plans through a Rider. 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. Optima Health has contracted with a vendor to administer the chiropractic benefits as applicable to all plans. A chiropractic Provider search feature and additional Provider information for the HMO/POS and PPO Chiropractic Networks are available on the Provider Web Portal. For authorization, billing and reimbursement information refer to the chiropractic vendor guidelines.

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 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.

Dental Coverage varies by plan type and/or employer group. FFM (Federally Facilitated Health Insurance Marketplace) plans include Dental Coverage according to the Affordable Care Act.

Dental Care Discount:

Optima Health Members may receive up to 20 percent off of Usual and Customary charges for dental services and appliances when receiving services from a Participating discount dental care Provider. A detailed description of the benefits and exclusions of this program and a listing of discount dental care Providers are available on the Member website.

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. Other disposable medical supplies are **NOT** covered.
- 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. 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. Medical Care Services (MCS) 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

The following applies to Commercial and Medicaid program plans:

- 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.
- Optima Health follows CMS units of measure for all rentals.

Equipment Rental Payment when a Member becomes disenrolled:

If the Plan determines that a Member became disenrolled during the 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 by Optima Health.
- 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 by Optima Health.
- 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

- Commercial Plan 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 Medical Care Services (MCS) to request an authorization.
- Requested changes in authorizations must be faxed to Medical Care Services within 30 days of the original authorization.

DME Service/Maintenance on Purchased Items

Service/Maintenance of purchased items requires prior authorization.

Commercial Lines of Business:

- Providers must bill with the appropriate HCPCS code for the purchased item and append the “MS” modifier.
- Optima Health allows for reimbursement of maintenance/service once every 6 months for parts and labor items that are no longer under warranty.

Optima Health Medicaid program follows DMAS requirements for billing of E1399 with an English description.

DME Miscellaneous Codes

- Digital hearing aids, custom and power wheelchairs and wheelchair accessories with no established allowance, will be reimbursed based on invoice. An invoice must be submitted with the claim in order for the equipment to be reimbursed.

Employee Assistance Program (EAP) Services

All Behavioral Health Providers that participate for Optima Health Commercial Products (Fully-Insured, Self-Insured Commercial HMO, POS and PPO) are contractually obligated to provide services for the Employee Assistance Program (EAP), per Exhibit A-1 of the Optima Health Behavioral Health Provider Agreement, unless there is a qualified written exception.

A Provider's assessment and referral of EAP services include:

- Diagnostic assessment,
- Intervention and/or short term counseling, and
- Referral to appropriate local resources

Providers will receive EAP referrals from employees of Optima Health. Appointments should be offered within 48 hours of the referral with a face-to-face assessment at that time, unless a later date is requested. Optima EAP will send a detailed provider packet via secure email or fax that includes all forms required for case documentation and reimbursement.

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 (revenue code 651) 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-authorized by Clinical Care Services (CCS).

Medical Transportation Services/Ambulance

Ambulance/stretchers 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 Clinical Care Services (CCS) on a case-by-case basis.

- Emergency ambulance/stretchers service is covered from the place where the Member was injured to the nearest hospital where treatment can be furnished when Medically Necessary.
- Ambulance/stretchers 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.**
- Please reference the Optima Health Medicaid Program Provider Manual for Medicaid program specific transportation policies and procedures.

Nutritional Counseling/Dietician

Coverage is limited to Medically Necessary conditions that must be managed by nutritional assessment or behavior modification. These include, but are not limited to:

- Pregnancy
- Diabetes Mellitus
- Morbid obesity
- Heart disease
- Hyperlipidemia
- Obstructive Sleep Apnea

All plans will cover diet evaluation and instruction by a contracted dietician or Physician. The patient is responsible for office visit Copayments each session.

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 Clinical Care Services (CCS) 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 Clinical Care Services. All pulse oximetry tests require prior-authorization.

All requests for liquid oxygen will require the ordering Physician to submit the Medical Necessity Ordering Form/Oxygen and must be approved by the Plan's Medical Director.

Initial authorizations will be setup for either three months or one year depending on the episode of illness. Oxygen systems do not fall under the rental to purchase procedure.

Physical and Occupational Therapy

Outpatient physical and occupational therapy are Covered Services when Medically Necessary and authorized by Clinical Care Services (CCS). Outpatient physical and occupational therapy may be performed by Participating therapy Providers meeting the Plan's therapy participation criteria. All therapy Providers must complete the Physical Therapy Provider Participation Criteria and Licensure/Malpractice Verification Requirements attesting that they meet Optima Health therapy criteria and agree to comply with all participation requirements and pass the Optima Health Self-assessed Physical Therapy Provider Office Site Evaluation. For purposes of this section, the term "therapy Provider" includes freestanding and hospital-based therapy centers.

Physical and Occupational Therapy policies and procedures may vary for the Optima Health Medicaid program. Please refer to Optima Health Medicaid Program Provider Manual for any Medicaid program specific policies and procedures.

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.

Ordering and Authorization Process:

- 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.**
- The Participating therapy Provider or facility can perform the evaluation without an authorization. Following the evaluation the therapy Provider or facility must contact Clinical Care Services to obtain authorization.

- Upon completion of the evaluation, the therapy Provider should proceed as follows:
 1. The therapy Provider must complete and fax an Authorization Request Outpatient, Physical-Occupational and Speech Therapies form to CCS for Members of Commercial plans.
 2. CCS will process and return the Authorization Request Outpatient, Physical-Occupational and Speech Therapies form to the therapy Provider indicating the authorization number, the number of visits authorized, the modalities and the time frame. If a treatment was provided in addition to the evaluation during the initial visit, that treatment must be indicated on the Authorization Request Outpatient, Physical-Occupational and Speech Therapies form. CCS will then determine if the treatment performed during the initial visit will be covered.
 3. The therapy Provider will use the Authorization Request Outpatient, Physical-Occupational and Speech Therapies form approved by CCS as the basis for continued therapy services, for the number of visits and time frame indicated.
 4. If the treatment plan changes or additional modalities or visits are needed for a Member, the therapy Provider must fax an updated Authorization Request Outpatient, Physical-Occupational and Speech Therapies form to CCS for appropriate authorization for Commercial Members.
- Please refer to the Optima Health Medicaid Program for Medicaid specific policies and procedures.

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.
- Therapy codes apply one Copayment per visit (date of service) for each modality of therapy provided.

Prosthetic and Orthotics

Prosthetic and orthotics are covered when determined to be Medically Necessary and appropriately pre-authorized by Clinical Care Services (CCS). Customized and non-customized single orthotics with requested charges equal to or greater than \$750.00 must be authorized for Commercial Plan Members. Authorization limit amounts may differ for some self-funded groups. Providers should call Provider Services to determine authorization requirements for self-funded groups. For Medicaid and Medicare guidance, please reference the appropriate Provider Manual or Provider Manual Supplement.

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 (age 21 for Medicaid program Members) 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.
- Breast prosthetics.
- Two prosthetic bras are covered for Members with a cancer diagnosis.

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.

Please see the Optima Health Medicaid Program Provider Manual for coverage variations.

Skilled Nursing Facilities (SNF's)

Placement in a Skilled Nursing Facility requires prior authorization. Clinical Care Services will make the necessary arrangements with the facility. Case managers are available to make the necessary arrangements to transition the patient home. Please see the Optima Health Medicaid Program Provider Manual for Medicaid program specific information.

Sleep Studies

Home sleep studies are the preferred method of testing. Facility-based studies require proof of a failed home sleep study or a medical reason why home sleep study testing is contraindicated.

Speech Therapy

- Speech therapy services require prior-authorization by Medical Care Services (MCS) for Commercial plans.
- 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

Preventive Vision Coverage

For most benefit plans, Members receive preventive vision benefits through our Vision Vendor. Preventive vision services are not reimbursed under the medical plan and should be obtained by Members through their Vision Vendor (or if applicable, other employer specific) vision benefits.

Vision Benefit

Each covered individual may receive an eye exam (at a plan specific Copayment) every 12 or 24 months, depending on the Member's vision benefit.

This includes:

- Case History: pertinent health information related to eyes and vision acuity test, unaided and with previous prescription.
- Screening Test: (for disease or abnormalities), including glaucoma and cataracts.

Diabetic Dilated Eye Exam Exception: For Members with diabetes, regardless of benefit plan, dilated retinal eye exams are covered every 12 months without a referral. These screening exams may be obtained through the Vision Vendor or participating Ophthalmologists or Optometrists.

Accessing Benefits

Members should first call the Member Services number on their Member ID card for details. Members should call their Vision Vendor for an appointment and provide their Member ID number for identification. Members may select a Provider by going to the Member website.

Providers should verify eligibility and coverage by contacting the Vision Vendor. Please use the Member's ID number to obtain eligibility and coverage information.

Exclusions

The following **are not covered**

- Orthoptic or vision training, subnormal vision aids and any associated supplemental testing
- Medical and/or surgical treatment of the eye, eyes or supporting structures.
- Corrective eyewear required by an employer as a condition of employment and safety.
- eyewear unless specifically covered under plan.
- Services provided as a result of any Worker's Compensation law.
- Discount is not available on frames where the manufacturer prohibits a discount.

Vision Materials Supplement

Groups electing the Vision Materials Supplement coverage have a benefit for expanded optical care service. The Member may be responsible for a plan specific Copayment for the materials in addition to the exam Copayment.

Discount Schedule

Members may be able to obtain discounts on exams and vision materials by selecting vision under the portal for more information.

PHARMACY SERVICES

Optima Health Plan manages the pharmacy program by evaluating the safety, efficacy, and cost-effectiveness of drugs. A pharmacy and therapeutics (P&T) committee, consisting of pharmacists and physicians representing different specialties, review the clinical appropriateness of drugs for inclusion in the formulary. The P&T committee also reviews and approves the clinical criteria for drugs with utilization management programs such as a prior authorization (PA), step therapy (ST), and quantity limits (QL). A team of pharmacists at Optima Health Plan are responsible for drug coverage and formulary management decisions with the guidance provided by the P&T committee.

Our formularies are developed with the inclusion of key agents within selected therapeutic classes. These agents offer comparable safety and efficacy yet are more cost-effective than similar agents. Optima Health formularies are available on our website and through the Provider Web Portal. Notification of changes to the formulary appears in providerNEWS (Optima Health Plan's provider newsletter) with a link to the formulary changes on the Provider Web Portal.

Members may enroll into plans that do not include a pharmacy benefit. The Member's ID card will identify pharmacy benefits under the "Rx" section which will include their cost-share for covered drugs.

Optima Health Formularies

Optima Health Plan offers four (4) prescription formulary program for our commercial members:

- Optima Health Open (4-tier);
- Optima Health Plans Standard Formulary (4-tier);
- OptimaFit (4-tier);
- Optima Health Small Group Plans (4-tier);

Optima Health Plans Open and Optima Health Plans Standard formularies cover many medications unless they are benefit exclusions. This allows for accessibility of multiple medications within a class and permits members and providers to determine the medication that is best for the individual member.

OptimaFit and Optima Health Small Group Plans formularies cover select medications within each therapeutic drug category that has been reviewed by the P&T Committee and meet the state regulatory agency's (such as Virginia Bureau of Insurance) benchmark. Members may request an exception for a drug that may not be included on the formulary.

Our Formularies require generic drug prescription usage whenever possible. These drugs are listed with the generic name on the Formularies. If a Member requests a brand name drug when a generic drug is available, the Member may be responsible for additional charges.

Tier Formulary Copayment Structure (Commercial Plans)

All Covered drugs, including specialty drugs are placed in one of four tiers for our commercial formularies. Copayments are dependent on both the member's pharmacy benefit structure and the tier in which the prescription drug falls. It is important for the Member and Provider to work together to determine which drug is appropriate.

- **Preferred Generic (Tier 1):** Medications on this tier have the lowest Member cost-sharing amount and include commonly prescribed generic drugs. Brand drugs may be included in Tier 1 if the Plan recognizes they show documented long-term decreases in illness.
- **Preferred Brand & Non-Preferred Generic (Tier 2):** Includes brand-name drugs, and some generic drugs with higher costs than Tier 1 generics, which 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.
- **All Other (Tier 4):** Includes those drugs classified by the Plan as Specialty Drugs. Tier 4 also includes covered compound prescription medications. For more information, reference the Specialty Drug section below.

Utilization Management Program

Optima Health Plan's clinical staff, along with the P&T Committee, may require utilization management edits prior to coverage or reimbursement for the drug. The Plan utilizes prior-authorization, step therapy, and/or quantity limits. The formulary will indicate if a covered drug has any restrictions or providers can refer to the prior-authorization, step edit, and quantity limit drug lists on the provider web portal.

- **Step Therapy** is a process to ensure that Optima Health Plan preferred medications are used as the first course of treatment. If the preferred medication is not clinically effective or if the member has side effects, another medication may be used as the second course of treatment. Optima Health Plan utilizes claim history for approval of second course treatments at the point-of-sale. Step therapy protocols are based on current medical findings, FDA-approved drug labeling and drug costs.
- **Quantity Limit** restricts the quantity of a drug that is covered within a given time period. This helps ensure the safety of our members by preventing high and/or inappropriate doses of medication at the point-of-sale. The quantity limits placed on medications are based on recognized standards of care, such as FDA recommendations for use, and may be periodically updated.
- **Prior Authorization** requires prescribing physicians to send clinical documentation as part of the medical necessity request. Prior authorizations are placed for selected medications that have specific indication for use, are high in cost, or have increased safety concerns.

An exception request 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 prescriber signature. For copies of the forms, go to the Provider section of the Provider Web Portal or call Pharmacy Authorizations at Clinical Care Services.

An exception request can be made by the Provider, on behalf of the Member, by either:

- Calling the Pharmacy Provider Services
- Faxing an exception request form along with clinical evidence to Pharmacy Provider Services

Formulary prior-authorization responses are generally received within 2 working days of Optima Health receiving the completed form and information from the Provider.

Mail Order Prescription Drug Program

Commercial product and FAMIS Members (excluding Medicaid Plan and Individual Plan Members) have the option of filling certain medications from a mail order pharmacy. Our members may purchase a 90-day supply of drugs from Express Scripts mail services.

- Members can register Express Scripts by signing in to the member portal: optimahealth.com/member
- Physicians can submit the prescription electronically directly to Express Scripts or contact them via phone.

For contact information on the mail order program, please reference the Optima Health Key Contact section at the beginning of this document.

Diabetic Supplies

Diabetic testing supplies may be covered under the Member's pharmacy or medical benefits. Most plans cover diabetic testing supplies under the Members pharmacy benefit which allows Members to buy their diabetic supplies from a local, in-network retail pharmacy. For Members who must obtain their diabetic testing supplies under their medical benefit, requests must be sent to Edgepark or Home Care Delivered medical supplies. The diabetic supply order form may be found on the Provider section of the Provider Web Portal or you may call Edgepark at 877-852-3512 or Home Care Delivered at 800-565-5644.

Members should contact their Member Services department for more information about their diabetic testing supply coverage.

Injectable and Infusion Medications Administered in the Physician's Office

Optima Health has an agreement with Proprium Pharmacy to fill and deliver injectable and infusion medication orders for administration in the Physician office. Proprium Pharmacy 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% coinsurance may apply to certain drugs requiring prior authorization. The prior authorization requirements also apply when using Proprium Pharmacy. 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.

Proprium Pharmacy 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. **Proprium Pharmacy will bill the Member for the Coinsurance or Copayment amount.** Proprium Pharmacy may be reached by calling 1-855-553-3568. 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.

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 mail, e-mail, newsletters, and postings on the Provider Web Portal.

Specialty Drugs

Specialty Drugs have unique uses and are generally prescribed for people with complex or ongoing medical conditions. Specialty Drugs generally require unique 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;
- Medications that can be self-injected; and
- Medications that can be delivered via injection, infusion, inhalation, or oral administration.

Specialty Drugs are only available through the specialty mail order pharmacy, Proprium Pharmacy. Please reference the Optima Health Key Contacts page for Proprium Pharmacy contact information.

Pharmacy Coverage Exclusions

The following is a list of products or categories that are not covered for reimbursement under the Member pharmacy benefit contract. **Benefits for self-funded plans may vary and coverage should be verified for self-funded plans.** 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:

1. Medications that do not meet the Plan's criteria for Medical Necessity are excluded from Coverage.
2. Copayment and Coinsurance are out of pocket amounts the Member pays directly to the pharmacy Provider for a Covered prescription drug. A Copayment is a flat dollar amount. A Coinsurance is a percent of Optima's Allowable Charge.
3. Member 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.
4. The Plan will not cover any additional benefits after benefit limits have been reached. Member will be responsible for payment for all outpatient prescription drugs after a benefit limit has been reached.
5. All covered outpatient prescription drugs must have been approved by the Food and Drug Administration and require a prescription either by state or federal law. Medications with no approved FDA indications are excluded from Coverage.
6. Over-the-counter (OTC) medications that do not require a Physician's authorization by state or federal law and any prescription that is available as an OTC medication are excluded from Coverage.
7. Some drugs require prior authorization from the Plan in order to be covered. The Physician is responsible for obtaining prior authorization. Benefits for Covered Services may be reduced or denied for not complying with the Plan's prior-authorization requirements.
8. All compounded prescriptions require prior-authorization and must contain at least one prescription ingredient. Compound prescription medications with ingredients not requiring a Physician's authorization by state or federal law are excluded from Coverage.
9. Non-durable disposable medical supplies and items such as bandages, cotton swabs, hypodermic needles, and durable medical equipment not listed as covered are excluded from Coverage.
10. Prescription or over the counter appetite suppressants and any other prescription or over the counter medication for weight loss are excluded from Coverage.
11. Immunization agents, biological sera, blood, or blood products are excluded from Coverage.
12. Injectables (other than those self-administered and insulin) are excluded from Coverage.
13. Medication taken or administered to the Member in the Physician's office is excluded from Coverage.
14. Medication taken or administered in whole or in part, while a Member is a patient in a licensed Hospital is excluded from Coverage.

15. Medications for cosmetic purposes only, including but not Limited to Retin-A for aging, are excluded from Coverage.
16. Medications for experimental indications and/or dosage regimens determined by the Plan to be experimental are excluded from Coverage.
17. Replacement prescriptions resulting from loss, theft, or breakage are excluded from Coverage.
18. Therapeutic devices or appliances, including but not limited to support stockings and other medical/non-medical items or substances, regardless of their intended use are excluded from Coverage.
19. Drug charges exceeding the cost for the same drug in a conventional packaging (i.e., convenience packages, unit doses, blister packs, etc.) are excluded from Coverage.
20. Infertility drugs are excluded from Coverage.
21. Medications for smoking cessation, including but not limited to Nicorette gum, nicotine patches, nicotine spray are excluded from Coverage.

Additional Pharmacy Policies

1. Members may have Transition of Care benefits for certain medications when they are newly enrolled. Transition of Care information is available to Members by calling Member Services.
2. 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.
3. 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.
4. 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.
5. At its sole discretions 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 whether to add or remove a drug from the Preferred Drug List. 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.

6. 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.
7. 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.
8. 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
9. 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.
10. Intrauterine devices (IUDs), and cervical caps and their insertion are covered under the Plan's medical benefits.
11. Written outpatient drug prescriptions must be executed on tamper-resistant prescription pads.

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 Lab

Optima Health reimburses Physicians for certain specific lab tests performed in the Physician's office. *Access the most current list of services that will be reimbursed by Optima Health when testing is performed in the Physician's office:*

<https://www.optimahealth.com/documents/forms/general/plan-management-in-office-lab-list.pdf>

In addition to the In Office Lab list, a limited number of specialty specific lab tests may be performed in certain specialty offices. Your Network Educator will provide you with details for your specialty. These specialties include:

Dermatology	Endocrinology	Hematology/Oncology
Infectious Disease	Nephrology	OB/GYN
Ophthalmology	Reproductive Medicine	Rheumatology
Urology		

The In Office Lab list applicable to medical providers only and does not apply to behavioral health providers.

All other testing must be performed by a Participating reference lab. Optima Health will reimburse Physicians for the draw fee. Charges from Physicians for lab tests other than the ones listed above will be denied as a non-allowed lab charge and the Member may not be held responsible.

Optima Health does not provide additional reimbursement to Participating reference labs for the draw/collection.

Certain highly specialized lab tests may be available only from a few labs. Some exceptions apply for Providers located in specific geographic areas. Please contact your Network Educator for guidance in these cases.

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 code 99000 as a handling or draw fee
- Optima Health will not reimburse CPT codes billed individually when they are considered part of a bundled CPT code

Reference Lab Providers

Any lab test not included on the “In-Office Lab” list must be sent to a Participating reference lab. Participating Reference Laboratory Providers are listed on the Provider Web Portal under the Provider search option.

Laboratory Draw Sites

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

Pre-Operative Lab and X-Ray

Members scheduled for surgery at a Participating Hospital may obtain services through 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, and must be ordered from a participating genetic testing laboratory.

Toxicology Lab Services and Medication Compliance Testing

Aegis Sciences Corporation provides in-network toxicology lab services for all Optima Health service areas. In depth medication compliance services, including pain management and substance abuse testing are available for Optima Health medical and behavioral health Providers for all Optima Health products.

REIMBURSEMENT POLICIES

Optima Health follows 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. Information and current policies for developing fee tables and gap filling fees for existing codes or assigning fees to new codes may be obtained by contacting your Contract Manager.

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 Providers 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 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 Medicaid program) claims for payment or member treatments for which payment would otherwise be made by using the DMAS form on the Optima Health Website

<https://www.optimahealth.com/documents/forms/general/provider-critical-incident-report-form.pdf> DMAS requires verbal reporting of incidents within 24 hours.

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:

<https://www.optimahealth.com/documents/provider-manuals/coordination-benefit-policies.pdf>

Dual Eligible Members with Both Medicare and Medicaid

If you provide services to a Member who is eligible for both Medicare and Medicaid, then you may not bill or hold liable the dual eligible Member for Medicare Parts A and B cost sharing if Medicaid is liable for such cost-sharing. You may either accept the Medicare Plan payment as payment in full or you may bill the appropriate State agency.

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

As part of the Optima Health audit process, Optima Health and/or its subcontractors may use statistical sampling and extrapolation of claims in determining the amount of an overpayment made to a Provider. The extrapolation methodology utilized by Optima Health is consistent with the methodology authorized in the Medicare Integrity Manual.

In most cases, when a Provider is paid in error, Optima Health automatically executes a retraction with 30 days advance notice to the Provider stating the reason for the retraction. 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 Availity 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”.

NPI

All claims submitted to Optima Health must include individual and Group Practice NPI numbers and taxonomy codes. Claims received without an NPI number and taxonomy code will be rejected or denied.

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 ID and Group number** should be placed in **boxes 1a and 11**. Paper claims will be accepted when billed under the Optima Health Member ID or the Social Security number.
- 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 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 correctly.
- 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 Timely Filing Policy.

Authorization Search

The Authorization Search Program matches newly received authorizations to pending claims. This program finds authorizations entered after claims are pending. 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 received 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 if 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.

Health Insurance Marketplace Three Month Grace Period Mandate

Plans sold on the Marketplace have a mandated three month grace period for individuals who receive an Advance Premium Tax Credit (APTC) when they have paid at least their first month's premium, but are delinquent in subsequent premium payments(s).

In accordance with the mandate, Optima Health will process claims for service rendered during the first month of the grace period. Claim payment for services received during the second and third month of the grace period will be suspended until the premium is paid in full or the grace period ends and the Member's enrollment is terminated for non-payment.

If the Member fails to pay the full premium balance before the end of the grace period, the Member will be disenrolled. At that time, all claims for services during the second and third months will be denied and the Member will be responsible for the payment of these services in full. Optima Health will not retract claim payments from services rendered during the first month of the grace period.

Providers will receive notification when claims are suspended for non-payment of premium during the second and third months of the grace period and will be informed of a grace period status when contacting Provider Services for eligibility verification. Eligibility status is also available 24 hours a day through Provider Connection on optimahealth.com/providers. Provider Connection will indicate that the Member is in the Grace Period with the dates that claims will be pended.

Claims Denied in Error

The Physician's office must follow-up with Optima Health within **365 days** of the date of service 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.

Dispute Resolution

Any dispute between the Parties arising out of or relating in any manner to the Provider Agreement, whether sounding in tort, contract, or under statute (a "Dispute") shall first be addressed by exhausting all Policies and Procedures applicable to the Dispute, including but not limited to claims payments, credentialing, utilization management, adverse benefit determinations, or other programs, including applicable appeals procedures, before either Party may seek to resolve the Dispute in any other forum or manner. If the dispute is not resolved by the Parties via the Policies and Procedures or is of a type not subject to the Policies and Procedures, the Parties shall engage in good faith negotiations between their designated representatives (such representatives shall be authorized to resolve the dispute). The negotiations may be initiated by either Party upon written request to the other (the "Meeting Request Notice"), provided such Meeting Request Notice is delivered in accordance with the notice requirements of the Provider Agreement within 60 days of the date on which the requesting party first had, or reasonably should have had, knowledge of the event(s) giving rise to the Dispute. The negotiations shall occur within 30 calendar days following the day the receiving Party receives the Meeting Request Notice, and neither Party may seek to resolve the Dispute in any other forum or manner unless the Dispute is not resolved within 60 days after the Meeting Request Notice.

The deadline for initiating any recovery efforts (including applicable regulatory timeframes and or statute of limitations) shall be tolled by the applicable dispute resolution procedures and appeal process(es) set forth in the Policies and Procedures and herein.

Any and all dispute resolution procedures shall be conducted only between the Parties and shall not include any member unless involvement of a member is necessary to the resolution of the dispute, which determination shall be made in the sole discretion of SHP or Payor.

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. Commercial and Medicaid Program providers must complete the Electronic Payment/Remittance Authorization Agreement to enroll. The form can be accessed at www.optimahealth.com/documents/education/eft-era-fillable-authorization-agreement.pdf.

For Medicare claims, EFT and ERA will be issued through PaySpan. This change will require a PaySpan account. For providers that already access PaySpan, updates will be required.

New PaySpan users — How to register:

Contact providersupport@payspan.com or 1-877-331-7154, option 1, for help obtaining registration codes and assistance with navigating the website. Provider Services Specialists are available to assist Monday through Friday from 8 a.m. to 8 p.m.

If provider data is not loaded in Optima Health's new claims platform or if feedback is received from PaySpan that there is no provider entry in the PaySpan system, a claim must be submitted to Optima Health to receive a paper check. This check will include registration information for PaySpan.

For current PaySpan users:

If providers already have an account, there will be a single registration code that is tied to the pay to entry. If there are multiple pay to entries in Optima Health's claims platform, providers will have multiple registration codes. To obtain a code, providers can contact PaySpan and provide their TIN/NPI.

If there are any questions, please contact a PaySpan Provider Service Representative at 1-877-331-7154.

Filing Claims Electronically

Providers that submit claims to Optima Health electronic claims program 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 Availity, or any clearinghouse that can connect through AllScripts/PayerPath, or Availity. Electronic claims may also be submitted directly to Optima Health by a Provider or Vendor via data files in HIPAA compliant format.
- The Optima Health Payor ID Number is 54154 for Medical Providers and 5415M for Behavioral Health Providers. The ID for Institutional Providers is 00453.
- 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 electronically will be accepted when billed under the Member’s Optima Health Member ID, the Member’s Social Security number or for the Optima Health Medicaid program, the Member’s Medicaid number. Providers should first review their Clearinghouse requirements for submission of Member Identification to confirm that their clearinghouse will accept claims using their chosen option for submission.
- 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:
 - The first 10 digits should be the NPI of the Provider submitted on the claim.
 - The 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.
 - Following the Member ID number is the earliest date of service included on the claim, in the format MMDDYYYY.
 - 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.
 - 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

The Optima Health Professional Companion Guide is available at:

<https://www.optimahealth.com/documents/communications/plan-management-hipaa-transaction-standard-companion-guide-x12-837p-5010.pdf>

The Optima Health Institutional Companion Guide is available at:

<https://www.optimahealth.com/documents/communications/plan-management-hipaa-transaction-standard-companion-guide-x12-837i-5010.pdf>

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 codes 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 and authorization requirements by calling Provider Relations and choose option 2.

Anesthesia

The most current ASA codes should be used when billing anesthesia codes. The claims processing system will automatically add the appropriate base units based on Medicare guidelines. If appropriate, use modifying units such as physical status and qualifying circumstances. Bill for time and modifying unit only, include start and stop times, and 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 pre-requisite 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.

Payments to Participating anesthesia Providers for in-office monitored anesthesia care are based on an all-inclusive case rate. Participating Providers are responsible for any associated payments for services provided in conjunction with diagnostic and surgical services provided in the office setting by non-participating Providers based on a participating Provider referral or subcontract arrangement.

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.

Psychiatric Nurse Practitioners must be licensed independently and credentialed by Optima Health. They may not utilize incident-to billing.

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 with Optima Health 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. (Revised 2016). Incident to:** <https://www.cms.gov/Medicare/Medicare-Contracting/ContractorLearningResources/Downloads/JA0441.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 is seen in the office fewer than six (6) times, the OB will be paid fee-for-service (FFS). If the Member is 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 is 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 sees the Member for antepartum care only with seven (7) or more visits, the Provider should bill with the antepartum code 59426. A GB modifier is required with the E&M antepartum (59425) and global antepartum (59426) visits. The Provider also needs to list the dates the Member is seen.

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.

Special Fee for Service Obstetrical Billing Arrangements:

Modifier GB- This modifier should be used by OB/GYNs, Health Departments, or Primary Care Physicians for obstetrical services when the global reimbursement does not apply or when there are complications of pregnancy.

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 of service.

CLAIMS POLICIES - MODIFIERS

AS Modifier – Surgical Assistants

Optima Health 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.
- Physician's Assistant or Nurse Practitioner must be credentialed with Optima Health and bill with a separate and distinct Provider number from the primary surgeon.
- 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 10 percent of the Optima Health 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

When a Preventive Examination and a Problem-Oriented Evaluation and Management service are reported on the same day for the same patient, the Problem-Oriented Evaluation and Management service, appended with modifier 25, is reimbursed at 50% of the allowed amount.

Preventive Medicine codes:

- 99381-99397 (Preventive Medical Exam)
- G0402 (Preventive Physical Exam)
- G0438-G0439 (Annual Wellness Exam)

Problem-Oriented codes:

- 99201-99215

Per CPT guidelines, modifier 25 (a significant, separately identifiable Evaluation and Management service by the same physician or other qualified health care professional on the same day of the procedure or other service) is required to be billed in conjunction with the Problem-Oriented visit Evaluation and Management code when a Preventive medicine service is reported on the same day for the same patient.

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:

- The procedure with the highest work Relative Value Unit (RVU) will be paid at 100 percent of the maximum payment amount.
- The procedure with the second highest work RVU will be paid at 50 percent of the maximum payment amount.
- The procedure with the third highest work RVU will be paid at 25 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.
- 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; 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 16 percent of the Optima Health 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 10 percent of the Optima Health fee maximum.

COMMERCIAL PRODUCT 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 for Commercial Products. The reconsideration filing deadline is **365 days** from the **date of service**.

The Reconsideration informal level of review is not applicable to the Optima Health Medicaid program or Medicare Advantage products. DMAS defines “Reconsideration” as a formal, first level of appeal, as described in the Appeals sections of the Optima Health Medicaid Program Provider Manual

Medicare Advantage plan regulations require a separate Medicare Appeals process as indicated in the Medicare HMO and OCC Provider Manual Supplements.

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 for Commercial Products

Optima Health attempts to resolve issues presented by Providers informally whenever possible. An internal Provider Appeals process is available to reconcile issues if an issue cannot be resolved informally. 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. Policies and Procedures for Medicaid and Medicare program Provider and Member Appeals may be found in the specific program Provider Manual Supplements.

Appealed Commercial claims must meet the following criteria:

1. An adverse payment decision is 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 Commercial Product Provider Appeals, Expedited Appeals and Member Appeals: <https://www.optimahealth.com/documents/provider-manuals/policies-provider-member-expedited-appeals-va.pdf>

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.

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 Program Integrity Unit (PIU), 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, and 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 PIU (Program Integrity Unit). The PIU 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 PIU 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 PIU 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 PIU 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 Program Integrity Lead and includes representatives from legal, clinical, pharmacy, compliance, government relations, claims, underwriting, and network management.

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, cases, and supporting documentation are 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 is 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 Health, 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

Program Integrity Audit, Reconsiderations and Appeals Policy and Procedures

As a Managed Care Organization, Optima Health is required by state and federal entities to audit claims, identify overpayments and educate all types of providers on program integrity issues.

Optima Health conducts claim audits either on a prepayment or post payment basis. Claim audits are conducted in order to confirm that healthcare services and supplies were delivered in compliance with the member's plan of treatment and/or to confirm that charges were accurately reported in compliance with Optima Health's policies and procedures, as well as general industry standard guidelines and State and Federal regulations.

In addition, Optima Health continually monitors provider-billing practices and conducts investigations for purposes of detecting inappropriate, inaccurate or abusive billing patterns, medical necessity, as well as patient safety and quality of care. Data on provider services for specified periods are compiled and compared with other providers within the same specialty/provider type and geographic peer groups. Providers are selected for audit based on their utilization and billing patterns, relative to their peers.

Providers who are an outlier may be subject to further analysis, including desk or on-site investigations. Investigations will include a review of the provider's medical records that pertain to the billed services, and may employ offset of overpayments or extrapolation methods.

Optima Health has a detailed written policy for the Program Integrity Audit process, including reconsiderations and appeals of audit findings. This policy contains definitions of the terms used, timeframes for record request responses, procedures for desk audits and on-site audits, timeframes for findings letters to be sent, and timeframes for Providers to request reconsideration of findings and request an appeal. The policy also includes the Optima Health Medical Record documentation standards. ***This link will take you to the complete policy:***

www.optimahealth.com/documents/policies/audit-reconsideration-appeal-audit-standards.pdf

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. Physician Queries are not accepted after an audit has been initiated. 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 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 that 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:

- Self
- 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:

<https://www.optimahealth.com/providers/provider-support/education/fraud-waste-and-abuse>

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 is 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** (<https://oig.hhs.gov/exclusions/>) 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.

Disclosure of Ownership and Control Interest Statement

Optima Health requires all Provider Disclosing Entities to complete a Disclosure of Ownership and Control Interest Statement at initial contracting/credentialing and at re-credentialing as a condition of Participation. Disclosure as a participating fee-for-service Provider for DMAS meets this requirement for Optima Health.

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.

Subcontractors must comply with 42 CFR Part 2 that prohibits subcontractors from re-disclosing Substance Abuse Treatment information. Disclosure of Substance Abuse Treatment Information is limited to information necessary for the subcontractor to perform services they are obligated to perform under its agreement.

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 that 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 \$11,463 to \$23,331 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.

VIRGINIA ETHICS AND FAIRNESS IN CARRIER BUSINESS PRACTICES

§ 38.2-3407.15. Ethics and fairness in carrier business practices.

A. As used in this section:

"Carrier," "enrollee" and "provider" shall have the meanings set forth in § [38.2-3407.10](#); however, a "carrier" shall also include any person required to be licensed under this title which offers or operates a managed care health insurance plan subject to Chapter 58 (§ [38.2-5800](#) et seq.) or which provides or arranges for the provision of health care services, health plans, networks or provider panels which are subject to regulation as the business of insurance under this title.

"Claim" means any bill, claim, or proof of loss made by or on behalf of an enrollee or a provider to a carrier (or its intermediary, administrator or representative) with which the provider has a provider contract for payment for health care services under any health plan; however, a "claim" shall not include a request for payment of a capitation or a withhold.

"Clean claim" means a claim (i) that has no material defect or impropriety (including any lack of any reasonably required substantiation documentation) which substantially prevents timely payment from being made on the claim or (ii) with respect to which a carrier has failed timely to notify the person submitting the claim of any such defect or impropriety in accordance with this section.

"Health care services" means items or services furnished to any individual for the purpose of preventing, alleviating, curing, or healing human illness, injury or physical disability.

"Health plan" means any individual or group health care plan, subscription contract, evidence of coverage, certificate, health services plan, medical or hospital services plan, accident and sickness insurance policy or certificate, managed care health insurance plan, or other similar certificate, policy, contract or arrangement, and any endorsement or rider thereto, to cover all or a portion of the cost of persons receiving covered health care services, which is subject to state regulation and which is required to be offered, arranged or issued in the Commonwealth by a carrier licensed under this title. Health plan does not mean (i) coverages issued pursuant to Title XVIII of the Social Security Act, 42 U.S.C. § 1395 et seq. (Medicare), Title XIX of the Social Security Act, 42 U.S.C. § 1396 et seq. (Medicaid) or Title XXI of the Social Security Act, 42 U.S.C. § 1397aa et seq. (CHIP), 5 U.S.C. § 8901 et seq. (federal employees), or 10 U.S.C. § 1071 et seq. (TRICARE); or (ii) accident only, credit or disability insurance, long-term care insurance, TRICARE supplement, Medicare supplement, or workers' compensation coverages.

"Provider contract" means any contract between a provider and a carrier (or a carrier's network, provider panel, intermediary or representative) relating to the provision of health care services.

"Retroactive denial of a previously paid claim" or "retroactive denial of payment" means any attempt by a carrier retroactively to collect payments already made to a provider with respect to a claim by reducing other payments currently owed to the provider, by withholding or setting off

against future payments, or in any other manner reducing or affecting the future claim payments to the provider.

B. Subject to subsection H, every provider contract entered into by a carrier shall contain specific provisions which shall require the carrier to adhere to and comply with the following minimum fair business standards in the processing and payment of claims for health care services:

1. A carrier shall pay any claim within 40 days of receipt of the claim except where the obligation of the carrier to pay a claim is not reasonably clear due to the existence of a reasonable basis supported by specific information available for review by the person submitting the claim that:

a. The claim is determined by the carrier not to be a clean claim due to a good faith determination or dispute regarding (i) the manner in which the claim form was completed or submitted, (ii) the eligibility of a person for coverage, (iii) the responsibility of another carrier for all or part of the claim, (iv) the amount of the claim or the amount currently due under the claim, (v) the benefits covered, or (vi) the manner in which services were accessed or provided; or

b. The claim was submitted fraudulently.

Each carrier shall maintain a written or electronic record of the date of receipt of a claim. The person submitting the claim shall be entitled to inspect such record on request and to rely on that record or on any other admissible evidence as proof of the fact of receipt of the claim, including without limitation electronic or facsimile confirmation of receipt of a claim.

2. A carrier shall, within 30 days after receipt of a claim, request electronically or in writing from the person submitting the claim the information and documentation that the carrier reasonably believes will be required to process and pay the claim or to determine if the claim is a clean claim. Upon receipt of the additional information requested under this subsection necessary to make the original claim a clean claim, a carrier shall make the payment of the claim in compliance with this section. No carrier may refuse to pay a claim for health care services rendered pursuant to a provider contract which are covered benefits if the carrier fails timely to notify or attempt to notify the person submitting the claim of the matters identified above unless such failure was caused in material part by the person submitting the claims; however, nothing herein shall preclude such a carrier from imposing a retroactive denial of payment of such a claim if permitted by the provider contract unless such retroactive denial of payment of the claim would violate subdivision 7. Nothing in this subsection shall require a carrier to pay a claim which is not a clean claim.

3. Any interest owing or accruing on a claim under § [38.2-3407.1](#) or [38.2-4306.1](#), under any provider contract or under any other applicable law, shall, if not sooner paid or required to be paid, be paid, without necessity of demand, at the time the claim is paid or within 60 days thereafter.

4. a. Every carrier shall establish and implement reasonable policies to permit any provider with which there is a provider contract (i) to confirm in advance during normal business hours by free telephone or electronic means if available whether the health care services to be provided are medically necessary and a covered benefit and (ii) to determine the carrier's requirements

applicable to the provider (or to the type of health care services which the provider has contracted to deliver under the provider contract) for (a) pre-certification or authorization of coverage decisions, (b) retroactive reconsideration of a certification or authorization of coverage decision or retroactive denial of a previously paid claim, (c) provider-specific payment and reimbursement methodology, coding levels and methodology, down-coding, and bundling of claims, and (d) other provider-specific, applicable claims processing and payment matters necessary to meet the terms and conditions of the provider contract, including determining whether a claim is a clean claim. If a carrier routinely, as a matter of policy, bundles or down-codes claims submitted by a provider, the carrier shall clearly disclose that practice in each provider contract. Further, such carrier shall either (1) disclose in its provider contracts or on its website the specific bundling and down-coding policies that the carrier reasonably expects to be applied to the provider or provider's services on a routine basis as a matter of policy or (2) disclose in each provider contract a telephone or facsimile number or e-mail address that a provider can use to request the specific bundling and down-coding policies that the carrier reasonably expects to be applied to that provider or provider's services on a routine basis as a matter of policy. If such request is made by or on behalf of a provider, a carrier shall provide the requesting provider with such policies within 10 business days following the date the request is received.

b. Every carrier shall make available to such providers within 10 business days of receipt of a request, copies of or reasonable electronic access to all such policies which are applicable to the particular provider or to particular health care services identified by the provider. In the event the provision of the entire policy would violate any applicable copyright law, the carrier may instead comply with this subsection by timely delivering to the provider a clear explanation of the policy as it applies to the provider and to any health care services identified by the provider.

5. Every carrier shall pay a claim if the carrier has previously authorized the health care service or has advised the provider or enrollee in advance of the provision of health care services that the health care services are medically necessary and a covered benefit, unless:

a. The documentation for the claim provided by the person submitting the claim clearly fails to support the claim as originally authorized;

b. The carrier's refusal is because (i) another payor is responsible for the payment, (ii) the provider has already been paid for the health care services identified on the claim, (iii) the claim was submitted fraudulently or the authorization was based in whole or material part on erroneous information provided to the carrier by the provider, enrollee, or other person not related to the carrier, or (iv) the person receiving the health care services was not eligible to receive them on the date of service and the carrier did not know, and with the exercise of reasonable care could not have known, of the person's eligibility status; or

c. During the post-service claims process, it is determined that the claim was submitted fraudulently.

6. In the case of an invasive or surgical procedure, if the carrier has previously authorized a health care service as medically necessary and during the procedure the health care provider discovers clinical evidence prompting the provider to perform a less or more extensive or complicated procedure than was previously authorized, then the carrier shall pay the claim,

provided that the additional procedures were (i) not investigative in nature, but medically necessary as a covered service under the covered person's benefit plan; (ii) appropriately coded consistent with the procedure actually performed; and (iii) compliant with a carrier's post-service claims process, including required timing for submission to carrier.

7. No carrier may impose any retroactive denial of a previously paid claim unless the carrier has provided the reason for the retroactive denial and (i) the original claim was submitted fraudulently, (ii) the original claim payment was incorrect because the provider was already paid for the health care services identified on the claim or the health care services identified on the claim were not delivered by the provider, or (iii) the time which has elapsed since the date of the payment of the original challenged claim does not exceed the lesser of (a) 12 months or (b) the number of days within which the carrier requires under its provider contract that a claim be submitted by the provider following the date on which a health care service is provided. Effective July 1, 2000, a carrier shall notify a provider at least 30 days in advance of any retroactive denial of a claim.

8. Notwithstanding subdivision 7, with respect to provider contracts entered into, amended, extended, or renewed on or after July 1, 2004, no carrier shall impose any retroactive denial of payment or in any other way seek recovery or refund of a previously paid claim unless the carrier specifies in writing the specific claim or claims for which the retroactive denial is to be imposed or the recovery or refund is sought. The written communication shall also contain an explanation of why the claim is being retroactively adjusted.

9. No provider contract may fail to include or attach at the time it is presented to the provider for execution (i) the fee schedule, reimbursement policy or statement as to the manner in which claims will be calculated and paid which is applicable to the provider or to the range of health care services reasonably expected to be delivered by that type of provider on a routine basis and (ii) all material addenda, schedules and exhibits thereto and any policies (including those referred to in subdivision 4) applicable to the provider or to the range of health care services reasonably expected to be delivered by that type of provider under the provider contract.

10. No amendment to any provider contract or to any addenda, schedule, exhibit or policy thereto (or new addenda, schedule, exhibit, or policy) applicable to the provider (or to the range of health care services reasonably expected to be delivered by that type of provider) shall be effective as to the provider, unless the provider has been provided with the applicable portion of the proposed amendment (or of the proposed new addenda, schedule, exhibit, or policy) at least 60 calendar days before the effective date and the provider has failed to notify the carrier within 30 calendar days of receipt of the documentation of the provider's intention to terminate the provider contract at the earliest date thereafter permitted under the provider contract.

11. In the event that the carrier's provision of a policy required to be provided under subdivision 9 or 10 would violate any applicable copyright law, the carrier may instead comply with this section by providing a clear, written explanation of the policy as it applies to the provider.

12. All carriers shall establish, in writing, their claims payment dispute mechanism and shall make this information available to providers.

C. Without limiting the foregoing, in the processing of any payment of claims for health care services rendered by providers under provider contracts and in performing under its provider

contracts, every carrier subject to regulation by this title shall adhere to and comply with the minimum fair business standards required under subsection B, and the Commission shall have the jurisdiction to determine if a carrier has violated the standards set forth in subsection B by failing to include the requisite provisions in its provider contracts and shall have jurisdiction to determine if the carrier has failed to implement the minimum fair business standards set out in subdivisions B 1 and 2 in the performance of its provider contracts.

D. No carrier shall be in violation of this section if its failure to comply with this section is caused in material part by the person submitting the claim or if the carrier's compliance is rendered impossible due to matters beyond the carrier's reasonable control (such as an act of God, insurrection, strike, fire, or power outages) which are not caused in material part by the carrier.

E. Any provider who suffers loss as the result of a carrier's violation of this section or a carrier's breach of any provider contract provision required by this section shall be entitled to initiate an action to recover actual damages. If the trier of fact finds that the violation or breach resulted from a carrier's gross negligence and willful conduct, it may increase damages to an amount not exceeding three times the actual damages sustained. Notwithstanding any other provision of law to the contrary, in addition to any damages awarded, such provider also may be awarded reasonable attorney's fees and court costs. Each claim for payment which is paid or processed in violation of this section or with respect to which a violation of this section exists shall constitute a separate violation. The Commission shall not be deemed to be a "trier of fact" for purposes of this subsection.

F. No carrier (or its network, provider panel or intermediary) shall terminate or fail to renew the employment or other contractual relationship with a provider, or any provider contract, or otherwise penalize any provider, for invoking any of the provider's rights under this section or under the provider contract.

G. This section shall apply only to carriers subject to regulation under this title.

H. This section shall apply with respect to provider contracts entered into, amended, extended or renewed on or after July 1, 1999.

I. Pursuant to the authority granted by § [38.2-223](#), the Commission may promulgate such rules and regulations as it may deem necessary to implement this section.

J. The Commission shall have no jurisdiction to adjudicate individual controversies arising out of this section.

1999, cc. [709](#), [739](#); 2004, c. [425](#); 2005, c. [349](#); 2014, cc. [157](#), [417](#); 2015, c. [709](#); 2019, c. [683](#).