

OPTIMA HEALTH PROVIDER MANUAL

OPTIMA MEDICARE HMO

SUPPLEMENT

This supplement is provided for Providers that Participate with Optima Medicare. Optima Medicare is a Medicare Advantage HMO product available in select service areas in the commonwealth of Virginia. Information in this supplement details additional information and exceptions that are specific to Optima Medicare HMO. Unless otherwise indicated in this supplement, information in the core Provider Manual applies to Optima Medicare as well as Optima Health Commercial plans. Please continue to refer to the core Provider Manual for policies and procedures not addressed in this supplement and contact your Network Educator for questions regarding Optima Medicare.

The Optima Medicare HMO offers Medicare Members a physician-led team approach to delivering the care seniors need. Support by a care manager helps coordinate medications, routine health screenings, doctor visits, and treatments. A patient-focused care team enables the patient to get to know their care manager, doctors, and other care providers over the long term.

TABLE OF CONTENTS

	PAGE
Product Overview	4
Member Identification and Information	
Identification Cards	6
Eligibility Verification	7
Optima Medicare Member’s Rights and Responsibilities	7
Member Services	9
Providers	9
Additional/Ancillary Services for Optima Medicare HMO	
Acupuncture	9
Alcohol Misuse Screening	9
Audiology Services	10
Chiropractic	10
Dental	10
Disposable Medical Supplies	10
Durable Medical Equipment	10
Gynecological Care	10
Hospice	10
Medical Nutrition	11
Obesity Screening	11
PT/OT/ST	11
Prosthetic Device Benefit	11
Smoking and Tobacco Use Cessation	11
Therapeutic Massage	12
Transportation Program	12
Vision Coverage	12
Welcome to Medicare Preventative Visit	12
Pharmacy	
Formulary	13
Medicare Part B Prescription Drugs	13
Medicare Part D Prescription Drugs	13
Utilization and Quality Assurance Program Information	13
Medication Therapy Management Program Information	15
Mail Order Prescription Drug Program	16
Coverage Exclusion and Limitations	16
Member Transition Process	19
Creams and Ointments	19
Days Supply Dispensing Limitations	19
Diaphragms	19
Laboratory Services	
Reference Lab Providers	19

Laboratory Draw Sites	20
Reimbursement	
Medicare HMO Claim Policies	20
Billing and Payments	
Contracted Amounts/Billing Covered Persons	20
Timely Filing Policy	21
Dual Eligible Members with Both Medicare and Medicaid	21
Optima Medicare Coordination of Benefits (COB)	21
Electronic Claims Filed With Zero Charge Amounts	21
Denied Claim Payment Reconsiderations and Appeals	21

PRODUCT OVERVIEW

Optima Health offers two Medicare HMO plans in the following counties: Alexandria City, Arlington, Charles City, Charlotte, Chesapeake City, Danville City, Fairfax, Fairfax City, Falls Church City, Franklin City, Gloucester, Halifax, Hampton City, Isle of Wight, James City, Loudoun, Mathews, Mecklenburg, Newport News City, Norfolk City, Pittsylvania, Poquoson City, Portsmouth City, Prince William, Suffolk City, Surry, Sussex, Virginia Beach City, Williamsburg City, York. Optima Medicare HMO plans are offered by Optima Health Plan, a Medicare Advantage Health Maintenance Organization (HMO) that contracts with the Federal government. Product offerings, designs and service areas are subject to annual review each calendar year.

The following grid shows general information for Medicare HMO products offered by Optima Health as of January 2020:

MEDICARE HMO PLAN TYPES Offered by Optima Health Plan		
<u>Optima Medicare HMO Plan Types:</u> <ul style="list-style-type: none"> • No referrals required • Primary Care Physician (PCP) selection required • No out-of-network coverage except care provided in an Emergency Department • Some services require prior-authorization 		
Product Name	Description	Features
Optima Medicare Value HMO	<ul style="list-style-type: none"> • Standard HMO type Medicare Advantage plan • Original Medicare benefits plus additional enhanced benefits 	<ul style="list-style-type: none"> • No Copayments for Primary Care Services and Original Medicare covered Preventive Services • Includes Copayments for Specialist services • Generally higher Copayments than Medicare Prime HMO plan


<p>Optima Medicare Prime HMO</p>	<ul style="list-style-type: none"> • Standard HMO type Medicare Advantage plan • Original Medicare benefits plus additional enhanced benefits. 	<ul style="list-style-type: none"> • No Copayments for Primary Care Services and Original Medicare covered Preventive Services • Includes Copayments for Specialist services • Generally lower Copayments than Medicare HMO Value plan
<p>Optima Medicare Classic HMO</p>	<ul style="list-style-type: none"> • Standard HMO type Medicare Advantage plan • No Part D coverage • Original Medicare benefits plus additional enhanced benefits. 	<ul style="list-style-type: none"> • No Copayments for Primary Care Services and Original Medicare covered Preventive Services • Includes Copayments for Specialist services • Generally higher Copayments than Medicare HMO Prime plan

MEMBER IDENTIFICATION AND INFORMATION

Optima Medicare HMO Member ID Cards

The Optima Medicare HMO identification card is for identification purposes only and does not verify eligibility or guarantee payment of Covered Services. Medicare HMO Members should present their card at the time of service. The sample card shown below is representative of the Member ID card.


Optima Medicare HMO Member ID Card Sample

Product Name Indicates Medicare Plan → Optima Health 
Optima Medicare Value (HMO)

Indicates Member ID# → Member Name: John Doe Sample
Member Number: 999999999*01
Rx Group Number: MAPDVRX
Effective Date: 01/01/20XX
Issuer: 80840

For Pharmacy Use When Filing a Claim → Part B and Part D Rx
RxBin: 610011
RxPcn: CTRXMED0

OV: \$0
SOV: \$30
UCC: \$30
ED: \$90

Medicare RX designation – Part D and Medicare RX logo. → MedicareRx
Prescription Drug Coverage 
H2563-003

Services Requiring Pre-Authorization (Not All-Inclusive) → Detailed benefit information at optimahealth.com and our mobile app

This card is used to obtain covered benefits. Present this card each time you seek health care services. Preauthorization may be required for: hospitalization, outpatient surgery, therapies, advanced imaging, DME, home health, skilled nursing, acute rehab, or prosthetics. If admitted to the hospital, please notify Optima Medicare within 48 hours of your admission.

MEMBER SERVICES: *(Translation Services Available)* 757-687-6160 OR 1-800-927-6048
1-866-603-7514 TTY 711
PHARMACY MEMBER SERVICES
NURSE ADVICE LINE: 757-552-7250 OR 1-800-394-2237
DOMINION NATIONAL MEMBER SERVICES: 1-888-291-6924
MEDICAL PRE AUTHORIZATION: 757-552-7540 OR 1-800-229-5522
MDLIVE: 1-866-648-3638
TTY Virginia Relay Service: *(Hearing Impaired)* 711 OR 1-800-828-1140
BEHAVIORAL HEALTH PRE AUTHS: 757-552-7174 OR 1-800-648-8420

MAIL BILLS AND/OR CLAIMS FOR SERVICES TO:
MEDICAL CLAIMS P.O. Box 5028 Troy, MI 48007-5028
BEHAVIORAL HEALTH CLAIMS P.O. Box 1440 Troy, MI 48099-1440

An HMO plan offered by Optima Health Plan

Eligibility Verification

Medicare Members may only change plans during the Medicare Annual Enrollment Period unless they qualify for a Special Election Period (SEP). Optima Medicare HMO Providers may access Provider Connection or call the Optima Health Interactive Voice Response (IVR) System 24 hours a day, seven days a week for rapid up-to-date eligibility verification. To view eligibility information online, log in to the secured Provider Connection site on the Provider Web Portal. To use the IVR System, call Provider Relations at the number on the Contacts page of the core Provider Manual. There are two options available to search for a Member:

Press 1 To enter Optima Health Member ID number

Press 3 To enter HCIN number

The IVR System provides:

- The Optima Health Member ID number if a HCIN number is used to search for the Member.
- Member's "eligible as of" or "terminated as of" date when applicable
- Member's Group number
- Primary Care Physician's (PCP) name when applicable

Specific Copayment and benefit information is available 24 hours a day on the Provider Web Portal or by speaking with a Provider Service Representative during business hours.

Optima Medicare Member's Rights and Responsibilities

Policy Statement:

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

Members Have the Right:

- To be treated with respect, dignity, and compassion and the right to privacy by Optima Health personnel, network doctors, and health care professionals
- To exercise these rights regardless of race, physical or mental ability, ethnicity, gender, sexual orientation, creed, age, religion or their national origin, cultural or educational background, economic or health status, English proficiency, reading skills, or source of payment for their care. Members should expect this right by both the Plan and contracting physicians
- To receive information about their health plan, its services, physicians, other health care professionals, facilities, and clinical guidelines
- To privacy and confidentiality for treatments, tests and procedures received.
- To voice concerns about the service and care received
- To register complaints and appeals concerning the health plan and the care provided
- To receive timely responses to concerns

- To participate in a candid discussion with doctors and other health care professionals in decision-making about medically appropriate treatment options and planning for conditions, regardless of cost or benefit coverage
- To be provided with access to doctors, health professionals, and health care facilities
- To receive information about and refuse to participate in, any experimental treatment
- To have coverage decisions and claims processed according to regulatory standards, when applicable
- To choose an Advance Directive to designate the kind of care the member wishes to receive should he become unable to express his wishes
- To have the right to inspect and copy, amend, request an accounting, and request restrictions to medical information that Optima Health creates
- To make recommendations regarding member rights and responsibilities
- To affirm that practitioners, providers, and employees:
 - Make utilization management decisions based on appropriateness of care, services, and existence of coverage;
 - Do not reward practitioners or other individuals for issuing medical denials of coverage; and
 - Do not encourage decisions that result in underutilization through financial incentives
 - Participate in understanding the member's health problems and assist in developing mutually agreed-upon treatment goals.

Members Have the Responsibility:

- To know and confirm benefits before receiving treatment
- To contact an appropriate health care professional when there is a medical need or concern
- To show their ID card before receiving health care services
- To pay any necessary copayment at the time they receive treatment
- To use emergency room services only for injury or illness that, in the judgment of a reasonable person, requires immediate treatment to avoid jeopardy to life or health
- To keep scheduled appointments
- To provide information needed for their care
- To follow agreed-upon instructions and guidelines of physicians and health care professionals
- To participate in understanding of health problems and developing mutually agreed-upon treatment goals
- To notify Optima Health of any changes to personal contact information
- To call Member services when there is a question about eligibility, benefits, claims, appeals, etc.
- To read and be aware of all materials distributed by Optima Health explaining policies and procedures regarding services and benefits

Optima Medicare Member Services

Medicare HMO Member Services (1-800-927-6048) and the free TTY/TTD phone line (1-800-828-1140 or 711) are available to Optima Medicare Members from 8:00 am to 8:00 pm ET 7 days a week from October 1 through March 31 and from 8:00 am to 8:00 pm ET, Monday through Friday, April 1 through September 30. On Thanksgiving Day, Christmas Day, weekends and holidays from February 15, through September 30, only the interactive voice response system is available on the regular Member Services phone number. These phone numbers are published in the member materials and assist the members in contacting the Plan with questions regarding their health plan benefits, eligibility, claims, behavioral health services, or any other questions/information related to their health plan benefit coverage.

PROVIDERS

Medicare Provider Participation Requirement

All Optima Health Medicare HMO Providers must be enrolled as Medicare providers as a requirement of participation. Any provider who has “opted out” of Medicare is not eligible to participate in the Optima Medicare HMO.

Non-Participating Providers

Optima Medicare HMO Plans will not pay if services are provided to the Optima Medicare Member by a non-Participating Provider.

ADDITIONAL/ANCILLARY SERVICES FOR MEDICARE

Acupuncture Services

Acupuncture visits are covered at a maximum of fifteen visits a year. An acupuncture provider search feature and additional provider information for the Medicare HMO Acupuncture Network is available on the Provider Web Portal. Optima Health contracts with American Specialty Health (ASH) for Medicare HMO acupuncture services. For billing and reimbursement information refer to the ASH guidelines

Alcohol Misuse Screening

Alcohol misuse screening is covered for adults with Medicare (including pregnant women) who misuse alcohol, but are not alcohol dependent. If the screening is positive for alcohol misuse, a qualified primary care physician or practitioner in a primary care setting may provide up to 4 brief face-to-face counseling sessions per year.

Audiology Services

Medicare HMO benefits for Audiology services vary based on the Medicare HMO plan purchased. Prior-authorization is required for hearing aids when covered by the Medicare HMO plan. Prior-authorization is not required for Medicare-covered diagnostic hearing exams.

Chiropractic Services

Medicare-covered chiropractic visits for manual manipulation of the spine to correct subluxation are covered. A chiropractic provider search feature and additional provider information for the Medicare HMO Chiropractic Networks are available on the Provider Web Portal. Optima Health contracts with American Specialty Health (ASH) for Medicare HMO chiropractic services. Prior-authorization for chiropractic services is obtained from ASH. For billing and reimbursement information refer to the ASH guidelines.

Dental Coverage

Optima Medicare HMO plans include some dental services. Dental services are provided by Dominion Dental. Every Medicare Advantage plan has an embedded routine dental benefit. Members have the option of purchasing additional supplemental dental coverage during the enrollment period if they choose too. Treatment of a dental accident is covered as a medical benefit under Medicare guidelines for the Optima Medicare HMO. The Dental Care Discount program does not apply to Medicare HMO Members.

Disposable Medical Supplies

Medicare-covered disposable medical supplies are covered according to Medicare guidelines.

Durable Medical Equipment (DME)

Pre-authorization is required for rentals, repairs, and for item charges greater than \$750.00. Medical Care Services will apply Medicare limitations for DME in the Optima Medicare HMO plan except in the case of rental equipment. When it is determined that the Member will require long term use of the equipment, purchase will be authorized, and the total rental amount will apply toward the purchase amount. Medicare HMO Members do not have a calendar year benefit maximum.

Gynecological Care

Cervical and Vaginal Cancer Screening is covered for Medicare HMO Members once every 2 years. Women at high risk are covered once a year.

Hospice Services

Optima Medicare HMO Members may receive care from any Medicare-certified hospice

program. Original Medicare coverage (rather than Optima Medicare HMO) pays for the hospice services. Optima Medicare HMO will continue to cover all other (non-hospice related) services.

Medical Nutrition

Medical nutrition therapy is covered when services are provided by Participating Providers. Prior-authorization is not required.

Obesity Screening and Therapy

Intensive counseling in a primary care setting is covered for Members that have a body mass index of 30 or more. This allows for coordination with the Member's comprehensive prevention plan.

Physical Therapy, Occupational Therapy and Speech Therapy (PT/OT/ST)

Optima Medicare HMO utilizes Medicare coding and payment methodologies for PT, OT, and ST. Prior-authorization is required.

There is no copay for physical therapy, occupational therapy or speech therapy when provided to Medicare HMO Members during an inpatient hospital stay or a home visit. When therapy is provided in an outpatient setting, such as a hospital outpatient department, independent therapist office or comprehensive outpatient rehabilitation facility, a Copayment applies.

Prosthetic Devices Benefit

Medicare-covered devices are covered with Copayments as stipulated by the Medicare HMO plan. Prosthetic devices are covered according to Medicare guidelines when appropriately prior-authorized by Clinical Care Services. Prior-authorization is required when requested item charges are greater than \$750.00.

Smoking and Tobacco Use Cessation

If the Medicare HMO Member uses tobacco but does not have a tobacco related disease, Members have coverage for two counseling quit attempts within a 12-month period that includes up to four face-to-face visits as a preventive service.

If the Medicare HMO Member uses tobacco and has a tobacco-related disease or is taking medicine that may be affected by their tobacco use, Optima Medicare HMO also covers cessation counseling services and provide two counseling quit attempts within a 12-month period, but the Member will pay the applicable cost sharing. Each counseling attempt includes up to four face-to-face visits.

Therapeutic Massage

Therapeutic Massage is covered as part of a non-opioid pain management treatment plan. A

massage provider search feature and additional provider information for the Medicare HMO Therapeutic Massage Networks are available on the Provider Web Portal. Optima Health contracts with American Specialty Health (ASH) for Medicare HMO Therapeutic Massage services. A referral is required for coverage of this benefit. For billing and reimbursement information, refer to the ASH guidelines

Transportation Program

Optima Medicare covers non-emergency transportation for eligible Members for medical appointments as well as emergency transportation. If an Optima Medicare HMO Member has no other means of transportation, transportation will be provided to and from a medical appointment with a Participating Provider for a maximum of 12 one-way trips per year.

Optima Health has contracted with Verida (formerly SoutheastTrans) to administer the Medicare transportation program (taxi and wheelchair). The Member should call 1-866-381-4860 five days in advance of a scheduled medical appointment to have the transportation arranged. Verida does not cover scheduled ambulance/stretchers transportation. Non-emergency ambulance/stretchers is approved and arranged by Optima Health Clinical Care Services for Optima Medicare HMO Members.

Vision Coverage

Vision benefits vary based on the Medicare HMO plan purchased. Medicare HMO Members receive preventive vision benefits through the Vision Vendor. Preventive vision services are not reimbursed under the medical plan and should be obtained by Members through their vision benefits.

Optima Medicare Members may obtain vision services to diagnose and treat diseases and conditions of the eye, through the Vision Vendor or Participating Optima Health Ophthalmologists or Optometrists.

Optima Medicare HMO Members also receive an allowance to purchase vision materials using the Vision Vendor.

Welcome to Medicare Preventive Visit

The Optima Medicare HMO covers the one-time “Welcome to Medicare” preventive visit available to all Medicare recipients within the first 12 months the Member has Medicare Part B.

In addition, Optima Medicare provides a New Member Health Risk Assessment screening for all new Optima Medicare HMO members. Screenings are most often performed in the Primary Care office, but may also be performed in the Member’s home during a scheduled face-to-face visit by

a Matrix Medical Network clinician. Matrix is a vendor contracted with Optima Medicare to assist with these screenings. Matrix will communicate any Member care management needs directly to the Optima Health Case Managers or the Primary Care Physician as appropriate.

PHARMACY

Formulary

The Formulary is called the Optima Medicare Formulary (List of Covered Drugs).

The Formulary:

- Provides quantity, form, dosage, and prior-authorization restrictions for certain drugs;
- Requires generic drug prescription usage whenever possible. These drugs are listed with the generic name on the Medicare Formulary. If a Member requests a brand name drug when a generic drug is available, the Member may be responsible for additional charges;
- Provides a framework and relative cost information for the management of drug costs;
- Copies are available on the Provider Web Portal with quarterly updates. Updates also appear in *Network News*, the Provider newsletter.

Medicare Part B Prescription Drugs

Members receive coverage for drugs covered under Part B of Original Medicare through their Optima Medicare HMO plan.

Medicare Part D Prescription Drugs

Optima Medicare HMO plans provide a five-tier Copayment structure. Copayments vary depending on the tier in which the prescription drug falls. Tiers include:

- **Tier 1:** Preferred generic drugs
- **Tier 2:** Non-preferred generic drugs
- **Tier 3:** Preferred brand drugs
- **Tier 4:** Non-preferred brand drugs
- **Tier 5:** Specialty drugs

Utilization and Quality Assurance Program Information

Optima Medicare works with physicians to ensure members get the most appropriate, safe, and cost-effective drugs. The Plan's Utilization Management and Quality Assurance program is designed to assure adverse drug events and drug interactions are avoided and ensure optimum medication use. The Utilization Management and Quality Assurance program is provided at no additional cost to members or providers.

Utilization Management and Quality Assurance programs incorporate tools to encourage appropriate and cost-effective use of Part D drugs. These tools include prior authorization, quantity limits, step therapy, additional charges and clinical interventions. Other tools may be used if necessary.

- PA = Prior Authorization. Optima Medicare requires physicians to get prior authorization for certain drugs.
- QL = Quantity Limits. For certain drugs, Optima Medicare limits the amount of the drug that it will cover. This may be in addition to a standard one-month or three-month supply.
- B/D= Some medications may not be billable under the Part D benefit. Various medications will need a determination whether it will be considered billable under Medicare Part B or Part D based on the medical use of the drug, situations depending on the drug form (e.g., inhalation, nebulizer, metered dose inhaler), or depending on the location where medication is administered (e.g. the same drug dispensed by a pharmacy is covered under Part B if provided as part of a service in a provider’s office, physician’s office or home).
- ST= Step Therapy. In some cases, Optima Medicare requires the Member to first try certain drugs to treat their medical condition before we will cover another drug for that condition. For example, if Drug A and Drug B both treat the Member’s medical condition, we may not cover Drug B unless the Member tries Drug A first. If Drug A does not work, Optima Medicare will then cover Drug B
- AN = Additional Charge. If Optima Medicare Members obtain a brand name drug when a generic equivalent is available, the Member will be required to pay the difference between the cost of the generic drug (which is paid by Optima Medicare) and the cost of the brand name drug in addition to the appropriate brand copay.
- NDS= Non-Extended Day Supply. Some medications are not available for 90-day supplies. This means that these medications can only be filled for 30 days or less.

Optima Medicare's formulary indicates if the drugs has Prior Authorization, Step Therapy, or Quantity Limit requirements. The formulary also indicates if additional charges may apply, if the drug requires a B versus D determination, or if the drug cannot be filled for more than a 30-day supply.

The Optima Medicare HMO product offers additional coverage of some prescription drugs not normally covered in a Medicare prescription drug plan (enhanced drug coverage). The chart below displays the drugs our plan covers under the enhanced drug coverage. The chart also displays the limitations for each drug and what the Member pays when they get a (30-day) supply of the drug.

Drug Name	Limits (QL= Quantity Limit)	Standard retail cost-sharing (in-network) (30-day supply)
Sildenafil (25mg, 50mg, 100mg)	QL (6 per 30 days)	\$12
Vitamin D2 capsules (50,000 IU)	QL (8 per 28 days)	\$0
Folic Acid tablets (1mg)	QL (30 per 30 days)	\$0

Benzonatate capsules (100mg, 200mg)	QL (60 per 30 days)	\$0
Guaifensin w/codeine syrup (100/10mg)	QL (120 ML per 30 days)	\$0

As part of the Utilization Management and Quality Assurance program, all prescriptions are screened to detect and address the following:

- drug-drug interactions that are clinically significant
- duplication of drugs (taking more than one drug in the same drug class)
- inappropriate drugs
- incorrect drug
- patient-specific drug contraindications
- over-utilization of drugs
- under-utilization of drugs
- abuse or misuse of drugs

A review of prescriptions is performed before the drug is dispensed. These are concurrent drug reviews and are clinical edits at the point-of-sale (at the pharmacy counter).

Retrospective drug utilization reviews identify inappropriate or medically unnecessary care. Optima Medicare performs periodic reviews of claims data to evaluate prescribing patterns and drug use that may indicate inappropriate use.

Physicians treating patients who are receiving potentially inappropriate drug therapy will receive provider-specific reports detailing the patient's drug utilization. The providers receive educational materials explaining the report and the intervention it addresses. The reports identify individual patients who may require evaluation, the reason for the report and options for the provider to consider.

Medication Therapy Management Program Information

Optima Medicare has a Medication Therapy Management Program (MTMP) that meets the Medicare Modernization Act requirements. Our Medication Therapy Management Program is approved by CMS for the program year. Members are eligible for Optima Medicare's Medication Therapy Management Program if they have at least 2 of the following conditions:

- Arthritis (Osteoarthritis and Rheumatoid Arthritis)
- Asthma

- Chronic Heart Failure
- COPD (chronic obstructive pulmonary disease)
- Depression
- Diabetes
- Dyslipidemia (high cholesterol)
- Hypertension (high blood pressure)

Members must also be taking four (4) or more Part D covered drugs and must be likely to exceed \$4,935 in annual costs for medications. Optima Medicare has a network of Optima Medicare Pharmacists that provide services for members eligible for the MTMP. While this program is not considered a benefit, members eligible for Optima Medicare's MTMP can receive these services at no cost to them. Members not eligible for the program can also receive the services but must pay the full cost to the participating pharmacy.

Mail Order Prescription Drug Program

Medicare Members may purchase a 63-90 day supply of drugs from Express Scripts Mail-Order Program. Physicians need only to call Express Scripts Mail-Order Program at 1-888-899-2653 to prescribe or ePrescribe.

Members can download and print the order form from our website. For more information on the mail order program, Members may call Express Scripts toll free at **1-888-899-2653**.

Coverage Exclusions and Limitations

If Medicare does not pay for a drug it will be excluded from coverage for Optima Medicare. The member is responsible unless the requested drug is found upon appeal to be a drug that is not excluded under Part D and Optima Medicare should have paid for or covered it because of the Member's specific situation.

Here are three general rules about drugs that Medicare drug plans will not cover under Part D:

- Part D drug coverage cannot cover a drug that would be covered under Medicare Part A or Part B.
- Drugs purchased outside the United States and its territories.
- Off-label use is usually not covered. "Off-label use" is any use of the drug other than those indicated on a drug's label as approved by the Food and Drug Administration. Generally, coverage for "off-label use" is allowed only when the use is supported by certain reference books. These reference books are the American Hospital Formulary Service Drug Information, the DRUGDEX Information System, and the USPDI or its successor. If the use is not supported by any of these reference books, then the Plan does not cover its "off-label use."

Also, by law, these categories of drugs are not covered by Medicare drug plans:

- Non-prescription drugs (also called over-the-counter drugs)
- Drugs when used to promote fertility
- Drugs when used for the relief of cough or cold symptoms
- Drugs when used for cosmetic purposes or to promote hair growth
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
- Drugs when used for the treatment of sexual or erectile dysfunction, such as Viagra, Cialis, Levitra, and Caverject
- Drugs when used for treatment of anorexia, weight loss, or weight gain
- Outpatient drugs for which the manufacturer seeks to require that associated tests or monitoring services be purchased exclusively from the manufacturer as a condition of sale

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

1. Medications that do not meet the Plan's criteria for Medical Necessity are excluded from Coverage.
2. Copayment and Coinsurance are out of pocket amounts the Member pays directly to the pharmacy provider for a Covered prescription drug. A Copayment is a flat dollar amount. A Coinsurance is a percent of Optima's Allowable Charge.
3. Prescriptions may be filled at a Plan pharmacy or a non-participating pharmacy that has agreed to accept as payment in full reimbursement from the Plan at the same level as the Plan gives to participating pharmacies.
4. All covered outpatient prescription drugs must have been approved by the Food and Drug Administration and require a prescription either by state or federal law. Medications with no approved FDA indications are excluded from Coverage.
5. Some drugs require Prior-authorization from the Plan in order to be covered. The Physician is responsible for obtaining Prior-authorization. Benefits for Covered Services may be reduced or denied for not complying with the Plan's Prior-authorization requirements.
6. At its sole discretion the Optima Health Pharmacy and Therapeutics Committee determines in which Tier a covered drug is placed. The Plan's Pharmacy and Therapeutics Committee is composed of Physicians and pharmacists. The committee reviews the medical literature and then evaluates whether to add or remove a drug from the preferred drug list. Efficacy, safety, cost, and overall disease cost are factors that are taken into consideration. The Pharmacy and Therapeutics Committee may establish monthly quantity limits for selected medications.
7. Diaphragms, intrauterine devices (IUDs), and cervical caps and their insertion are covered under the Plan's medical benefits.

8. All compounded prescriptions require prior-authorization and must contain at least one prescription ingredient. Compound prescription medications with ingredients not requiring a Physician's authorization by state or federal law are excluded from Coverage.
9. Non-durable disposable medical supplies and items such as bandages, cotton swabs, hypodermic needles, and durable medical equipment not listed as covered are excluded from Coverage.
10. Insulin, syringes, and needles are covered under the Pharmacy benefit. Diabetic supplies and equipment, in-person outpatient self-management training and education, including medical nutrition therapy, for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes, and noninsulin-using diabetes if prescribed by a health care professional legally authorized to prescribe such items under law, other than those listed as covered under the Pharmacy benefit, are covered under the Plan's medical benefit.
11. Prescription or over the counter appetite suppressants and any other prescription or over the counter medication for weight loss are excluded from Coverage.
12. Immunization agents, biological sera, blood, or blood products are excluded from Coverage.
13. Injectables (other than those self-administered and insulin) are excluded from the Pharmacy benefit.
14. Medication taken or administered to the Member in the Physician's office is excluded from the Pharmacy benefit.
15. Medication taken or administered in whole or in part, while a Member is a patient in a licensed Hospital is excluded from the Pharmacy benefit.
16. Medications for cosmetic purposes only, including but not Limited to Retin-A for aging, are excluded from Coverage.
17. Medications for experimental indications and/or dosage regimens determined by the Plan to be experimental are excluded from Coverage.
18. Replacement prescriptions resulting from loss, theft, or breakage are excluded from Coverage.
19. Therapeutic devices or appliances, including but not limited to support stockings and other medical/non-medical items or substances, regardless of their intended use, are excluded from Coverage.
20. Drug charges exceeding the cost for the same drug in a conventional packaging (i.e., convenience packages, unit doses, blister packs, etc.) are excluded from Coverage.
21. Infertility drugs are excluded from Coverage.
22. Benefits will not be denied for any drug prescribed, on an inpatient or outpatient basis, to treat a covered indication so as long as the drug has been approved by the United States Food and Drug Administration for at least one indication and the drug is recognized for treatment of the covered indication in one of the standard reference compendia or in substantially accepted peer-reviewed medical literature.
23. Benefits will not be denied for any drug, prescribed on an inpatient or outpatient basis, approved by the United States Food and Drug Administration for use in the treatment of cancer on the basis that the drug has not been approved by the United States Food and Drug Administration for the treatment of specific type of cancer for which the drug has been prescribed, provided the drug has been recognized as safe and effective for treatment of that specific type of cancer in any of the standard reference compendia.

24. Benefits will not be denied for any drug, prescribed on an inpatient or outpatient basis, approved by the United States Food and Drug Administration for use in the treatment of cancer pain for the reason that the dosage is in excess of the recommended dosage of the pain-relieving agent, if the prescription has been prescribed for a person with intractable cancer pain.

Member Transition Process

The Optima Medicare HMO provides a transition process for new Members who are taking drugs that are not on the formulary, current Members affected by a formulary change from one year to the next and Members that transition to a different level of care. A temporary supply of the non-formulary or coverage restricted drug may be authorized.

Creams and Ointments

A Medicare HMO Member may receive more than one tube of ointment or cream per prescription order or refill as long as it does not exceed a 90 day supply. If a prescription exceeds quantity limitations for a 90 day supply and the claim rejects, the pharmacist should call Pharmacy Authorizations. A Copayment per tube may apply.

Days Supply Dispensing Limitations

Optima Medicare HMO Members may receive up to a 90-day supply of a prescription at a retail pharmacy. A 90-day supply is interpreted as a consecutive 90-day supply.

Diaphragms

Diaphragms are not a Medicare pharmacy benefit.

LABORATORY SERVICES

Laboratory services for Optima Health Members may only be performed by Optima Medicare HMO contracted lab Providers. All laboratories, including Physician offices, participating with Optima Health, must have the appropriate CLIA certificate.

Reference Lab Providers

Any lab test not included on the “In-Office Lab” list must be sent to a Participating reference lab. Optima Medicare Participating Reference Laboratory Providers (current as of the printing of this manual) are as follows:

Hampton Roads Area Participating Reference Labs:

Sentara Reference Lab:

Client Services/Lab Results - 757-388-3621
Scheduling - 757-388-2030

Chesapeake Regional Medical Center Lab: 757-312-6118

Hampton Roads Area Specialty Lab:

EVMS: Specialty services only. Call for a list of procedures: 757-446-5972

Laboratory Draw Sites

Providers have the option of sending the Medicare Member with orders to a Participating reference laboratory draw site. Members and Providers may locate the nearest Participating Laboratory draw site by using the Provider Web Portal or by calling Optima Health Provider Relations.

REIMBURSEMENT

Medicare HMO Claim Policies

Optima Medicare HMO reimbursement and claim policies are based on those currently used by Medicare. Medicare policy and procedural information is available at <http://www.cms.gov/>. The CMS website can give your practice information regarding Medicare's National Correct Coding Initiative (NCCI) Edits.

BILLING AND PAYMENTS

Contracted Amounts/Billing Covered Persons

By entering into a Provider agreement with Optima Medicare, you have agreed to accept payment directly from us. This constitutes payment in full for the Covered Services you render to Medicare Members, except for Copayments, Coinsurance, Deductibles and any other monies listed in the "Patient Responsibility" portion of the remittance advice. **You may not bill Members for Covered Services rendered or balance bill Members for the difference between your actual charge and the contracted amount. In cases where the Copayment is greater than the allowed amount for services rendered, only the allowed amount for the services should be collected. Should you collect more than the allowed amount, you will be expected to refund the Member the difference of the two amounts.**

In order to bill a Medicare HMO Member for Non-Covered Services, the Member must have been informed in writing prior to receiving the service that the service is not covered under their Medicare HMO plan and must sign a waiver with Medicare approved language stating they are willing to pay for the service.

Timely Filing Policy

Optima Medicare timely filing requirements follow Medicare timely filing guidelines.

Dual Eligible Members with Both Medicare and Medicaid

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

Optima Medicare Coordination of Benefits (COB)

Typically members enrolled in the Optima Medicare HMO do not have Commercial Insurance coverage in addition to Medicare. It is possible for a member to have other coverage through their spouse. In the case of other coverage, Optima Medicare follows original Medicare guidelines for COB.

Electronic Claims Filed With Zero Charge Amounts

Electronic Medicare HMO claims may be submitted with zero charge amounts.

DENIED CLAIM PAYMENT RECONSIDERATIONS AND APPEALS

The standard Optima Health process for Pre-Service or Current Requests for Reconsideration of an Adverse Decision/Denial for Payment does not apply to the Optima Medicare HMO. The process for Optima Medicare HMO appeals, including the process for expedited determinations and appeals is outlined in detail in the Medicare Classic HMO, Medicare Value HMO and Medicare Value HMO Evidence of Coverage Documents (EOC) at www.optimahealth.com