

## **ABOUT OPTIMA BEHAVIORAL HEALTH**

Optima Behavioral Health (OBH) was founded in 1986. From the beginning, it has been our intention to work in partnership with the practitioner community to deliver effective and affordable behavioral health services to the people of Virginia and surrounding areas. Our management philosophy is based on a firm commitment to develop and nurture a responsive, respectful relationship with our practitioner partners and to maintain open lines of communication with the clinical community. Towards that goal, practitioner input is solicited through participation on OBH Regional Advisory Boards, Provider Education Seminars, participation in OBH-sponsored clinical research studies, and Provider Satisfaction Surveys. While these formal avenues are in place, they do not replace the opportunity for you to contact us directly with any concern, question or feedback. Provider Services staff is always ready to assist you at (800) 648-8420 or (757) 552-7174.

The OBH Philosophy is also grounded in a commitment to clinical integrity. OBH staff is comprised of licensed clinicians from each mental health discipline, including psychiatry, addictionology, clinical social work, nursing, psychology and counseling. Decisions regarding utilization management are based on the clinical needs of a member and on practice guidelines established by professional organizations and outcomes research. The OBH Level of Care Criteria are included as part of this manual and we strongly encourage providers to use these to guide the treatment process. The transition to a managed care environment has been a formidable challenge for most practitioners. As part of our commitment to a partnership with the practitioner community, OBH provides continuing education opportunities in various areas of therapy. Through our newsletter, “*Clinically Speaking*”, we try to keep you abreast of changes in the marketplace, new lines of business, and policy or procedural changes.

Information regarding Optima Behavioral Health policies and procedures can be accessed on our web site, [www.OptimaBehavioralHealth.com](http://www.OptimaBehavioralHealth.com). Our current Practitioner Manual, as well as any updates or revisions is available for review and download at this location.

## HOW CAN I USE THIS MANUAL?

The OBH Practitioner Manual is intended to be a resource for both practitioners and office staff. We understand that you deal with an enormous amount of information in the course of practice management and that your time is best spent with patients, not paperwork. Therefore, we've designed this manual to help you find the information that you need quickly and to answer commonly-asked questions in a clear and concise way.

There are many circumstances that are unique or cannot be adequately addressed in this format. Our services cover individuals who are covered by various health plans that may differ in important ways in terms of benefits, exclusions and access. While this manual provides a summary of most products, services and plans, it is not a substitute for the member's Evidence of Coverage or Summary Plan Description. Therefore, we encourage you to call us with any questions that may not be directly or specifically answered by this manual.

The OBH Practitioner Manual is only one of many avenues of communication we have established with our provider network members. If you have question, concerns, or comments, you may call us directly or you may also contact us through our website at [www.OptimaBehavioralHealth.com](http://www.OptimaBehavioralHealth.com) or via e-mail at [OBHproviders@sentara.com](mailto:OBHproviders@sentara.com).

**OBH Provider Services Representatives can offer information on Claims, Authorizations, Benefits, Appeal, and Care Services.**

Optima Behavioral Health  
4417 Corporation Lane, Suite 250  
Virginia Beach, Virginia 23462

Provider Services  
Local Number: (757) 552-7174  
Toll-Free: (800) 648-8420  
Fax: (757) 552-7499

Network Management  
Fax: (757) 552-7114  
Toll-free Fax (866) 751-7645

Fraud and Abuse Hotline  
Local Number: (757) 687-6326  
Toll-free Number: (866) 826-5277

# CREENTIALING AND NETWORK PARTICIPATION

The following section contains answers to frequently asked questions about credentialing and network participation. Please feel free to contact Provider Service toll-free at (800) 648-8420 or (757) 552-7174 for more details or any other questions you may have.

## About Credentialing

### How can my practice partners get an application to become part of this network?

Any licensed behavioral health practitioner may submit a written request for network participation or complete the “[Request Network Participation](#)” form on [www.OptimaBehavioralHealth.com](http://www.OptimaBehavioralHealth.com). The practitioner will then receive a response to their participation request based on network development needs and requirements.

Effective January 1, 2008, Optima Behavioral Health will only be accepting Council for Affordable Quality Healthcare (CAQH) Universal applications for initial and recredential applications. All providers and/or office managers that have not utilized the CAQH application can contact CAQH for their assistance via their website [www.geoaccess.com/das/](http://www.geoaccess.com/das/), through the CAQH Helpdesk at (888) 599-1771, or via e-mail [help@caqh.geoaccess.com](mailto:help@caqh.geoaccess.com).

Note: If you do not have access to a computer and/or internet services, please contact CAQH at 888-599-1771 to request a paper application. Once you have completed the paper application, please submit it to CAQH along with a copy of your licensure, DEA if applicable, curriculum vitae or resume, and current malpractice insurance certificate. CAQH will enter your information into their system for you.

Please note OBH Credentialing Department will initiate adding all OBH existing provider names into the CAQH database that do not already participate with CAQH at this time. This process will create a CAQH ID and also initiate CAQH sending and initial packet for information to the practitioner’s office on how to utilize the CAQH application.

### How long does the credentialing process take?

The credentialing process usually takes between 90 to 120 days from the date in which an application is deemed complete. Please note that this time frame is contingent upon the **completion** and **submission** of all of the requested information.

### Why do you need to collect so much information for the credentialing process?

NCQA (The National Committee on Quality Assurance), a national quality assurance organization that accredits managed care organizations, stipulates what material is required for practitioner credentialing. The information regarding your clinical experience and expertise is verified and reviewed by the OBH Credentialing Committee as required by NCQA. The information is then used to assist us in effectively matching patient needs with provider expertise, as part of our Practitioner and Member Matching Program.

### **Is there an application or processing fee to join OBH's network?**

No, there is not a fee at this time.

### **What is the status of my application?**

You can find out the status of your application by calling toll-free ((800) 648-8420 or (757) 552-7174, and speaking with a Provider Service Representative.

### **When do I get a contract and a practitioner manual?**

Once your completed application is received, a contract will be prepared and sent to you for review and approval. You should sign and return both copies of your contract to OBH. Once it is received by OBH and your application has approved by the OBH Credentialing Committee, you will receive a welcome letter directing you to the on line Provider Manual and other resources.

### **Can I see patients before I receive my welcome letter?**

You may see a member before you are credentialed only if the member's plan has an out-of-network benefit. However, this is likely to result in a higher cost to the member.

To avoid any unnecessary out-of-pocket costs to the member or claims reimbursement issues, please contact OBH toll free at (800) 648-8420 or (757) 552-7174 and follow the prompts for the appropriate department to verify member benefits and authorization requirements.

### **How will I get patient referrals?**

Some of the OBH's plans require the member to contact OBH's Customer Service Department to pre-authorize care or may require the member to contact their Employee Assistance Program before seeking services. Our Customer Service staff can assist you in determining plan requirements. Customer service will refer the member to care based on certain criteria, including geographic location, practitioner specialty and expertise, and the ability of the provider to respond promptly. Other OBH plans allow members to contact you directly or access out-of-network benefits.

However, please be aware that some plans may require pre-authorization for payment whether the member is accessing in-network or out-of-network benefits.

To identify the specific type of coverage a member has, contact OBH toll free at (800) 648-8420 or (757) 552-7174 and follow the prompts for the appropriate department.

### **If I have been approved recently by the Credentialing Committee, when can I begin receiving reimbursement for seeing patients?**

Once you have been approved by the Credentialing Committee, you will receive a welcome letter. Upon receipt of your welcome letter, you may begin seeing members, obtaining in-network authorizations, and submitting claims for in-network reimbursement.

If you are unsure about your practitioner status please contact OBH toll-free at (800) 648-8420 or (757) 552-7174. We will be happy to assist you.

**If I am a Licensed Professional Counselor and am certified to perform Psychological Testing is there any additional paperwork I need to complete to be eligible to bill these services for the Optima plans?**

Yes, there is a two-page application that needs to be filled out and submitted for credentialing. Click on this link for the application, [Psychological Testing Application](#). Once the application is complete you can submit it to Network Management via fax to 757-552-7114.

**If I am a Licensed Clinical Psychologist and am certified to perform Neuro-psychological Psychological Testing is there any additional paperwork I need to complete to be eligible to bill these services for the Optima plans?**

Yes, there is a two-page application that needs to be filled out and submitted for credentialing. Click on this link for the application, [Neuro-Psychological Testing Application](#). Once the application is complete you can submit it to Network Management via fax to 757-552-7114.

**Do you have different networks for various plans?**

While the majority of our Optima plans use our entire statewide commercial provider network, there are a few exceptions. We have our government programs, Optima Family Care (a Medicaid product) and Optima Medicare Plans (a Medicare product), in which all the statewide providers may or may not participate. We also have the Sentara Employee Assistance Program Network that is a subset of our statewide network.

**How do I know which patient I can see?**

When a member presents seeking mental health services, just check the member's I.D. Card for plan type. If you need additional information or are in doubt about your status as a practitioner in any particular plan, call OBH toll-free at (800) 648-8420 or (757) 552-7174 for assistance.

**Is there anything I can do to increase the likelihood of receiving referrals from OBH?**

Yes, you can assist us by keeping us informed of any changes related to your practice. We use this information that you provide to us to match providers with members during the referral process.

Many practitioners have not advised us, via their application, notification or update, etc., that they offer a particular service, specialty or program offering. We encourage you to keep us updated regarding your current office locations, services and resources by directing this

information to our attention in Network Management. We ask that you complete the [Practitioner Update Form](#) whenever you experience any of these changes. We will be happy to ensure that your practitioner file is appropriately updated. We must be advised via the [Practitioner Update Form](#) of any change of address or if you decide to withdraw from the network. You can find this form on [www.OptimaBehavioralHealth.com](http://www.OptimaBehavioralHealth.com) on the provider resources page.

**If I am a Sentara provider and move to a different group practice or go into solo practice, what do I need to do?**

In addition to submitting a Practitioner Update form along with a W-9 form specifying your new Tax ID number, Network Management will need to determine whether or not you will need to sign an individual contract. Some practices have group contracts with OBH so the practitioners are not individually contracted with Sentara. If you require a contract, one will be sent out to you. Your effective date for participation for an individual contract will be the date the signed contract is received at OBH. You may not obtain authorizations or reimbursement at the in-network level prior to completing this step. You may call provider services to verify that your information has been changed at (800) 648-8420 or (757) 552-7174.

**Does my participation in OBH's network prevent me from participating with any other managed care firm?**

No. Your agreement with OBH is not an exclusive agreement.

**Is it necessary to go through the credentialing process more than one time?**

Yes, as an accredited health plan we require that providers are periodically re-credentialed. Failure to comply with the plans recredentialing requests may result in the termination of your status with OBH.

**How often will I need to be re-credentialed?**

Practitioners are re-credentialed according to the following guidelines:

- Within 12 months:

Providers identified by the Credentials Committee as having any quality concerns

- Within 24 months:

Providers with malpractice claims, medical license sanctions or NPDB issues that are identified by the Credentials Committee as needing more frequent review

- Within 36 months:

All remaining Providers with no issues identified by the Credentials Committee

## **PATIENTS AND CUSTOMERS**

The behavioral health care marketplace has changed dramatically over the past several years. The relationship of health plans to patient, employer, practitioner and payor has become increasingly complex. OBH offers several types of services and products to our clients, and in this section we offer a brief description of how practitioners interface with the various types of plans we manage.

### **Who is the OBH Client/Patient?**

OBH manages the behavioral health benefits for health plans funded or purchased by employers or governmental entities. The covered employee is considered to be the “*subscriber*.” Dependents, retirees and other beneficiaries are considered “*members*”. When a covered subscriber/member seeks or is referred for behavioral health care, that care is managed by OBH.

Since OBH manages benefits for over 536,000 covered lives, you may encounter one of these members throughout Virginia, as well as in adjoining states. Typically, a covered member/subscriber will have an I.D. Card which identifies the plan type, as well as the procedures required to access care and to verify benefits. *Of course, in the case of an emergency, clinically appropriate intervention should be provided regardless of evidence of eligibility.*

### **Who Are Our Customers?**

#### Insurance and Health Plans

OBH manages only the behavioral health benefits of a health insurance plan; this is referred to as a “*carve out*”. OBH manages the behavioral health benefits for the Optima Health Plans.

#### Employers

Many of our clients are employers who provide health coverage for their employees. There is a growing trend among large employers to “self-fund” the insurance coverage they provide to their employees. In these cases, the employer acts as its own insurance company and may establish its own specific benefits, limitations, copayments, etc. Instead of paying a set premium to an insurance company, the employer pays the health care costs (claims) incurred by employees. Employers often contract directly with OBH to oversee, or “administer”, their behavioral health benefits. Large industries such as food store chains or shipbuilding are examples of employers who contract directly with OBH to manage their behavioral health benefits.

Employers also contract with OBH for Employee Assistance Program (EAP) services. We offer both stand-alone EAP services, as well as our integrated model, which incorporates EAP services into the behavioral health benefits. Hospitals and municipalities across Virginia contract with OBH for EAP services.

## Governmental Agencies

OBH manages the behavioral health benefits for several local and regional federal/state initiatives, including the Medallion II public-private partnership (Medicaid) and Medicare.

## **How Does a Member Access Care?**

### When a Member Contacts OBH

When a member calls us seeking behavioral health services, first we verify eligibility and coverage. We talk with the member to determine any geographic considerations and the need for a particular specialty. We provide a referral to an appropriate practitioner to meet the member's clinical service needs and give him or her the practitioner's phone number to call and schedule an appointment.

OBH offers members and practitioners simple, direct access to a full range of behavioral health services 24 hours a day, seven days a week. Members are not required to obtain a PCP referral, but some plans do have an EAP (Employee Assistance Program) gatekeeper component.

### When a Member Contacts a Practitioner

When a member contacts a practitioner seeking behavioral health services, check the member's I.D. Card for plan information and contact us for verification of eligibility and coverage and for assessment and referral guidance. Most plans require pre-authorization for payment prior to the practitioner rendering any clinical services.

While on the telephone with a member or provider, OBH authorizes medically appropriate services, and an authorization letter is sent to the practitioner, identifying the number of sessions authorized. For this reason, it is critical for you to keep your fax number updated to ensure the receipt of authorization letters. For continued authorization, the practitioner may be required to submit an [Individual Service Plan](#) (ISP) to the OBH Care Services Department. Continuing treatment is authorized in the context of the OBH Level of Care Criteria for Medical Necessity.

If a practitioner is providing Medication Management only, authorizations may be obtained telephonically. Typically authorizations are given for a year from the date of the call. The authorization may be updated by phone either before the visits are utilized or before the authorization end date, whichever comes first.

#### **NOTE:**

OBH manages a variety of plans, including HMO, PPO and POS plans. Some plans offer an out-of-network benefit and some may allow direct practitioner access. However, some plans require pre-authorization for payment before in-network or out-of-network services are rendered. Should you provide services without pre-authorization when it is required, the claim will be denied for failure to pre-authorize. For those plans that allow direct practitioner access without pre-authorization, the initial authorization letter is generated after the first claim for services is submitted. If you have questions regarding a member's benefit plan, please contact OBH toll free at (800) 648-8420 or (757) 552-7174 and follow the prompts for the appropriate department.

If you or your patients have questions about their benefit plans and the requirements for accessing care, please contact us toll free at (800) 648-8420 or (757) 552-7174 and follow the prompts for the appropriate department. This call will ensure that you and your patients avoid any unnecessary penalties or out-of-pocket payments for unauthorized care. We will be happy to assist you with any questions.

### **How Do I Identify an OBH Member?**

If a patient contacts you directly without first contacting OBH's Customer Service Department, please check the back of the patient's member I.D. Card to identify the appropriate contact for pre-authorizing care. It is important to verify that the patient has followed the proper procedure for accessing care to ensure benefit coverage and facilitate prompt claims payment.

If the patient does not have an I.D. Card or prior authorization, please ask for the following information and call us to verify eligibility and coverage:

<p><b>Subscriber Information</b></p> <ul style="list-style-type: none"><li><input type="checkbox"/> Subscriber's Member I.D. Number</li><li><input type="checkbox"/> Subscriber's Name</li><li><input type="checkbox"/> Subscriber's Medicaid Number, if Applicable</li><li><input type="checkbox"/> Subscriber's Date of Birth</li></ul>
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You may call our Customer Service Department at OBH toll free at (800) 648-8420 or (757) 552-7174 and follow the prompts for the appropriate department to verify that the subscriber/member has met the access and pre-authorization requirements prescribed by his or her plan. We will be happy to clarify coverage or answer any questions you may have.

**Remember, failure to verify coverage or properly pre-authorize care may result in a reduction in reimbursement or denial of claims.**

### **Member Right and Responsibilities**

#### Policy Statement

The Member Bill of Rights and Responsibilities assures that all members are treated in a manner consistent with the Plan's mission, goals and objectives and assures that members are aware of their obligations and responsibilities upon joining the Plan and throughout their membership with the Plan.

#### Member Notice

As a member of the Plan, you are entitled to all covered benefits; however, you must learn how the Plan works, follow the proper procedures, and use the proper network – doctors, hospitals, mental health providers and other health care specialists – participating with the Plan.

## Members Have the Right:

To be treated in a manner reflecting respect for your privacy and dignity as a person.

To be informed regarding your diagnosis, treatment and prognosis in terms you can reasonably be expected to understand.

To receive sufficient information to enable you to give informed consent prior to the initiation of any procedure and/or treatment.

To participate with practitioners in decision-making about your health care and refuse treatment to the extent permitted by law, and be made aware of the potential medical consequences of such action.

To a candid discussion of appropriate or medically necessary treatment options for your condition, regardless of cost or benefit coverage.

To expect that all communications and records pertaining to your health care will be treated as confidential. Any data shared with employers is not implicitly or explicitly member identifiable unless specific consent has been obtained. No records will be without your written authorization to protect access to your medical information. In the case of a minor, release of information is allowed only by authorization of a legal guardian or court order.

To select a behavioral health practitioner and expect the practitioner to provide or arrange for, and coordinate all care you require.

To express complaints or appeals to the Plan about the managed care organization or care provided, and expect a response to that complaint or appeal within a reasonable period of time.

To reasonable access to necessary medical services.

To be informed of the Plan's policies and procedures regarding services, benefits, practitioners and providers, and member rights and responsibilities, and be notified of any significant changes in those policies and procedures.

Discuss your medical record with your physician and receive, upon request, a summary of that record (at a nominal charge) as required under State law. The Plan's staff can only release records with your physician's approval and signed consent.

To obtain from the Plan a certificate of creditable coverage which shows prior, continuous coverage. With the certificate, you may be able to receive coverage under your next health plan with either no waiting period for pre-existing conditions or a reduced waiting period.

To make recommendations regarding member rights and responsibilities.

Members Have the Responsibility:

To work with your behavioral health practitioner to help establish the proper patient/practitioner relationship.

To schedule appointments and arrive on time for those appointments or notify the behavioral health practitioner's office if you must cancel or come late for a scheduled appointment. Charges for missed appointments are not covered by the Plan.

To meet the financial obligations regarding member premiums and copays when services are rendered.

To ask any questions and understand the answers about your illness and/or treatment.

To obtain prior authorization from OBH before seeking consultation or other medical services, except in potentially life-threatening situations.

To get and carefully consider all information necessary to give informed consent for a procedure or treatment.

To weigh the potential consequences of any refusal to comply with the behavioral health practitioner's instructions or recommendations.

To follow the plans and instructions for care that you have agreed on with your practitioners.

To be courteous, considerate and cooperative in dealing with your behavioral health practitioner, his/her office staff, and employees of the Plan, and to respect the rights of fellow Plan members.

To express opinions, concerns or complaints in a constructive manner to avoid similar problems in the future.

To read and be aware of all material distributed by the Plan explaining policies and procedures regarding services and benefits, and to follow those policies and procedures when receiving care.

To provide the Plan and providers with complete and accurate information necessary to care for you, for your medical record and for Plan membership records. This includes notifying the Plan of any changes in status such as phone number, address, and number of dependents (i.e., birth, marriage, divorce, etc.), and information regarding other health insurance coverage for coordination of benefits purposes.

To assist the Plan in compiling a complete medical record by providing, or by authorizing the Plan to obtain necessary medical information. Ultimately, it is your responsibility to furnish the Plan with any medical records needed to process a complaint, grievance or appeal of a denied claim when the Plan has been unable to obtain this information.

OBH cannot ensure these rights for members who elect to receive care from behavioral health practitioners who do not participate in our network.

## **Special Needs Members**

Optima Health and Optima Behavioral Health (OBH) will use all reasonable means to facilitate health care 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 ID card. In the event that a Member Services representative needs assistance in accommodating the member, the representative may contact Medical Care Services (MCS) or Sentara Behavioral Health Services (OBH) for additional resources and assistance.

For the purposes of communications with hearing impaired members or those members who speak little English or are non-English speaking, Optima Health and OBH utilizes various resources, including a TTY (also referred to as TDD) phone line at 1-800-225-7784 or 757-552-7120, as well as the AT&T Language Bank for foreign language interpretations.

The TDD phone line is available for members Monday through Friday, 8:00 a.m. through 7:00 p.m. for incoming calls, and is answered by Customer Operations staff. This number is published in the member materials and assists the members in contracting the Plan for questions regarding their health plan benefits, eligibility, claims, mental health services, or any other questions/information related to their health plan benefit coverage.

All auxiliary aids (e.g. TTY phone), sign language and foreign interpreter services will be made available to members, employees and practitioners who provide services to Plan members. Members will be notified of such services via member materials (Member/Enrollment Guides).

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. Optima Family Care Members that have been identified as hearing impaired and who speak limited or no English and who require interpreter services may have these services arranged by the Plan, as directed by the DMAS contract.

Members covered under all other plans (OHP and OHIC products) may be provided assistance with the coordination of interpreter services, however, all charges for interpreter services will be the responsibility of the provider as directed by the Americans with Disabilities Act (ADA).

## **Resources for Sign Language/TTY Services and Language Interpreters**

The resources listed below may be utilized for the purposes of communication with and assisting member that are hearing impaired or non-English speaking or with limited English:

### **Hearing Impaired:**

Virginia Department for the Deaf and Hard of Hearing

[www.vddhh.org](http://www.vddhh.org)

Voice/TTY- 804-662-9502

Voice/TTY- 1-800-522-7917

Virginia Relay

[www.varelay.org](http://www.varelay.org)

Voice- 1-800-828-1140

TTY- 1-800-828-1120

**Foreign Language:**

AT&T Language Line

[www.LanguageLine.com](http://www.LanguageLine.com)

1-800-874-9426

American Red Cross- Richmond Chapter

Language Bank

[www.greaterrichmond.redcross.org](http://www.greaterrichmond.redcross.org)

804-780-2250

Serves Richmond City, Henrico, Chesterfield, Hanover, Goochland and Powhatan counties.

American Red Cross- York/Poquoson Chapter

[www.york-poquoson.redcross.org](http://www.york-poquoson.redcross.org)

757-898-3090

Serves Peninsula areas

# **PARTNERS FOR CONTINUING QUALITY IMPROVEMENT AND CLINICAL EFFECTIVENESS**

## **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 and OBH staff and participating practitioners and may include representatives from other organizations.

Each year, Optima Health, with OBH develops a QI Program and Work Plan that outlines our efforts to improve clinical care and service to our members.

## **NCQA Accreditation**

As part of our commitment to quality, Optima Health/OBH voluntarily participates in the accreditation process administered by the National Committee for Quality Assurance (NCQA). NCQA is an independent, non-profit organization whose mission is to improve health care quality.

NCQA evaluates health care in three different ways: through the accreditation process (a rigorous on-site review of key clinical and administrative processes), through the HEDIS® performance measures, and through a comprehensive member satisfaction survey.

## **HEDIS®**

Healthcare Effectiveness Data and Information Set (HEDIS®) performance measures are a part of the NCQA accreditation process. The information that is provided by HEDIS® helps employers and customers understand the value and quality of care provided by their health plan.

Participating in the HEDIS® process allows the community the ability to evaluate their plan for cost and quality, and for making comparisons among other health plans.

Some of the major areas of performance measured by HEDIS® are:

- Effectiveness of Care
- Access/Availability of Care
- Satisfaction with the Experience of Care

## **Clinical Guidelines**

Each year, Optima Health/OBH produces a clinical guideline publication that is coordinated with the assistance of local primary and specialty care physicians. These guidelines are based on

published national guidelines, literature review, and clinical experience. They offer the most current recommendations in disease management techniques. 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 and consultants in the management of patient care. Clinical Guidelines are available to providers on the OBH web site under Provider Resources and on CD.

[Treating Major Depressive Disorder](#)

[Bi-Polar Disorder Algorithms](#)

[Schizophrenia Algorithms](#)

[Monitoring Clients on Second-Generation Antipsychotics for Metabolic Effects](#)

[Helping Patients who Drink Too Much](#)

### **Patient Appointment Access Guidelines**

Access to care is recognized as a key component of quality care. All Optima Health/OBH Providers are obligated by contract to provide necessary Covered Services to Members on a 24-hour per day, 7-day per week basis, or to arrange coverage for their patients in their absence.

Appointment Access Standards for Behavioral Health:

- Emergent: 6 hours
- Urgent: 48 hours
- Routine: 10 days

### **Continuity and Coordination of Care**

Optima Health/OBH strives to ensure that all members receive the highest quality of care and utilizes systematic methods of detecting problems specific to continuity and coordination of care. Ongoing collaboration between primary care and Behavioral Health specialists promotes a continuous plan of care that benefits the members.

It is Optima's policy to monitor and identify potential problems with continuity and coordination of care for all of our members. Information on continuity and coordination of care will be collected at the time of the HEDIS® chart reviews and Behavioral Health Treatment Record Reviews.

The following information should be recorded in the Behavioral Health provider's record for Optima Health members:

- 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.
- A referral from a Primary Care Physician is not required for a member to access mental health services. Continuity and coordination of care is encouraged by OBH. After obtaining the patient's informed consent prior to the release of information, the practitioner is expected to notify the PCP when the member presents for an initial behavioral health evaluation and

continued treatment. Significant changes in the patient's condition, changes in medication and termination of treatment should be communicated to the members primary care physician. [\(Confidential Exchange of Information Form\)](#)

### **Medical Record Documentation Standards/Guidelines**

Medical record audits for Practitioners will be performed annually. Selection of providers/practices will be determined by review of the organization's needs and approved by the QI Manager/Senior Medical Director.

- Medical records are audited utilizing a Treatment Record Review Documentation Worksheet.

Records should be maintained for each member and kept confidential, secure, organized and reflective of continuity of patient care. Patient information should be in chronological (or reverse chronological) order and in a consistent, logical format.

The OBH Treatment Record Documentation Guidelines are available to Providers on the OBH web site. Provider records will be evaluated based on these guidelines and appropriate feedback will be given. The guidelines incorporate the following accepted standards for medical record documentation:

- 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
- Evidence of continuity of care
- Risk Assessment

### **Medical Record Policies**

Participating providers must treat all communications and records pertaining to the member's health care 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. The Code of Virginia requires a health care provider 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. All medical records must be kept in accordance with applicable state and federal laws.

### **Additional QI Information**

If you would like to request a copy of Optima Health's HEDIS® Performance Measures, request a CD (or hard copy) of our clinical guidelines or have any other questions concerning the QI process, please contact the Quality Improvement department at 757-552-7350 or toll free at 1-866-425-5257.

# COMMUNICATION

## **Provider Website**

OBH is committed to enhancing services for providers by offering online capabilities. OBH website can be accessed at [www.OptimaBehavioralHealth.com](http://www.OptimaBehavioralHealth.com). This website contains information for both the provider and the member, including:

- [OBH Provider Manual](#)
- [Clinically Speaking Newsletter](#)
- [Sentara EAP Affiliate Provider Manual](#)
- [Frequently Used Forms](#)
- [Commonly Asked Provider Questions](#)
- [Update Provider Address and Other Information](#)
- [Request Network Participation](#)

Finding an OBH provider is as easy. Just log onto [www.optimahealth.com](http://www.optimahealth.com) and click on Find a Provider, and then click on Search Tools, then Find a Behavioral Health Provider.

## **Provider Newsletter**

OBH practitioner newsletter, [Clinically Speaking](#), is distributed every other month and can also be found on the OBH website. One is mailed to each provider group. Please share it with all of your providers in your group. In addition to current OBH news and information, this newsletter shares policy updates and changes, monthly articles from the medical director, survey results, and quality improvement activities.

## **Provider Educational Seminars**

OBH sponsors three free provider educational seminars annually in different venues throughout the provider network. These educational seminars, offering continuing medical educational credit, are dedicated to the discussion of mental health topics and designed to increase physicians' and clinicians' knowledge of mental health disorders. One copy is mailed to each provider group. Please share this information with each provider in your office. They are also posted on our website for downloadable copies.

## **Medical Care Review Committee**

The Medical Care Review Committee is a OBH peer review body of actively practicing clinicians, including four psychiatrists. This committee is responsible for conducting peer review of behavioral care services, recommending clinical protocols and guidelines, reviewing new technology developments, monitoring the quality of care provided to our members, monitoring the utilization of inpatient and outpatient services, and identifying and advising OBH of behavioral health practitioner educational needs to address quality issues. This committee meets every other month.

## **Regional Advisory Committees**

OBH has four regional advisory committees (Hampton Roads, Blue Ridge, Central Virginia, and Southwestern Virginia) that several times throughout the year. These committees, consisting of network behavioral health providers, are responsible for reviewing issues related to new lines of business, changes in business, and product development, discussing legislative input supporting the development of appropriate policies and operations, evaluating information and assisting in the assessment of the quality of the OBH delivery of care. These committees report to OBH Quality Improvement Committee.

## **Member Satisfaction Survey**

OBH conducts an annual member satisfaction survey, Experience of Care and Health Outcomes Survey (ECHO™), to measure, monitor, and improve the satisfaction of our members. The survey results are distributed to our Quality Improvement Committee and appropriate departments for review and development of corrective action plans.

## **Practitioner Satisfaction Survey**

OBH conducts an annual provider satisfaction survey of provider's opinions regarding clinical and administrative processes. Survey data is collected, aggregated, trended, and used to identify opportunities for improvement. The survey results are distributed to OBH providers via [Clinically Speaking](#) newsletter and OBH peer review committees. Based on the survey results, the OBH develops a corrective action plans to improve practitioner satisfaction.

## **Facility Site Visits**

OBH develops working relationships with our high volume facilities by conducting periodic facility site visits to improve communication and share information. During these site visits, the facility profile is reviewed and discussed (including the number of admissions, average length of stay, readmission rate within thirty (30) days and ninety (90) days, rate of aftercare appointment scheduled within seven (7) days of discharge and discharge with access to firearm). OBH also utilizes these visits to discuss other issues regarding coordination of services (HIPAA concerns, patient safety concerns, coordination of care with community resources, physician-specific issues, finance, contracting, and claims).

# **CARE SERVICES PROGRAM**

## **Our Care Services Philosophy**

The philosophy of OBH Care Services Department is to collaborate with practitioners to ensure delivery of the highest quality, most cost-effective mental health and substance abuse care in the most clinically appropriate, least-restrictive environment. Open communication between the Care Services staff and OBH practitioners is sought in order to better understand the clinical status and needs of our members. The Care Services staff makes authorization decisions by applying an established set of medical necessity criteria. Open communication allows for more informed decision-making about use of benefits and payment for services. Providers should contact the Care Services Department at OBH for information regarding specific medical necessity criteria.

The Care Services systems and processes are described further in the following pages. Please contact our Care Services Department with any questions you may have regarding this information or any of our policies and procedures.

## **Medical Necessity Criteria**

OBH philosophy is to manage the delivery of mental health and substance abuse care in a manner that will provide the individual patient that treatment which is likely to be the highest quality, most clinically appropriate and most effective in the least restrictive setting possible. OBH utilizes the nationally recognized set of medical necessity criteria, Mihalik Medical Necessity Manual for Behavioral Health. Developed by the Mihalik Group, the MNC manual is updated annually based on oversight and input from a Mihalik Manual are also approved by OBH Medical Care Review Committee to ensure we have input from local practitioners as well. Contact OBH Case Management for specific questions related to medical necessity criteria at 757-687-6490.

## **Pre-authorization**

Some of the plans administered by OBH require behavioral health services to be pre-authorized. The practitioner or the member may obtain pre-authorization by calling OBH toll free at (800) 648-8420 or (757) 552-7174 and follow the prompts for the appropriate department. Pre-authorization and referral will be determined based on the member's benefit plan and medical necessity of the requested care. Failure to pre-authorize care can result in a denial of claims and/or penalties for the practitioner.

## **Performance Standards for Crisis, Urgent and Routine Outpatient Appointments**

Depending on the clinical needs of a member, the level of urgency for access to care varies. The levels of urgency are considered to be emergent, urgent and routine, and guidelines have been established for each level to support a timely response to a request for care. When a OBH practitioner receives a referral from the Care Services Department or a member, OBH uses the following guidelines:

Emergent Request - respond telephonically within 30 minutes  
Urgent Request - respond telephonically within 2 hours  
Routine Appointment - respond telephonically within 24 hours of contact

Once contact has been made to schedule an appointment, the timeframe in which the member needs to be seen for treatment also depends on the level of urgency of the request. These timeframes support member's getting the most appropriate care at the most appropriate time. OBH access to care timeliness standards are defined in the following guidelines:

Emergent Appointment – within six (6) hours of receipt of request  
Urgent Appointment – within forty-eight (48) hours of the request  
Routine Appointment – within ten (10) working days of the request

### **Outpatient Authorizations and Concurrent Review**

After the initial authorization for care has been used and a OBH practitioner is recommending continued care for a member, a clinical update on the member's status may be requested.

Clinical updates are documented on the [Individual Service Plan \(ISP\)](#) forms. Each ISP should be submitted to the Care Services Department for review

### **Psychological Testing and Neuropsychological Testing**

Psychological testing is a highly specialized procedure used in a focused manner to assist the treating provider with diagnosis and/or treatment planning which he/she cannot successfully accomplish through other means [e.g., clinical evaluation, application of DSM-IV criteria, review of relevant history, consultations with other treating providers (including but not limited to the member's Primary Care Physician), interviews with parents, teachers, review of school records, etc.]. Therefore, psychological testing is not authorized as a routine procedure, but rather is a covered benefit only when the treating provider cannot diagnose and/or implement an appropriate treatment plan successfully without the benefit of the testing.

While benefits differ from contract-to-contract, in general, psychological testing for the diagnosis and/or treatment of the following is not a covered benefit:

- learning disabilities
- mental retardation
- developmental disabilities
- educational testing
- fitness for duty evaluations
- intellectual, cognitive or academic functioning
- parenting capacity assessments
- assessment pursuant to custody issues, court-ordered assessments pursuant to civil action, including personal injury

When neuro-psychological testing is requested pursuant to a medical condition or circumstances such as a head injury or stroke, the testing authorization should be requested under the member's medical benefits. This service would be paid from the "medical" and not the "mental health benefit."

The testing psychologist completes the [Psychological & Neuropsychological Testing Request Form](#), then faxes the form to the appropriate fax number (757) 552-7176 or toll-free (888) 576-9675.

If the treating provider does not have a testing psychologist in mind, he/she can request names of testing psychologists by calling our service department at (757) 552-7174 or (800) 648-8420.

Upon receipt of the completed testing form, OBH reviews the request to determine if the testing is medically necessary.

OBH has ten (10) business days from the date received to complete the review of the Request for Psychological Testing in an outpatient setting. Notification of the decision is provided by mail.

OBH has two (2) business days from the date received to complete the review of the Request for Psychological Testing in an inpatient setting.

### **Emergency Room Services**

Members do not need prior approval from their PCP or the Plan before seeking care at the Emergency Room (ER). All Members are encouraged to contact their PCP, Behavioral Health Provider, or the Plan via the After Hours Program for instructions on the type of care to receive. All visits (not recommended by an agent of the plan) may be retrospectively reviewed to determine coverage. Only true emergencies will be approved for payment. If a visit is denied payment, the member is responsible for the payment of the visit. Exceptions: Under Optima Family Care, the participating hospital or physician receives a flat triage fee for providing non-emergent care. Optima Family Care FAMIS members will have a higher co-payment for non-emergent ER services.

### **Inpatient Authorizations and Concurrent Review**

All inpatient care requires pre-authorization. Please contact the OBH Care Services Department toll free at (800) 648-8420 or (757) 552-7174 and follow the prompts for the appropriate department for pre-authorization. The OBH Care Manager will review the presenting problems with the mental health provider or facility representative, apply OBH medical necessity criteria and render an authorization if the criteria is met for the requested level of care. If the Care Manager determines the request does not appear to meet criteria for the requested level of care, the case will be referred to OBH's Medical Director or a OBH Physician Advisor (PA) for review. If necessary, the Medical Director or PA will discuss the case directly with the Attending Physician.

After an admission has been authorized, a concurrent review will be scheduled between the OBH Care Manager and the patient representative identified by the facility. Concurrent reviews are scheduled prior to the end date of each authorization and are conducted telephonically. Upon obtaining a clinical update from the facility and continued care is recommended, the Care Manager will apply OBH medical necessity criteria and authorize as appropriate. The Care Manager will consult and/or refer a case to OBH Medical staff if it appears criteria is not met or if there are quality of care concerns. The frequency of concurrent reviews is determined on an individual case basis and the clinical needs of the member.

When a case is referred to OBH Medical staff, the concurrent review continues between a OBH physician or Physician Advisor (PA) and the member's attending physician. After obtaining the clinical information from the attending physician, the OBH physician will determine if medical necessity criteria is met. If not, a denial of the authorization request is issued, and the Attending Physician is advised of his/her right to appeal the denial. Written notification of this decision is mailed within twenty-four (24) hours of the determination.

### **Discharge Planning**

Effective discharge planning is crucial to the continued success of treatment and is expected to be incorporated into the treatment plan for both inpatient and outpatient care. For inpatient care, a specific and detailed discharge plan should be developed within 24 hours of admission by the inpatient treatment team. The OBH Care Manager will review the appropriateness of the discharge plan as part of each concurrent review. The OBH Care Manager collaborates with the facility utilization reviewer to ensure that an outpatient appointment is scheduled within seven (7) days of discharge if possible.

OBH Care Services staff will follow up with the member upon discharge to assist the member transitioning to a lower level of care and address any barriers that may prevent the member from complying with the aftercare plan. The Care Services staff will telephone the outpatient treatment team to verify the member kept their appointment. If the member failed to keep the appointment, OBH collaborates with the treating providers and the member to facilitate the member receiving continued care. OBH is prepared to coordinate the necessary care for a member, regardless of the complexity of a member's treatment needs, and to maximize the use of available resources to them. OBH is available to its network practitioners to assist and problem-solve as needed to overcome members' barriers to treatment and support continued progress.

### **Preferred and Standard Drug List (Formulary)**

Prescription drugs are covered if the member's employer purchased the Prescription Drug Rider. If the member has prescription drug benefits, a co-payment will appear on his/her ID card under the "Rx" section. Guidelines regarding preferred and standard drug use must be followed.

The Preferred and Standard Drug List is available on [www.optimahealth.com](http://www.optimahealth.com) with quarterly updates. This list will provide you with information about which drugs require pre-authorization.

Physician offices needing additional information about a drug may contact the Pharmacy Authorization Team at 757-552-7540 or 1-800-229-5522 (option 4) or Provider Relations at 1-800-229-8822 (option 4).

### **Submission of Clinical Information**

Because authorization for care is based on medical necessity, OBH relies on the clinical information provided by the treating practitioners of its members. Communication of the members' needs by the practitioner is essential in getting the care authorized. When there is lack of clinical information to make a medical necessity decision, an authorization cannot be made and ultimately, claims could be rejected. If the member is not aware that OBH may not reimburse the cost of treatment nor is in agreement to be responsible for the charges, the OBH practitioner is not permitted to bill the member for service provided. Practitioners are encouraged to submit any needed clinical information as requested by OBH to avoid claims non-payment.

### **Appeals**

In the event that an agreement about treatment cannot be reached, the member has the right to appeal a medical necessity decision no later than 180 calendar days for commercial products, 60 for Medicare products, and 30 days for Medicaid products from the date of receipt of the denial letter. A member would contact the Customer Service Department for an appeal package to be sent to them at (757) 552-7174 or (800) 648-8420. Medicaid members also have the right to appeal directly with DMAS. The practitioner has the right to appeal a medical necessity decision no later than 30 calendar days from date of receipt of the denial letter. In order to appeal a medical necessity decision, the practitioner should contact OBH Provider Services Department at toll free at (800) 648-8420 or (757) 552-7174 to file an appeal.

### **Appropriate Service and Coverage**

OBH facilitates the delivery of appropriate care and authorization decisions are based on the treatment needs of its members. OBH does not compensate, allow financial incentives or encourage in any way the limitation of appropriate benefit and/or service access.

# CLAIMS

## How Do I Get Paid?

One of OBH's goals is to reimburse you in a timely manner. This section is devoted to providing the basic guidelines and information you need to assist us in meeting this goal and paying you on time. When submitting claims, outpatient practitioners should use the CMS-1500 form, facilities need to file claims on the UB04 listing in detail the charges for services rendered. Claims should be submitted within 120 days of the date of service in order to be reimbursed by OBH. We have a commitment to process all claims payments within thirty (30) days of the receipt of claims.

Providers can participate in our Electronic Data Interface (EDI) claims submission program with Optima Behavioral Health. Please visit the provider page of the [www.optimahealth.com](http://www.optimahealth.com) website for the EDI Transaction Overview for additional information.

OBH also accepts Electronic Data Interface claims submission through the claim vendor, Payer Path. If you elect to use another EDI Vendor please make sure your EDI vendor can submit your claims through Payer Path on your behalf. If you need additional information please contact Payer Path directly at (804) 560-2400.

## Timely Filing

**Participating providers** have agreed through their contracts to submit claims within a certain amount of time from the date of service. In addition, **members** have agreed through their group contracts to submit claims for reimbursement within a certain amount of time from the date of service. The submission time period includes any mail time. In other words, the claim must be received within the time frame and not just mailed within the time frame.

Any claim received more than the specified number of days from the date of service will be denied as a Late Claim submission unless documentation outlining the reason for the delay, proof of timely filing and documented support of on-going investigation is included. All late claims received more than the specified number of days from the date of service must include satisfactory documentation to support timely filing and follow-up.

**Satisfactory** documentation includes documentation outlining the reason for the delay, proof of timely filing and documented support of on-going investigation. Satisfactory documentation also includes a letter or a telephone call questioning the lack of payment from OBH. Along with the necessary [Claims Reconsideration Form](#) attached.

**Unsatisfactory** documentation includes the following: illegible billing statement, a copy of the original claim with a different submission date, a copy of the claim with the date of service circled, or a notation on the claim that the claim was originally sent on XXX date. The claim will be denied D30B – late claim active follow-up not documented provider responsible.

Any late claims not received due to a malfunction of the EDI program or deemed to be a result of an error by the Plan will be considered with approval by the Claims Director.

Any claim received more than 365 days from the date of service will be denied as a Late Claim submission .

### **Reconsideration of Payments or Denials**

You have the option of submitting your claim for reconsideration. All Reconsideration Requests should be mailed to Claims, PO Box 1440, Troy, Michigan 48099-1440 with the [Reconsideration Request Form](#), that could be found on our website <http://www.OptimaBehavioralHealth.com> on the Provider Resources Page under Download Frequently Used Forms, along with any supporting documentation. Please be sure to mark field 19 on the CMS 1500 form with the word “recon”. Failure to do so may cause your claim to deny a duplicate claim. Please watch you remittance advises for the reconsideration decision. Once your claim has been filed and gone through the Reconsideration process, you may now file an Appeal. (If you have submitted an appeal with out having gone through the reconsideration process, please note that it will not be processed as an appeal. It will be processed as a reconsideration. Please refer to your remittance advice for the decision.) Please see refer to page\_\_ of this manual for information on the Appeals process.

### **Incorrect Insurance Information**

If the provider receives corrected insurance information from the member and provides supporting documentation (for example, original dated registration, new registration, etc.), the provider will receive reimbursement from OBH. The provider must follow all OBH filing deadlines for the product after the corrected information is received.

### **Other Issues**

If the provider can not adhere to the guidelines due to unusual internal issues (staff turnover, computer problems, etc) the plan will evaluate and decide if an exception is warranted.

### **Coordination of Benefits**

OBH follows industry standards for coordinating benefits. When a member is covered by more than one insurance managed by OBH, authorization must be obtained for **each** of the insurance plans. When filing for claims payment, submit the primary insurance claims first and then submit the secondary insurance claim with the explanation of benefits attached.

### **Copayment, Coinsurance and Deductibles**

Copayment, coinsurance and deductible amounts vary depending on the member’s specific benefit structure and plan type. Copayment, coinsurance and/or deductible amounts to be collected from the patient appear on the Remittance Advice form, which accompanies your claim payment. If you have difficulty identifying copayments, coinsurance or deductible amounts

please contact us at toll free (800) 648-8420 or (757) 552-7174 and follow the prompts for the appropriate department.

### **Balance Billing**

**Sentara Behavioral Health Service's Practitioner Agreements prohibit practitioners from balance billing members.** This means that no contracted practitioner may bill a member for any amount in excess of the rates agreed upon with OBH, except for copayments and deductibles which are permitted under the member's health benefit plan.

Practitioners may bill members for services which are specifically excluded under the member's plan, but only if the member signs a financial agreement promising to pay for such non-covered services before the services are rendered. Once a member's benefits are exhausted, a provider may arrange for services to the member in any legal manner that the provider and member agree upon.

### **Eligibility**

When an OBH patient is referred to you, every effort is made to verify eligibility. However, if a patient is later determined to be ineligible or loses eligibility, you will be notified by the claims payor via remittance advice. You may then bill the patient directly.

### **Delays in Claim Payment**

Please review the claims forms carefully to ensure accuracy and completeness and prevent delays in claims processing. Some common problems or mistakes, which create delays, include:

Date of service is before or after the authorized treatment period

Explanation of benefits from primary carrier is not attached to the claim when secondary coverage is requested. (This is often referred to as "Coordination of Benefits" or COB, describing the situation where an individual is covered by more than one benefit plan. Per your contract with OBH, you are entitled to recover a total of your contracted rate through payments by the payors.)

Form is missing the federal tax ID number

Incorrect member information

Insufficient itemization of charges

Member has exceeded benefits

Member not enrolled for date of service

No prior authorization was obtained

Pre-existing conditions not covered, subject to an employer plan

Provider is billing for unauthorized services

Services were rendered by a provider who was not authorized by OBH

Visits or days provided exceed the number of visits or days authorized

Missing appropriate provider id number (NPI)

After calling for pre-authorization, you will receive an authorization for services letter that provides the address of the claims payor and the authorization number. To ensure that you will be paid in a timely manner, fill in all required information on the UB04 or CMS 1500 and, submit the form to the claims payor as indicated in the authorization letter. Claims lacking information will be returned for your completion before processing. In all instances, OBH's Claims staff will be happy to assist you and will pursue resolution of these issues as quickly as possible.

We have provided a quick reference for claims submission on the following page. Please call OBH Customer Service at (800) 648-8420 or (757) 552-7174 whenever you need further guidance or have any questions about claims issues.

<b>Claims Plan Type</b>	<b>Number to Call with Questions</b>	<b>Form to Use</b>	<b>Where to Submit Claim</b>	<b>Authorization Requirements</b>
<b>Sentara Employee Health Plans</b>	(800) 648-8420 (757) 552-7174	CMS-1500	Optima Behavioral Health C/O CLAIMS PO Box 1440 Troy, MI 48099-1440	EAP referral is mandatory. The member must call EAP
<b>OPTIMA Commercial Plans</b>	(800) 648-8420 (757) 552-7174	CMS-1500	Optima Behavioral Health C/O CLAIMS PO Box 1440 Troy, MI 48099-1440	Must go to a participating network provider for coverage/call to determine if authorization is required
<b>Optima Medicaid Plans</b>	(800) 648-8420 (757) 552-7174	CMS-1500	Optima Behavioral Health C/O CLAIMS PO Box 1440 Troy, MI 48099-1440	Must go to a participating network provider for coverage/call to determine if authorization is required
<b>Optima Medicare Plans</b>	(800) 648-8420 (757) 552-7174	CMS-1500	Optima Behavioral Health C/O CLAIMS PO Box 1440 Troy, MI 48099-1440	Must go to a participating network provider for coverage/call to determine if authorization is required
<b>Children's Health System</b>	(800) 648-8420 (757) 552-7174	CMS-1500	Optima Behavioral Health C/O CLAIMS PO Box 1440 Troy, MI 48099-1440	EAP referral is mandatory. The member must call EAP
<b>BonSecours</b>	Hampton Roads (800) 327-3257 Richmond (804) 281-8510 Emergency & After Hours (804-342-1501	CMS-1500	Optima Behavioral Health C/O CLAIMS PO Box 1440 Troy, MI 48099-1440	EAP referral is mandatory. The member must call EAP

# APPEALS

## Provider Administrative Appeals

Optima Behavioral Health (OBH) attempts to resolve issues presented by Providers informally whenever possible. If an issue cannot be resolved informally, an internal Provider Appeal process is available to reconcile issues.

For a claim to be eligible for an **Appeal**, the claim must have had a post service **adverse payment decision**, have been denied **Provider Responsible**, and have already gone through the **Reconsideration** process. (If you have submitted an appeal with out having gone through the reconsideration process, please note that it will not be processed as an appeal. It will be processed as a reconsideration. Please see your remittance advice for the decision.)

To be eligible for **Appeal**, claims must meet the following criteria:

1. **Post-service** adverse payment decisions made by OBH
2. **Provider Responsible**. Examples include:
  - Disputes regarding coding, capitation, contractual payments and rates, and/or usual, reasonable and customary (UCR) charges.
- Denials based upon the Provider's failure to obtain prior authorization of services, timely filing, delayed treatment, length of stay and level of care.
3. Have already gone through the **reconsideration** process.

## Request to Appeal

1. The Provider or his/her designee may request an appeal in writing within 60 days from the claim reconsideration denial date.
2. Detailed information and supporting written documentation should accompany the appeal.
3. The appeal may be submitted by:
  - Facsimile: (757) 687-6232 or (866) 472-3920
  - Mail: OBH/Optima Health Provider Appeals Department  
P O Box 62876  
Virginia Beach, VA 23466

1. The Appeals Coordinator will thoroughly research and gather all relevant documentation including, but not limited to, claims processing history, scanned documents from the I-Max database, denial codes, medical records, operative notes, etc.
2. The following individuals may review each case: the Appeals Coordinator, Appeals Manager or Team Coordinator, Medical Director, Provider Contract Manager, and a Certified Professional Coder.
3. A decision will be rendered within forty-five (45) business days of receipt of the appeal request.
4. If the decision is made to reverse the payment decision, the Provider Appeals Coordinator will forward the information to the Claims Department for processing as appropriate.

5. Written notification of the OBH **final** decision will be sent to the Provider within ten (10) business days from the date of the decision.

### **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. For more information please see the Member Appeals section of this manual.

### **Provider and Member Complaints**

OBH is committed to achieving and maintaining member and practitioner satisfaction. Some of the ways OBH accomplishes this is through timely reporting, documenting, tracking, reviewing, and resolving complaints. Specifically, complaints about practitioners, practices, and facilities, which relate to quality of clinical care or access to care issues are monitored. This process helps us to obtain important feedback from providers and members about our services and identify opportunities for improvement.

If a provider or member is dissatisfied with some aspect of care, the provider or member can file a complaint and/or request an inquiry to our Customer Service Department at (757) 552-7174 or toll free at (800) 648-8420. An inquiry is a question about care or service, while a complaint is a statement of dissatisfaction.

If a patient complains to OBH about some aspect of the care you have provided, it is your responsibility to participate in the internal OBH complaint process and the resolution efforts by providing necessary information and/or responses in a timely manner as requested.

If a member is dissatisfied with some aspect of care, he or she (or a designated representative) may contact Customer Service to present the concern. A member may either present the concern as an inquiry or make a complaint to our Customer Service Department at (757) 552-7174 or toll free at (800) 648-8420. An inquiry is a question about care or service, while a complaint is a statement of dissatisfaction.

As a provider you may be the first to be aware of a customer's concern. Please help us to facilitate customer satisfaction and maintain the integrity of our programs by encouraging the customer to contact us with any questions and concerns.

Our Customer Service Representatives will be happy to assist you with this process. Please call us at toll free at (800) 648-8420 or (757) 552-7174.

### **Credentialing and/or Denial of Credentialing**

OBH's Credentialing Committee reviews all practitioner applications for credentialing and recredentialing. The Committee then votes to approve or deny an applicant's participation in OBH's practitioner network based on all available information. (Note: OBH is prohibited from discriminating against any practitioner applicant on the basis of age, race, gender, religion, national origin or other illegal criteria.) After the Committee makes a final decision regarding participation or continued participation in OBH's network, practitioner applicants are informed if the practitioner's application is denied or if the practitioner's application is approved.

In order to ensure the quality of our network practitioners and the integrity of our community image, OBH may at times deny, suspend or terminate the network participation of practitioners or practitioner's applications.

If a practitioner's application for credentialing or recredentialing is denied, he or she will be sent the process for appeal of the decision.

### **Suspension of Network Participation**

Summary suspension of practitioner network participation may be invoked by the OBH Medical Director or his/her designee for sufficient cause. The summary suspension will be documented in writing to the practitioner. The practitioner will be required to respond in writing to facilitate an ongoing agreement for continuing care or continued suspension. The provider may submit a letter to appeal any adverse determination.

## **FAIR BUSINESS PRACTICE ACTS (FBPA)**

In accordance with the OBH Provider Contracts and FBPA, if a specific policy or procedure is not outlined in your contract, or in this manual, OBH will make this information available within Ten (10) business days of a Provider's written request for information. Providers may contact their Network Educator or Contract Manager to request copies of specific policies.

In addition, providers may contact the Provider Services (number on page 2) during normal business hours to determine in advance if services to be provided are covered and medically necessary.

## **HIPAA PRIVACY STATEMENT**

### **Confidentiality**

OBH is committed to ensuring fair and ethical practices and to affirming the right of complete confidentiality for all members served by OBH or its contracted practitioners. When providing services to a OBH member, contracted practitioners are expected to provide services consistent with the standards of their licensing board and national professional associations. In addition, practitioners are expected to protect client confidentiality as required by state and federal laws. Practitioners are also expected to be in compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) rules and regulations.

OBH is in compliance with the Privacy Rule and Security Rule under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). To ensure the protection of confidential information and patient health information, OBH 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.

## **AFTER HOURS NURSE TRIAGE PROGRAM**

The After Hours Nurse Triage Program provides an avenue of care for Plan 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 them 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 room or an urgent care center, Sentara Behavioral Health may retrospectively review the visit for payment determination.

### **Benefits**

Physicians benefit from the program in a number of ways:

- Patients will appreciate your providing this additional benefit to their health-care.
- 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.
- After a patient contact, After Hours nurses will fax a copy of the assessment sheet to the physician.

### **Information**

Information about the program and how to use it is available for offices to distribute to patients. Call Provider Relations at 1-800-229-8822 (toll free) or 757-552-7474 to have a representative send a supply. Magnets and cards with the program's phone number and hours are also available.

### **Telephone Number and Hours**

Members may be directed to their ID cards or [www.optimahealth.com](http://www.optimahealth.com) for telephone contact numbers. The program is available from 5 p.m. to 8 a.m. Monday through Friday and 24 hours a day on weekends and holidays.

### **Exception**

Certain self-funded groups may not participate with OBH's After Hours program. ID cards for those groups do not list the After Hours Program.

# OPTIMA FAMILY CARE/FAMIS

## Medallion II

Medallion II, also called FAMIS Plus for Children, is a Virginia Department of Medical Assistance Services (DMAS) program for Medicaid enrollees that operates in numerous localities throughout the Commonwealth of Virginia. Enrollees in specified eligibility categories in Medallion II localities must enroll with one of the Medicaid-contracted managed care organizations (MCOs) available in those localities. Optima Family Care was one of the first managed care organizations to participate in the Medallion II Program in 1995. This successful program continues to expand within Virginia. The following groups are **excluded** from enrollment in Medallion II:

- Those who are approved by DMAS or its designee for some waiver programs.
- Those who are admitted to a state mental health institution, hospice or a nursing home (Family Care members only, hospice care does not exclude FAMIS members from coverage)
- Those who are involved in a foster care program
- Those who are involved in Spend-down
- Those who are otherwise exempted from enrollment by DMAS

## FAMIS

FAMIS stands for Family Access to Medical Insurance Security. FAMIS is Virginia's program that helps families provide health insurance to their children who do not have health insurance. Providers who participate with Optima Family Care automatically participate with FAMIS. Providers do not need to sign an additional or separate contract with Optima Health to provide care to FAMIS members. FAMIS reimbursement is identical to that of Optima Family Care.

## Enrollment

The Virginia Department of Medical Assistance Services (DMAS) uses Enrollment Brokers to provide enrollment services for Medallion II Medicaid and FAMIS members. DMAS contracts with MAXIMUS for Medicaid enrollees and Affiliated Computer Services (ACS) to provide enrollment services for FAMIS enrollees. The Enrollment Brokers provide basic information about MCOs to recipients who request it. They have information on hand about the provider and hospital networks of each MCO. They also have information about special services offered by the MCOs such as adult vision care, dental care and disease management programs. Upon request, recipients will receive an MCO comparison chart. This chart is also mailed to all new Medallion II eligible recipients in an effort to help them make an informed decision when choosing their MCO.

Medallion II Medicaid eligible recipients may enroll in an MCO such as Optima Family Care by calling the Managed Care Help Line at 1-800-643-2273. During the call, a representative will help the eligible select a PCP who participates with the HMO they

choose. MAXIMUS representative will also conduct a brief health risk assessment on the individual. These assessments are forwarded to the HMO at the first of each month along with a membership list of new HMO members.

Eligible recipients interested in enrolling in FAMIS may call the FAMIS Central Processing Unit (CPU) at 1-866-873-2641 or visit the FAMIS web site at [www.famis.org](http://www.famis.org) to request an application. FAMIS applications are also available at local Department of Social Services (DSS) offices.

Enrollees have the right to change from one plan to another plan for any reason during the first ninety (90) calendar days following the effective date of enrollment. Enrollees may disenroll from a plan at any time for good cause. The request must be in writing to DMAS. The Department will define the reasons under which good cause may exist. Eligibility verification for Optima Family Care and FAMIS members is handled the same as for other Optima Health members by accessing [www.optimahealth.com](http://www.optimahealth.com) or by calling Provider Relations.

### **Benefits**

General benefit information for Optima Family Care and FAMIS is available at [www.optimahealth.com](http://www.optimahealth.com) or for more specific behavioral health benefits you may call your provider relations representative at 1-877-687-6297.

### **DMAS Contract Requirements**

As a contracted provider for Optima Family Care/FAMIS you have agreed to abide by all rules and regulations in the contract between OBH and DMAS. Specific requirements that relate to compliance with the DMAS Contract, CMS regulations and any other relevant state and federal laws or regulations include but are not limited to:

1. You agree to provide medical services to all populations identified as eligible by DMAS and to comply with all non-discrimination requirements of the DMAS agreement.
2. You must be Medicaid certified and cannot be excluded from participation in Medicare or state health care programs.
3. No terms of your agreement are valid which terminate legal liability of OBH in the DMAS Contract.
4. You agree to participate in and contribute required data to OBH quality improvement and other assurance programs.
5. You agree to abide by the terms of the OBH contract for timely provision of emergency and urgent care. Where applicable, you agree to follow those procedures for handling urgent and emergency care cases stipulated in any required hospital/emergency department Memorandums of Understanding signed by OBH in accordance with the DMAS contract.
6. You agree to submit OBH utilization data in the format specified by OBH, so OBH can meet DMAS specifications.
7. You agree to clearly specify referral approval requirements to your participating providers and/or any subcontractors.
8. You agree not to charge Medicaid enrollees for missed appointments.

9. You agree not to bill a Medicaid enrollee for medically necessary services covered under the DMAS contract and provided during the enrollee's period of OBH enrollment. This provision shall continue to be in effect even if OBH becomes insolvent. However, if an enrollee agrees in advance of receiving the service, and in writing, to pay for a non-Medicaid covered service, then OBH, an OBH provider, or an OBH subcontractor can bill.

10. You shall promptly provide or arrange for the provision of all services required under the provider agreement. This provision shall continue to be in effect for subcontract periods for which payment has been made even if the provider becomes insolvent until such time as the enrollees are withdrawn from assignment to the provider.

11. Except in cases of death or illness, you agree to notify OBH at least thirty (30) days in advance of disenrollment and agree to continue care for your panel enrollees for up to thirty (30) days after such notification, until another PCP is chosen or assigned. Per the provider contract, you agree, upon termination, to provide covered services to covered persons hospitalized or under ongoing treatment until such hospitalization or treatment terminates or until covered person's care can be arranged.

12. You agree to act as a PCP for a predetermined number of enrollees.

13. PCPs agree to provide comprehensive, periodic health assessments, or screenings, which meet reasonable standards of practice, as specified in the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) medical periodicity schedule established by DMAS.

14. You agree to report members you suspect of fraud and abuse by calling Provider Relations or the OBH Fraud and Abuse Hotline.

15. You agree to provide representatives of OBH, as well as duly authorized agents or representatives of the Department, the U.S. Department of Health and Human Services, and the State Medicaid Fraud Unit access to your premises and your contract and/or medical records in accordance with the DMAS contract. You agree otherwise to preserve the full confidentiality of medical records in accordance with the DMAS contract.

16. You agree to comply with all record retention and maintenance requirements, including but not limited to:

- Medical records must be made available to recipients and their authorized representatives within ten (10) working days of the record request.
- Copies of medical records must be forwarded to OBH within (10) working days of OBH's request.
- For EPSDT services, the medical record shall indicate which age-appropriate screening was provided in accordance with the periodicity schedule (Optima Family Care only):

1) Comprehensive health and developmental history, including assessment of both physical and mental health development

2) Comprehensive unclothed physical examination including vision and hearing screening, dental inspection, nutritional assessment, review and administration of appropriate immunizations according to age, health history and the schedule established by the Advisory Committee on Immunization Practice (ACIP)

3) Appropriate laboratory tests according to the recommendations of DMAS and health assessment of the individual. Minimum tests shall include hemoglobin/hematocrit/EP, hereditary/metabolic screening, urinalysis, tuberculin test for high risk groups, blood lead testing in accordance with EPSDT periodicity schedules and guidelines using blood level determinations as part of scheduled

periodic health screenings appropriate to age and risk and in accordance with the EPSDT schedule. All testing shall be done through a blood level determination. Results of lead testing, both positive and negative, shall be reported to the Virginia Department of Health, Office of Epidemiology.

4) Health education/anticipatory guidance

5) Referral for further diagnosis and treatment or follow-up of all correctable abnormalities uncovered or suspected.

17. You agree to obtain and document the consent form of 42 C.F.R. §441.259 prior to the performance of any sterilization, and to comply with the thirty (30) calendar day waiting period requirement as specified in Code of Virginia, §54.1-2974.

18. You agree to ensure confidentiality of family planning services in accordance with the DMAS contract, except to the extent required by law, including, but not limited to, the Virginia Freedom of Information Act.

19. You agree to advise every pregnant member of the value of HIV testing and agree to request consent to such testing as set forth in §54.1-2403.01 of the Code of Virginia. Any pregnant member may refuse consent to HIV testing and any recommended treatment. You agree to document refusal in the patient's record.

20. You agree to provide contract services to Optima Family Care and FAMIS members in the same manner as you provide those services to all non-Medicaid enrollees.

21. You understand that therapeutic abortion is not covered by Optima Family Care but by DMAS. File all abortion claims directly with DMAS, attaching the Abortion Certification Form (DMAS form #3006). FAMIS requests should go to Optima Medical Care Services at 1-800-229-5522 or 757-552-7540.

22. Where applicable, you agree to provide care according to the following appointment standards:

- Emergency: Immediately upon request
- Urgent: 24 hours
- Symptomatic: 1 week
- Routine: 30 days (does not apply to routine physicals or appropriate monitoring of chronic conditions)
- Initial Prenatal Care:
  - First trimester: 14 days
  - Second trimester: 7 days
  - Third trimester: 3 days
  - High-Risk 3 days or immediately if emergency

23. You agree to assist enrollees with their special needs which include knowledge deficit of managed care, health maintenance practices and preventive care services and communication challenges due to lack of language, lack of consistent phone services and frequent changes in home address. You may render assistance by referring members to Medical Care Services or Member Services. You may also refer members to community resources such as WIC, Head Start and Early Intervention. Lack of access to transportation affects access to and delivery of medical services. You agree to arrange transportation by approved Optima Family Care transportation providers.

24. You agree to assist enrollees who are potentially eligible for Early Intervention Services with referral to local interagency councils.

25. You agree to cooperate with the external review organization contracted by DMAS to perform quality studies. In addition to the Member Rights and Responsibilities listed in the Office Visit Procedures and Member Resources section of this manual, Optima Family Care has the following additional member rights:

- While receiving health care services there will be no discrimination based on race, ethnicity, national origin, religion, sex, age and mental or physical disability.
- Upon request, members shall receive a copy of the Plan's Practice Guidelines.
- Members shall be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation.
- Members may obtain from the Plan information on how providers are paid. The MCO is prohibited from providing incentives for denials, limiting or discontinuing medical services.
- Members have the freedom to exercise their member rights and expect that they will not be negatively affected by the Plan and its providers by exercising those rights.

### **Optima Family Care Transportation Program**

Optima Family Care covers non-emergency transportation for eligible members for medical appointments as well as emergency transportation. If an Optima Family Care member has no other means of transportation, transportation will be provided to and from a medical appointment with a participating provider.

OBH has contracted with a vendor to administer the transportation program (taxi and wheelchair) for Optima Family Care. The current vendor is LogistiCare. The member is expected to call 1-877-892-3986 five (5) days in advance of a scheduled medical appointment to have the transportation arranged and pre-authorized. LogistiCare does not cover scheduled ambulance/stretchers transportation. Non-emergency ambulance/stretchers is approved and arranged by Optima Medical Care Services for Optima Family Care members.

FAMIS members do not have coverage for non-emergency transportation. For more information regarding transportation, please call 1-877-892-3986 (toll free).

# **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 health care program requirements.

## **Confidentiality**

Information designated as confidential should not be discussed with anyone other than on a "need to know" basis. In addition, agents and vendors have a responsibility to avoid disclosure of non-confidential internal information about the company, its employees, its clients and its business associates unless specifically authorized by the company.

## **Business Information**

Optima Health considers its pricing information, pricing policies, terms, market studies, business or strategic plans, and any other similar information to be confidential. The sharing of information with competitors is a highly sensitive matter, particularly where that information could form the basis of a pricing agreement.

All bids or proposals should be accurate, complete and directly responsive to the prospective customer's request, and may not contain any information that is false or intentionally misleading.

## **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, 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 Anti-Kickback Act of 1986 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, reflect the services and care provided to members, and are justified by documentation. Optima Health agents and vendors are required to report any potential or suspected improper billing practices or violations of standard billing practices or of company policies and procedures.

## **False Claims**

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

The Federal False Claims Act covers fraud involving any federally funded contract, including Medicare and Medicaid. Liability is established for any person who knowingly presents or causes a false or fraudulent claim for payment by the U.S. government. “Knowingly” is defined as a person having actual knowledge of false claim information and acting in deliberate ignorance or reckless disregard of the information. Healthcare providers violating the Federal False Claims Act can be subject to civil monetary penalties ranging from \$5,500 to \$11,000 per false claim and three times the amount of the government’s damages.

**The Criminal Penalties for Acts Involving Federal Health Care Programs provides for felonious criminal penalties and a fine of not more than \$25,000 and/or imprisonment for not more than five years for whomever makes false statements or submits false claims.**

Any Optima Health contractor, agent, or vendor who is aware of or suspects any false report or document, false claim, improper billing practices, or violations of company policies and procedures must report their concern to the Optima Compliance Committee or to the Optima 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 health care program or other health care plan.

The Deficit Reduction Act of 2005 became effective on January 1, 2007 and requires health care 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; co-payment 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 health care 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.

## **Agents and Vendors with Contracts Providing Services to Medicare Recipients**

- (1) All agents and vendors with contracts to provide services to Medicare recipients agree to comply with the following requirements:
  - (a) ***Must adopt and maintain arrangements satisfactory to CMS and Optima to protect enrollees from incurring liability for payment of any fees that are the legal obligation of Optima.***
  - (b) Shall not hold any beneficiary enrollee liable for payment of any such fees; and
  - (c) Shall indemnify the beneficiary enrollee for payment of any fees that are the legal obligation of Optima.
- (2) All such agents and vendors agree that HHS, the Comptroller General, or their designees have the right to inspect, evaluate, and audit any pertinent contracts, books, documents, papers, and records of involving transactions related to CMS' contract with Optima.
- (3) All such agents and vendors agree that HHS', the Comptroller General's, or their designee's right to inspect, evaluate, and audit any pertinent information for any particular contract period exists through 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later.
- (4) All such agents and vendors agree that any services or other activity performed by the company shall be consistent and comply with Optima's contractual obligations under its contract with CMS.
- (5) All such agents and vendors understand and agree that Optima shall monitor the company's performance on an ongoing basis and may terminate this Agreement if Optima or CMS determines that the company is not satisfactorily performing its delegated activities and reporting responsibilities under this Agreement.
- (6) All such shall comply with all applicable Federal laws, regulations, and CMS instructions in performing its obligations under this Agreement.
- (7) All such agents and vendors agree that this Agreement may be amended to include other terms and conditions as CMS may find necessary and appropriate.