Optum

2025
Optum Health
Administrative Guide

Optum Washington Network, LLC, d.b.a. Optum Care Network of Washington

Quick Reference Guide (QRG)

Welcome

Optum Washington Network, LLC, d.b.a. Optum Care Network of Washington is an organization that is delegated to perform certain functions on behalf of health plans. OCN has a local management team. This QRG provides an overview of information you will need when caring for members of this Optum network.

Portal Access and Digital Solutions

Website: **partner.optum.com/washington/**
Use our website to sign in to the Optum Care Provider Center, a tool that gives you access to eligibility, prior authorization, and claims information in real time. You'll also find our referral lookup tool, important forms and many other resources: **onehealthport.com**

- Check member eligibility status
- Complete prior authorization and referral management tasks for multiple health plans
- View individual claim submissions and submit claim inquiry
- Securely access health plan documents, policies and guides
- Attestation review and submission
- Secure messaging with teams from this Optum network

Forms and Resources

Optum.com > Business > Providers > Resources > **Forms and resources**

Credentialing and Health Care Professional Updates

Clinician request for credentialing: Clinicians requesting participation with this Optum network should contact their local Optum network account manager. Please ensure that your CAQH account is current and accurate to prevent delays in credentialing. (Note: Clinicians requesting participation with Optum should contact **OCNWAContracting@optum.com**.)
Health care professional updates: To make NPI, TIN, or clinician demographic updates, submit the Provider Group/Practitioner Change Form (found in the Appendix) to **credentialingpnw@optum.com**.
Credentialing questions: credentialingpnw@optum.com

Optum Care Service Center

Eligibility, claims/authorization status, general billing questions, prior authorization intake
Phone: **877-836-6806**, 8 a.m.–5 p.m. PT, Monday–Friday

Submitting a Claim
(see manual for additional health plan payer ID and addresses)

EDI: For electronic submissions, use payer ID **LIFE1**
Claims should be submitted electronically.

Paper claims, though not preferred, can be mailed to:
Optum Care Claims
PO Box 30788
Salt Lake City, UT 84130-0788

Electronic Funds Transfer

Access Optum Pay at **myservices.optumhealthpaymentservices.com**.
Enrollment: Once you have submitted your online Optum Pay enrollment, it may take up to 10 business days for enrollment to be activated.
Optum Pay Support: Contact **877-620-6194**, 8 a.m.–5 p.m. PT, Monday–Friday

Hospital Admission Notifications

Notify Optum Care Network of hospital admissions no later than 24 hours after admission and 24 hours post discharge. Notifications should be submitted electronically online. Submit by phone or fax if online not available.
Online: **onehealthport.com**
Phone: **877-836-6806**
Fax for inpatient notification and clinical submissions: **253-627-4708**

Prior Authorizations

Prior authorization and admission notification are required for certain services based on the patient's benefit plan. Prior authorization requests should only be submitted electronically online unless online not available.
Online: **onehealthport.com**
Phone: **877-836-6806**, 8 a.m.–5 p.m. PT, Monday–Friday
Fax—New Auth (General): **855-402-1684**
Fax—Part B New Auth: **855-402-1684**
Fax—Clinical Submissions for New or Existing Auth: **855-402-1684**

Member Eligibility and Benefits

Member Eligibility: Check member eligibility status at **onehealthport.com**. *Disclaimer: Please check the health plan's website for the most up to date member eligibility information as the data provided at the provider portal is not a guarantee of payment or eligibility.*
UHC members: **uhcprovider.com/eligibility**
Humana members: **humana.com/provider**
Coordinated Care members: **coordinatedcarehealth.com/providers**
Member Benefits: Direct members to the appropriate contact for all benefit related questions
UHC members: **800-866-1086** TTY 711
Humana members: **800-457-4708** TTY 711
Coordinated Care members: **877-644-4613**

Member Services
Please refer to member's ID card for member services contact information.

Optum Physical Health (PT/OT/ST/Chiro)
Online: **myoptumhealthphysicalhealth.com**
Phone: **800-873-4575**
Optum Behavioral Health or substance abuse
Phone: **800-985-2596** TTY 711
Non-Emergency Transportation
Phone: **866-418-9812**

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Overview

Purpose and use of this guide

The administrative guide contains important information about the Optum network in Washington (Optum Washington Network, LLC, d.b.a. Optum Care Network of Washington), policies and procedures, claims submission and adjudication requirements. General recommendations are provided to support and enable participating clinicians and administrators to deliver effective care for members of this Optum network through contracts with plan benefit packages (PBP) listed below insured through this network.

Plan name and type	CMS contract	Group #	Type
AARP® Medicare Advantage	H3805	90890	HMOPOS
	H3805	91651	
	H3805	91647	
	H3805	92118	
AARP® Medicare Advantage Patriot	H4604	90912	HMOPOS
AARP® Medicare Advantage Plan 1	H3805	90902	HMO
	H3805	91656	
AARP® Medicare Advantage Plan 2	H4604	90913	HMOPOS
	H4604	90432	
AARP® Medicare Walgreens	H3805	90894	HMOPOS
	H3805	90409	
Humana Gold Diabetes	H5619	076/832	HMO
Humana Gold Plus	H2486	076/549	HMO
	H2486	076/550	
Humana Gold Plus	H5619	076/570	HMO
	H5619	076/118	
	H5619	076/616	
	H5619	076/112	
	H5619	076/833	
	H5619	076/542	
	H5619	076/156	
	H5619	076/113	
	H5619	076/545	
	H5619	076/617	
	H5619	076/114	
	H5619	076/116	
	H5619	076/530	
	H5619	076/537	
	H5619	076/541	
	H5619	076/536	
Humana Gold Plus	H1036	076/662	HMO
	H1036	076/346	
	H1036	076/596	
UHC AARP® Medicare Advantage	H3805	90910	HMO
	H3805	90907	
	H3805	90288	
UHC AARP® Medicare Advantage	90288	90291	HMO
UHC AARP® Medicare Advantage	H2001	90391	PPO
	H2001	90393	
	H2001	90376	
	H2001	90378	
	H2001	90389	
UHC AARP® Medicare Advantage	H2406	90799	PPO
	H2406	90858	
	H2406	92127	
	H2406	90797	
	H2406	90819	
	H2406	90818	
	H2406	90821	
	H2406	90797	
	H2406	90819	
	H2406	90818	
	H2406	90821	
UHC AARP® Medicare Advantage	H1278	90744	PPO
	H1278	90746	

Plan name and type	CMS contract	Group #	Type
UHC AARP® Medicare Advantage Choice	H1278	90738	PPO
	H1278	90361	
UHC AARP® Medicare Advantage Choice Plan 1	H1278	90742	PPO
	H1278	90740	
UHC AARP® Medicare Advantage Choice Plan 2	H1278	90750	PPO
	H1278	90369	
UHC AARP® Medicare Advantage Extras	H3805	90427	HMOPOS
	H3805	90294	
	H3805	90423	
UHC AARP® Medicare Advantage Patriot	H3805	90156	HMO
UHC AARP® Medicare Advantage Patriot	H1278	90748	PPO
UHC AARP® Medicare Advantage Plan 1	H3805	92117	HMOPOS
UHC AARP® Medicare Advantage Plan 1	H3805	90153	HMO
	H3805	90415	
UHC AARP® Medicare Advantage Plan 2	H3805	90155	HMO
UHC Medicare Advantage	H4604	90911	HMOPOS
UHG Medicare Advantage Cement Masons	H3805	92149	HMO
UHG Medicare Advantage City of Seattle	H3805	92210	HMO
UHG Medicare Advantage Harrison Electrical	H3805	92133	HMO
UHG Medicare Advantage HMO UFCW Local 555	H3805	92204	HMO
UHG Medicare Advantage Machinist H&W Trust	H3805	92169	HMO
UHG Medicare Advantage Pacific Coast Shipyards	H3805	92176	HMO
UHG Medicare Advantage Retirees Wellfare Trust	H3805	92190	HMO
Coordinated Care			

This manual is effective Jan. 1, 2025, for all providers currently participating in this Optum network in Washington. It is effective for all care providers who join our Optum network on or after Jan. 1 of 2025. This manual is subject to change. We frequently update content in our effort to support our health care providers.

This guide is not intended to be exhaustive nor contractually binding. In the event of a conflict or inconsistency between this administrative guide and your network contractual agreement or applicable federal and state statutes and regulations, the terms of the contractual agreement along with federal and state statutes and regulations shall control.

Optum reserves the right to supplement this guide to ensure that the information, terms and conditions remain in compliance with all governing Center for Medicare Service (CMS) regulations and relevant federal and state laws.

The purpose of this guide is to provide key information to our contracted network clinicians and provide support in delivering effective care for mutual patients in accordance with this Optum network and industry standards.

The vision of Optum is to meet individual patient's needs through a connected set of practices and services. We look forward to working with you to achieve this vision and to providing you with the support needed to help you improve the health and well-being of your patients.

Terms and definitions used in this guide

- "Member" or "customer" refers to a person eligible and enrolled to receive coverage from a payer for covered services as defined or referenced in your agreement
- "You", "your" or "provider" refers to any health care provider subject to this guide and includes physicians, health care professionals, facilities and ancillary providers, except when indicated
  - All items are applicable to all types of health care providers subject to this guide
- "Your agreement", "provider agreement", or "agreement" refers to your participation agreement with us.
- "Us", "we" or "our" refers to Optum Washington Network, LLC, d.b.a. Optum Care Network of Washington on behalf of itself and its other affiliates for those products and services subject to this guide
- Any reference to "ID card" includes both a physical and digital card
- "Administrative guide" refers to the provider manual

Delegation defined

Delegation is a formal process or contract granting an enterprise authority to execute specific functions on behalf of an organization. Optum Care Network (OCN) has been granted specific delegation functions by certain health plans. The health plan is the responsible party for the benefit plans it offers to its members. As the delegating party, the health plan must remain apprised of the delegate's actions, ensuring adherence to compliance standards.

In full delegation, this translates to providing certain administrative services on behalf of the plans to credential providers, provide care management services, administer utilization management, and adjudicate claims. OCN has additional plan relationships that serve to delegate specific functions of health plan work. Please refer to the Delegation by Plan table in the Appendix for full details on this delegation.

Business Overview

Optum network in Washington

Optum Washington Network, LLC, d.b.a. Optum Care Network of Washington is a service organization and independent practice association focused on helping independent physician practices, as well as large medical groups and hospital systems, succeed at value-based care in a way that is easier, faster and more cost-effective. We do this by providing seamless data technology that puts actionable data at the fingertips of health care professionals; streamlined whole-person care to help address the needs of patients with complex conditions; and a dedicated Optum account manager who brings the expertise, training and support needed to help you succeed at value-based care.

We offer a full range of services to assist health care professionals and other providers in their managed care and business operations. The network is a health care innovator, with a track record for quality, financial stability and extraordinary services. We are well positioned to continually invest in new infrastructure and systems for the benefit of our contracted health care professionals and to accommodate the impending changes of health care reform.

Optum Washington Network, LLC, d.b.a. Optum Care Network of Washington service area

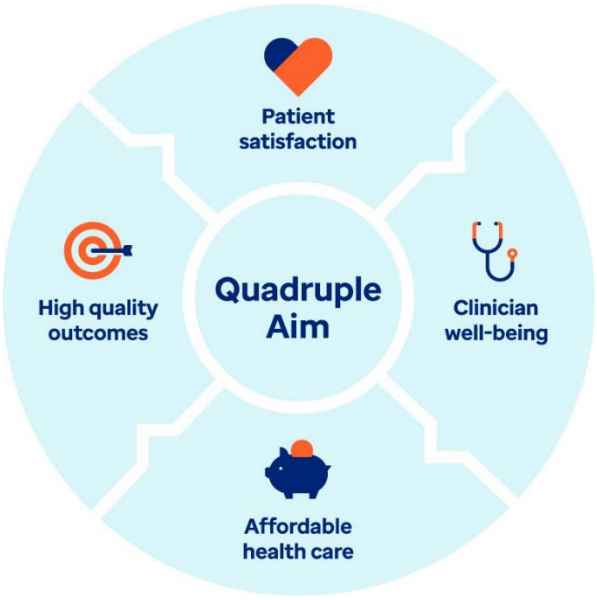
Optum Washington Network, LLC, d.b.a. Optum Care Network of Washington serves the state of Washington. This Optum network serves Medicare Advantage members insured through specified plans in the following counties: Ada | Adams | Bannock | Bear Lake | Benewah | Benton | Bingham | Blaine | Boise | Bonner | Bonneville | Boundary | Camas | Canyon | Caribou | Cassia | Chelan | Clackamas | Clallam | Clark | Clearwater | Columbia | Cowlitz | Custer | Deschutes | Douglas | Elmore | Ferry | Franklin | Fremont | Garfield | Gem | Gooding | Grant | Hood River | Idaho | Island | Jackson | Jefferson | Jerome | Josephine | King | Kitsap | Kittitas | Kootenai | Lane | Latah | Lemhi | Lewis | Lincoln | Linn | Madison | Marion | Mason | Minidoka | Multnomah | Nez Perce | Okanogan | Oneida | Owyhee | Payette | Pend Oreille | Pierce | Polk | San Juan | Shoshone | Skagit | Skamania | Snohomish | Spokane | Teton | Thurston | Twin Falls | Valley | Wahkiakum | Walla Walla | Washington | Whatcom | Yakima | Yamhill

Strong values focused on the Quadruple Aim

The Quadruple Aim is a strategic framework, made up of 4 core pillars, that guides our clinical priorities and efforts towards a more sustainable health care system.

- High quality outcomes
- Satisfied patients
- Affordable health care
- Clinician well-being

As we aspire to enable healthier lives and to help make the health system work better for everyone, our focus on the Quadruple Aim — improved outcomes, outstanding patient and provider experiences, and a lower total cost of care — will help guide us in our delivery of coordinated, patient-centered care.



A message from Dr. Imelda Dacones, *President*

Thank you for being a participating clinician with Optum Care Network of Washington (OCN). We appreciate your partnership in providing affordable, high-quality health care for our members and communities.

As a health care provider, your primary focus should be on your patients and their care. We understand this and exist to support you in your endeavors. Our patient-centered value-based care model, with its wrap-around services and administrative functions that work with multiple payers, frees up your time for your own self-care. Our goal is to ensure that you have the resources and support you need to provide the best possible care for your patients.

With OCN, you have the support of a health care industry leader while you remain independent and able to make your own decisions. You also have a national team of doctors connecting you, your practice and your care delivery to the latest evidence-based breakthroughs. And you have access to local resources with a collaborative team always ready to help you and your patients.

This provider manual offers valuable information about the Optum Care Network of Washington and how to work effectively with us. We hope it will be a user-friendly reference guide and educational resource for you and your staff. We strive to continually improve and provide the best service and useful information to you. Please do not hesitate to reach out if you have questions regarding this manual.

Our secure provider portal is located on our home page. It is available for your convenience to verify eligibility, claims status, submit and review prior authorization status, and medical inquiries.

As your partner and support, we, OCN, are here to ensure a seamless experience for you, your staff, and our patients and enrollees.

Together, we will help people live their best lives.

With gratitude,
Imelda Dacones, MD FACP
President, Optum Care Network of Washington (OCN)

Online Resources and Contact Information

Online Resources and Contact Information

How to contact OCN

You may contact OCN through the following methods:

- **Provider portal:** The portal is a secure, online, customized experience that assists providers in caring for OCN patients. It is a one-stop shop offering claims insights, prior authorization submission and status, and population health performance data. These tools can help providers improve patient care and lower costs. Log in at **onehealthport.com**.
- **Optum Care Service Center:** Our service advocates are available to answer questions on topics such as health care professional search, claims, eligibility and more
  - Phone: **877-836-6806**, 8 a.m.-5 p.m. PT, Monday-Friday
- Network relations and contracting: **OCNWAContracting@optum.com**
- Mailing address for general information:
  Optum Care Network Administration
  904 7th Ave, 2nd Floor, Admin Office
  Seattle, WA 98104
- Each practice in our network is supported by a dedicated practice engagement manager (PEM) who is your go-to resource. To acquire contact information for your PEM, contact our team at **engagementteam@optumpnw.com.**

Network engagement

Your OCN Practice Engagement Manager and Network Medical Director work to help you succeed in all areas of quality, patient experience, accurate coding and documentation, affordability, and growth. This program applies specifically to primary care practices with attributed membership.

- Primary OCN relationship owner with clinic
  - Partners with clinic leadership to strive for optimal performance in quality, accurate coding and documentation, patient experience, and affordability to improve long-term clinical outcomes while lowering the total cost of care
  - Leads and schedules meetings with the clinic
  - Ensures clinic has tools and data needed for success in patient care delivery
  - Communicates Quality Incentive Program (QIP) elements and achievements
- Population health performance
  - Provides point of care tool delivery, training, and submission tracking
  - Provides performance and incentive reporting
  - Supports MA marketing and growth coordination
  - Supports care management service coordination
  - Provides clinics with information on new and existing wraparound services
- Training/education
  - Assesses practice training needs
  - Coordinates Primary Care Provider (PCP), staff, and clinic administrator education on accurate coding and documentation, quality, and affordability

Administrative guide

This guide and other resources for your Optum network can be found at **optum.com/en/business/hcp-resources.**

Portal access

Summary

The Optum Care Provider Center (OCPC) is a secure, online, customized experience that assists providers in caring for OCN patients. It is a one-stop shop offering claims insights, prior authorization submission and status, and population health performance data. These tools can help providers improve patient care and lower costs.

The OCPC provides access to the following:

- Eligibility status
- Claims status
- Prior authorization status
- Prior authorization submission
- Attestation review and submission
- Secure messaging with OCN teams

User access

To access the OCPC, providers will need to perform one of the following steps (using One Health Port is the easiest and preferred method to gain access):

- Navigate to the OCPC website via **onehealthport.com** using OHP user ID and single sign-on and choose Optum logo
- Navigate to the OCPC website **onehealthport.com**
  - Complete the fields under the *Provider Registration – New User* section
  - The request will then be reviewed by an OCN system administrator
  - Once account registration is approved, an email will be sent to the provider with log in information and instructions
  - Log in to OCPC and finalize setup

Language and hearing-impaired assistance

Optum wants to ensure that all patients get their questions answered on topics like benefits, claims and prior authorization. For those that may need translation or interpreter assistance, there is help available upon request and at no cost to your patients.

Language assistance

For patients who are more comfortable speaking to a bilingual service advocate, one can be assigned when the patient calls Optum, or we can bring an interpreter on the call to assist.

Hearing impaired assistance

There is also access to assistance for patients that are hearing impaired. Let your patients know that assistance is available by using their text telephone (TTY) or by dialing 711 from any telephone.

It is the health care professional's responsibility under Title III of the Americans with Disabilities Act to promptly make accommodations for the hearing impaired when requested and to cover the cost of the interpreter, when necessary, to avoid a delay in care. Patients have the right to a certified medical interpreter or sign language interpreter to interpret health information accurately. Health care professionals cannot charge the patient for the costs of sign language interpreter services or auxiliary aids.

- For more information, call your Optum Service Center at **877-836-6806**, 8 a.m.–5 p.m. PT, Monday-Friday
- The TTY 711 and language lines are open 24 hours a day, 7 days a week.

Credentialing and Recredentialing

Getting started with our network

If not already participating in our network but interested in beginning your journey with Optum Health Networks, please contact **OCNWAContracting@optum.com**.

Credentialing

Credentialing refers to the process performed by this Optum network to verify and confirm that a clinician meets the established policy standards and qualifications for participation with this network. There are currently no fees charged for credentialing. Upon completion of the credentialing verification process, each applicant is presented for review and recommendation to the Medical Director/Credentialing Committee Chair (or designee) or the Credentialing Committee, which is comprised of physicians and practitioners of various specialties.

This Optum network performs credentialing activities on behalf of the health plan(s) identified in this guide for which a credentialing delegation agreement has been executed. Credentialing applies across all lines of business for health plans with a credentialing delegation agreement.

Initial credentialing

The initial credentialing process is from receipt of completed credentialing application to committee approval. The credentialing time frame is directly dependent upon receiving verification from the primary sources in a timely manner. If receipt of those verifications is delayed in any way, it will hold up the completion of the process. If the packet is not complete (e.g., required documents are not attached, fields on application not filled in, etc.) this will also delay processing of the application. *Note: For newly contracted groups, credentialing is initiated within the contracting process. The initial credentialing process takes approximately 30-60 days.*

Please ensure the provider's CAQH account is current and correct to prevent delays in credentialing.

CAQH provider support: **proview.caqh.org/PR**

Providers joining your practice

All providers* joining an existing practice must complete the credentialing process with this Optum network. Until the provider has successfully completed the credentialing process, claims may not be reimbursed appropriately and/or denied payment. Contact **credentialingpnw@optum.com** at least 60 days prior to your new provider seeing patients to minimize any reduction or denial of payment.

Please note, in the event a contracted provider or group is adding a provider, the credentialing process must be completed, and there must be a fully executed contract in place prior to the practitioner seeing members of this Optum network. It is fraudulent practice to bill under one provider when services are provided by another provider.

To ensure accurate records and provider directories, please report all demographic changes directly to **credentialingpnw@optum.com** for processing. Please use the Provider Group/Practitioner Change Form found in the Appendix for this submission.

**Unless the practice has a credentialing sub-delegation arrangement in place with this Optum network where the practice has assumed all credentialing responsibility that meets our network's standards*

Types of providers credentialed

Optum networks may credential the following provider types:

- ARNP
- CDP
- CNM
- CRNA
- CRNP
- DO
- DPM
- LMFT
- LMHC
- LSW
- MD
- OD
- OT
- PA-C
- PharmD
- PhD
- PsyD
- PT
- RD
- RNFA
- ST
- SUDP

Providers adding location(s)

Unless a credentialing sub-delegation arrangement is in place with this Optum network, all provider locations must complete the credentialing process. Until the additional location has successfully completed the credentialing process, authorizations and claims payment will be delayed. Contact **credentialingpnw@optum.com** at least 60 days prior to your new location seeing patients to minimize any denial of authorization or reduction in payment.

Types of facilities credentialed

Optum networks may credential the following facility types:

- Ambulatory surgery center
- Behavioral health (facility)
- Birthing center
- Chemical dependency treatment center
- Home health
- Home infusion therapy
- Hospital
- Independent diagnostic testing facility
- Laboratory
- Neuro-developmental facility
- Radiology*
- Radiology oncology
- Skilled nursing facility
- Urgent care center
- Wound care

** Excluding therapeutic/interventional radiologists who credential individually*

Sub-delegation of credentialing

This Optum network may delegate specific credentialing and recredentialing responsibilities to practice entities. Determination of whether a practice can be delegated is dependent on the successful results of a pre-delegation audit and execution of a credentialing sub-delegation agreement. Contact **credentialingpnw@optum.com** for additional information regarding eligibility and qualification.

Credentialing corrective action

Should this Optum network determine a provider or facility has failed to meet performance expectations, as specified in the credentialing policies and procedures, pertaining to quality of care, patient services, or established performance or professional standards, a corrective action plan may be implemented.

If a corrective action is not satisfactorily resolved within the designated period, this Optum network has authority to recommend extension of the corrective action plan or suspension/termination from network participation. Providers/facilities who are suspended or terminated may have the right to appeal. Where an appeal is not reversed or when required by law, this Optum network will notify the National Practitioner Data Bank and network affiliated entities (health plans) as required by law and contractual agreements.

The credentialing policies and procedures may be provided upon request for additional details regarding corrective action, suspensions, terminations, and appeals.

Rights related to the credentialing process

Practitioners and other health care providers applying for Optum Network have the following rights regarding the credentialing process:

- To review the information submitted to support your credentialing application
- To correct erroneous information
- To be informed of the status of your credentialing or re-credentialing application upon request

You may review the status of your Optum credentialing application by contacting your Optum network account manager.

Professional liability insurance coverage requirements

To complete credentialing requirements, each health care provider must provide evidence of professional malpractice coverage in minimum amounts of $1 million per occurrence and $3 million aggregate or amount required by state law.

Recredentialing

Recredentialing occurs at least every 36 months. Prior to the process beginning, the clinician will receive a request to complete or update their CAQH application and verify their information and attestation is current and up to date. CAQH requires the re-attestation process be completed every 120 days. Optum will also accept a completed WPA with required attachments, submitted directly to **credentialingpnw@optum.com**.

Providers are required to immediately notify their local Optum network credentialing department if they no longer meet the group's credentialing criteria (for example, medical license revoked, opt-out of Medicare, etc.).

Please note, in the event a contracted provider or group is adding a provider, the credentialing process must be completed, and there must be a fully executed contract in place prior to the practitioner seeing members of this Optum network. It is fraudulent practice to bill under one provider when services are provided by another provider.

To ensure accurate records and provider directories, please report all demographic changes. Please use the Provider Group/Practitioner Change Form found in the Appendix and submit all changes to **credentialingpnw@optum.com** for processing.

Facility recredentialing

Recredentialing occurs at least every 36 months. Prior to the 3-year credentialing anniversary, facilities will be notified that recredentialing is due and be sent a recredentialing application to complete. Non-response or failure to return a completed recredentialing application(s) and supporting documentation may be considered a voluntary termination of network participation, unless otherwise determined by the Optum Credentialing Committee.

All facility locations must complete the recredentialing process. Until the additional location has successfully completed the recredentialing process, authorizations and claims payment will be delayed.

Provider Responsibility

Primary care physician responsibilities

As a PCP, you are responsible to provide medically necessary primary care services. You are the coordinator of our members' total health care needs. You are responsible for seeing all members on your panel who need assistance, even if the member has never been in for an office visit. Some benefit plans require PCPs to submit electronic referrals for the member to see another network health care professional. See section on referrals later in this guide for detailed information on referral requirements.

Non-discrimination

You must not discriminate against any patient regarding quality of service or accessibility of services because they are our member. You must not discriminate against any patient based on:

- Age
- Claims experience
- Color
- Disability
- Ethnicity
- Evidence of insurability
- Gender identity
- Genetic information
- Medicaid status for Medicare members
- Medical history
- Mental or physical disability or medical condition
- National origin
- Race
- Religion
- Sex or gender
- Sexual orientation
- Source or type of payment
- Type of health insurance

You must maintain policies and procedures to demonstrate you do not discriminate in the delivery of service and accept for treatment any members in need of your service.

Cooperation with quality improvement and patient safety activities

You must follow our quality improvement and patient safety activities and programs. These include:

- Quick access to medical records when requested
- Timely responses to queries and/or completion of improvement action plans during quality-of-care investigations
- Participation in quality audits, including site visits and medical record standards reviews and Healthcare Effectiveness Data and Information Set (HEDIS®) record review
- Allowing use of practitioner and health care professional performance data
- Notifying us when you become aware of a patient safety issue or concern

Medicare compliance expectations and training

The Centers for Medicare & Medicaid Services (CMS) requires Medicare Advantage (MA) organizations and Part D plan sponsors to annually communicate specific Compliance and Fraud, Waste and Abuse (FWA) requirements to their "first tier, downstream, and related entities" (FDRs). FDRs include contracted physicians, health care professionals, and facilities and ancillary providers, as well as delegates, contractors, and related parties. CMS and other federal or state regulators require that you and your employees meet certain FWA and general compliance requirements.

FDRs are expected to have an effective compliance program which includes training and education to address FWA and compliance knowledge. This Optum network's expectation remains that FDRs and their employees are sufficiently trained to identify, prevent, and report incidents of non-compliance and FWA. This includes temporary workers and volunteers, the CEO, senior administrators or managers, and sub-delegates who are involved in or responsible for the administration or delivery of MA or Part D benefits or services.

We have general compliance training and FWA resources available at **unitedhealthgroup.com**. The required education, training and screening requirements are as follows.

Standards of conduct awareness – what you need to do

- Provide a copy of your own code of conduct, or the UnitedHealth Group's (UHG's) Code of Conduct at **unitedhealthgroup.com** > About > Ethics & Integrity > UnitedHealth Group's Code of Conduct. Provide the materials annually and within 90 days of hire for new employees.
- Maintain records of distribution standards (i.e., in an email, website portal or contract) for 10 years. We, our plan sponsors, or CMS, may request documentation to verify compliance.

Fraud, waste and abuse and general compliance training – what you need to do

- Provide FWA and general compliance training to employees and contractors of the FDR working on MA and Part D programs
- Administer FWA and general compliance training annually and within 90 days of hire for new employees

Exclusion checks

Prior to hiring or contracting with employees, you must review federal (HHS-OIG and GSA) and state exclusion lists, as applicable. This includes the hiring of temporary workers, volunteers, the CEO, senior administrators or managers and subdelegates who are involved in or are responsible for the administration or delivery of Medicare Advantage plan sponsor benefits or services delegated to this Optum network.

Exclusion checks – what you need to do

- Make sure potential employees are not excluded from participating in federal health care programs. For more information or access to the publicly accessible excluded party online databases, use the following links:
  - Health and Human Services – Office of the Inspector General OIG List of Excluded Individuals and Entities (LEIE) at **oig.hhs.gov/**
  - General Services Administration (GSA) System for Award Management at **sam.gov/sam**
- Review the exclusion lists every month and disclose to your Optum network representative any exclusion or any other event that makes an individual ineligible to perform work directly or indirectly on federal health care programs. Maintain a record of exclusion checks for 10 years. We, our plan sponsors, or CMS, may request documentation of the exclusion checks to verify they were completed.

Preclusion list policy

The Centers for Medicare and Medicaid Services (CMS) has a preclusion list effective for claims with dates of service on or after April 1, 2019. The preclusion list applies to both MA plans as well as Part D plans. The preclusion list is comprised of a list of prescribers and individuals or entities who:

- Are revoked from Medicare, are under an active reenrollment bar, and CMS has determined that the underlying conduct that led to the revocation is detrimental to the best interests of the Medicare program; or
- Have engaged in behavior for which CMS could have revoked the prescriber, individual or entity to the extent possible if they had been enrolled in Medicare and that the underlying conduct that would have led to the revocation is detrimental to the best interests of the Medicare program
- Have been convicted of a felony under federal or state law within the previous 10 years and that CMS deems detrimental to the best interests of the Medicare program

Care providers receive a letter from CMS notifying them of their placement on the preclusion list. They can appeal with CMS before the preclusion is effective. There is no opportunity to appeal with Optum network or the plan sponsor. CMS updates the preclusion list monthly and notifies MA and Part D plans of the claim rejection date, the date upon which we reject or deny a care provider's claims due to precluded status. Once the claim-rejection date is effective, a precluded care provider's claims will no longer be paid, pharmacy claims will be rejected, and the care provider will be terminated from this Optum network. Additionally, the precluded care provider must hold Medicare beneficiaries harmless from financial liability for services provided on or after the claim rejection.

Reporting misconduct

If you identify compliance issues and/or potential fraud, waste or abuse, please report it to this Optum network immediately so that we can investigate and respond appropriately. Please see the reporting misconduct section of the **UnitedHealth Group code of conduct**. Reports may be made anonymously, where permitted by law:

- UHC members report at **uhc.com/fraud** or by calling **844-359-7736**
- Humana members report at **ethicshelpline.com** or by calling **877-584-3539**
- Coordinated care members report at **coordinatedcarehealth.com/providers/resources/report-fraud** or by calling **866-685-8664**

Privacy

You must make reasonable efforts to limit use and disclosure of Protected Health Information (PHI), as defined under the Health Insurance Portability and Accountability Act (HIPAA) privacy rule, to the minimum necessary to accomplish the intended purpose. The minimum necessary standard should not affect treatment, payment or health care operations (TPO). The Privacy Rule requires written member authorization for uses and disclosure that fall outside of the TPO.

Other regulations to follow include, but are not limited to:

- The Cures Act
- Information Blocking Rules
- Telephone Consumer Protection Action 47 USC Section 227

Guide updates

This Optum network reserves the right to supplement this guide to ensure that its information and terms and conditions remain in compliance with all governing Center for Medicare and Medicaid Services (CMS) regulations and relevant federal and state laws. This guide will be amended as needed.

Provider change notice requirements

Notify us at the address in your agreement within 3 business days if any of these situations occur:

- Material changes to, cancellation or termination of liability insurance
- Bankruptcy or insolvency
- Any indictment, arrest or conviction for a felony or any criminal charge related to your practice or profession
- Any suspension, exclusion, debarment or other sanction from a state or federally funded health care program
- Loss, suspension, restriction, condition, limitation or qualification of your license to practice. For health care professionals, any loss, suspension, restriction, condition, limitation or qualification of staff privileges at any licensed hospital, nursing home or other facility.
- Relocation or closure of your practice and, if applicable, transfer of member records to another health care professional/facility
- External sanctions or corrective actions levied against you by a government entity

Notification of changes must be proactive

Every quarter, you, or an entity delegated to handle credentialing activities, are expected to review and update care provider information available to our members. You or the delegate must tell us of changes to the information at least 30 calendar days before the change is effective, to the extent possible. This includes adding new information and removing outdated information, as well as updating the information listed in the following paragraph. Delegates are responsible for notifying us of these changes for all the participating care providers credentialed by the delegate. If you or a delegate fails to (1) update records, or (2) give 30 days prior notice of changes to the extent possible, or (3) attest to the information, you, or the participating care providers credentialed by the delegate, may be subject to penalties. Penalties may include a delay of processing claims or the denial of claims payment, until the records are reviewed and attested to or updated.

You and the delegates are required to update all care provider information, such as:

- Address(es) of practice location(s)
- Ages / genders served
- Care provider groups affiliation
- Email address(es)
- Hospital privileges
- Languages spoken / written by staff
- License(s)
- NPI(s)
- Office hours
- Office phone number(s)
- Patient acceptance status
- Specialty
- Tax identification number

If a health care provider leaves your practice, notify us immediately. This gives us time to notify impacted members. When you submit demographic updates, list only those addresses where a member may make an appointment and see the care provider. On-call and substitute care providers who are not regularly available to provide covered services at an office or practice location should not be listed at that address. Please submit all changes on an Optum roster, which can be provided by your Optum account manager or network representative. Please contact your Optum network representative for more information.

To change an existing TIN, add a health care professional or update your practice or facility information

All changes should be sent to **credentialingpnw@optum.com** for processing. Please use the Provider Group/Practitioner Change Form found in the Appendix for this submission. OCN credentialing will notify health plans monthly for those plans which OCN has a delegated credentialing agreement in place.

If a provider terminates from your practice, your participation agreement requires notification to OCN via email to **credentialingpnw@optum.com** within 30 days of departure. You are required to inform OCN who patients should be reassigned to via e-mail. For more information on this topic, please refer to the Patient Reassignment section of the provider manual.

Termination of participation

Providers/facilities are contractually required to provide adequate notice of termination of network participation pursuant to the contract terms and provision governing termination notice as termination will impact patient care and your credentialing status with this Optum network's contracted health plans. Upon termination with this Optum network, your credentialing will revert to being performed directly by the health plans with whom you are contracted. Providers/facilities should plan accordingly to ensure no disruption in services for patients. Please refer to your provider or facility participation agreement termination and continuity of care provisions.

Change in ownership/control

Changing ownership or control of a practice requires a conversation with your Optum network account manager to determine next steps and impacts to contracting and credentialing. Contact your Optum account manager to begin this process.

Closing your practice

Closing your practice due to retirement or business considerations is a complex undertaking. The process can be very different for primary care providers and specialists. This Optum network would like to support you in locating resources for your transition and understanding actions required. Please contact your Optum account manager for assistance planning these logistics. The table below provides a start in preparing for such a change.

Considerations	PCP	Specialist
Notify your Optum account manager via letter or email with a copy of the patient notification letter	☐	☐
Letter notifying patients of change	☐	☐
Communicate how patients may obtain their records	☐	☐
Recommendations for new providers	☐	☐
How to contact the office during and after the transition	☐	☐
Communicate changes to non-Optum health plans	☐	☐
Instruct patients to contact the health plan regarding a PCP change	☐	
Close patient panel	☐	
Identify patients currently in care management	☐	
Provide access to medical records to Optum (current year)	☐	☐

Administrative terminations for inactivity

Up-to-date directories are a critical element of providing our members with the information they need to take care of their health. To offer more exact and up-to-date directories, we:

- Administratively terminate agreements for care providers who have not submitted claims for one year on the basis that they are not actively treating Optum patients and have voluntarily ceased participation in our network
- Inactivate any TIN under which there have been no claims submitted for one year on the basis that they are not in active use. Because other TINs associated with a particular agreement have been active, this is not a termination of the agreement with the provider. Providers may contact Optum to reactivate an inactivated TIN

When care providers inform Optum of a practitioner leaving a practice, our network will make multiple attempts to document the change. We administratively terminate a care provider once the following actions are taken:

- The Optum network receives verbal notice that a practitioner is no longer with a practice
- The Optum network makes 3 attempts to obtain documentation confirming the practitioner's departure but does not receive the requested documentation
- The clinician has not submitted claims under that practice's TIN(s) for 6 months prior to our Optum network's receipt of verbal notice the practitioner left the practice, or the effective date of departure provided to us, whichever is sooner

Member dismissals initiated by a PCP (Medicare Advantage)

Dismissal of a patient from a practice who is covered under a Medicare Advantage HMO plan must be coordinated with the health plan and in accordance with applicable state regulations. The health plan will need the cause for dismissal and appropriate documentation. Please refer to health plan specific provider manuals for releasing a patient from your practice.

Patient assignment and reassignment

OCN manages patients assigned to primary care providers (PCPs) for Humana Medicare Advantage HMO, AARP® Medicare Advantage HMO through UnitedHealthcare (UHC MA), UHC Medicaid and Coordinated Care. Patients are assigned to a Primary Care Provider through one of the following processes:

- The patient chooses a PCP at the time of enrollment
- The health plan assigns a PCP after enrollment if the patient has not designated a PCP

Practices should make every attempt to engage patients assigned to them and establish care.

In some cases, patients may be assigned to your practice in error. When this occurs, the health plan must be notified, and assignment must be corrected in their system(s). Patients who have not been seen by your practice but have been assigned to you should not be reassigned to another PCP unless that patient has initiated the process by following the steps below (see also Population Health section of the provider manual).

- Humana:
  - Patients may call Humana customer service number on the back of their ID card to request a different PCP, or
  - Patients may complete a PCP change form and fax to Humana
- UHC Medicare Advantage:
  - Patients may call the UHC customer service number on the back of their ID card to request a different PCP
- UHC Medicaid:
  - Patients may call the UHC customer service number on the back of their ID card to request a different PCP, or
  - Patients may complete a **PCP change form** and submit by UHC as directed on the form
- Coordinated Care:
  - Patients may call the Coordinated Care customer service number on the back of their ID card to request a different PCP

Threats or filing of legal action by a member

Threats or filing of legal action against a care provider

We do not automatically move the member to another medical group/IPA because threats or filing of a lawsuit or other similar grievance or complaint.

We consider transfer if:

- The complaint is about problems with quality of care or inappropriate behavior AND the care provider requests removal from their care
- The transfer would not affect the member's current treatment, which must be confirmed by the treating care provider
- The member wants another care provider who is part of the same medical group/IPA but located in a different office

If a transfer is effected, the treating care provider must cooperate in the transfer of medical records and information to the new care provider.

Threats or filing of legal action against a medical group/IPA

We do not deny the member access to care providers within a medical group/IPA because of threat or filing of a lawsuit or other similar grievance or complaint. We consider a transfer if the member's complaint is about problems with the general practices and procedures of the medical group/IPA. Note: If you receive notification of a member's plan to sue, please notify your care provider advocate.

Medicare opt-out

We follow and require our care providers to follow Medicare requirements for physicians and other practitioners who opt out of Medicare. If you opt out of Medicare, you may not accept federal reimbursement. Care providers who opt out of Medicare (and those not participating in Medicare) are not allowed to bill Medicare or its MA benefit plans during their opt-out period for 2 years from the date of official opt-out. For our MA membership, we and our delegated entities do not contract with or pay claims to care providers who have opted out of Medicare.

Exception to Medicare opt-out policy

In an emergency or urgent care situation, if you have opted out of Medicare, you may treat a MA beneficiary and bill for treatment. In this situation, you may not charge the member more than what a non-participating care provider is allowed to charge. You must submit a claim to us on the member's behalf. We pay Medicare covered items or services furnished in emergency or urgent situations.

Provider privileges

In order to help our members get access to appropriate care and to help minimize out-of-pocket costs for members, providers must have privileges at applicable participating facilities or arrangements with a participating practitioner to admit and provide facility services to patients. This includes but is not limited to full admitting hospital privileges, ambulatory surgery center privileges and/or dialysis center privileges.

Member communications

Some member communications require CMS or Optum approval. This includes:

- Anything with the Optum and/or plan name or logo
- Correspondence that describes benefits
- Marketing activities

Approval is not necessary for communication between care providers and patients that discuss:

- Their medical condition
- Treatment plan and/or options
- Information about managing their medical care

Part C reporting requirements

MA organizations are subject to additional reporting requirements. We may request data from our contracted care providers. This data is due by 11:59 p.m. PT on our established reporting deadline. Some measures are reported annually, while others are reported quarterly or semi-annually. This includes but is not limited to:

- Grievances
- Organization determinations/reconsiderations, including source data for all determinations and re-openings
- Special needs plans care management (if applicable)
- Mid-year network changes
- Payments to care providers

Additional Medicare Advantage requirements

As a first-tier entity to a MA organization, this Optum network and its network care providers agree to meet all laws and regulations-applicable to recipients of federal funds. If you participate in the network for our MA products, you must comply with the following additional requirements for services you provide to our MA members:

- You may not discriminate against members in any way based on health status
- You must allow members direct access to screening mammography and influenza vaccination services
- You may not impose cost-sharing on members for the influenza vaccine or pneumococcal vaccine or certain other preventive services
- You must provide female members with direct access to a women's health specialist for routine and preventive health care services
- You must make sure your hours of operations are convenient to members
- You must make sure medically necessary services are available to members 24 hours a day, 7 days a week
- Primary care providers must have backups for absences
- You must adhere to CMS marketing regulations and guidelines. This includes but is not limited to the requirements to remain neutral and objective when assisting with enrollment decisions, which should always result in a plan selection in the Medicare beneficiary's best interest. CMS marketing guidance also requires that providers must not make phone calls or direct, urge or attempt to persuade Medicare beneficiaries to enroll or dis-enroll in a specific plan based on the care provider's financial or any other interest. You may only make available or distribute benefit plan marketing materials to members in accordance with CMS requirements.
- You must provide services to members in a culturally competent manner taking into account limited English proficiency or reading skills, hearing or visual impairment and diverse cultural and ethnic backgrounds. Make available all plan materials, services, and information, including those produced or distributed by contracted providers, in accessible format as referenced in Section 504 of the Rehabilitation Act of 1973. Provide required materials on a standing basis in an accessible format upon receiving a request for the materials or when otherwise learning of the enrollee's need for an accessible format (42 C.F.R §§ 422.2267(a)(3) and 423.2267(a)(3).
- You must cooperate with our procedures to tell members of health care needs that require follow-up and provide necessary training to members in self-care
- You must document in a prominent part of the member's medical record whether they have executed an advance directive
- You must provide covered health services in a manner consistent with professionally recognized standards of health care
- You must make sure any payment and incentive arrangements with subcontracted are specified in a written agreement, that such arrangements do not encourage reductions in medically necessary services and that any physician incentive plans comply with applicable CMS standards
- You must comply with all applicable federal and Medicare laws, regulations and CMS instructions, including but not limited to (a) federal laws and regulations designed to prevent or ameliorate fraud, waste and abuse including, but not limited to, applicable provisions of federal criminal law, the False Claims Act (31 U.S.C. §3729 et seq.) and the Anti-Kickback Statute (§1128B of the Social Security Act), and (b) HIPAA administrative simplification rules at 45 CFR Parts 160, 162 and 164
- The payments you receive from us or on behalf of us are, in whole or in part, from federal funds. You are therefore subject to certain laws applicable to individuals and entities receiving federal funds
- You must cooperate with our processes to disclose to CMS all information necessary for CMS to administer and evaluate the MA program and disclose all information determined by CMS to be necessary to assist members in making an informed choice about Medicare coverage
- You must comply with our processes for notifying members of your agreement terminations
- You must submit all risk adjustment data as defined in 42 CFR 422.310(a), and other MA program-related information as we may request, to us within the time frames specified and in a form that meets MA program requirements. By submitting data to us, you represent to us, and upon our request you shall certify in writing that the data is accurate, complete and truthful based on your best knowledge, information and belief.
- You must comply with our MA medical policies, policy guidelines, coverage summaries, quality improvement programs and medical management procedures
- You must cooperate with us in fulfilling our responsibility to disclose to CMS quality, performance and other indicators as specified by CMS
- You must cooperate with our procedures for handling grievances, appeals and expedited appeals. This includes but is not limited to providing requested medical records within 2 hours for expedited appeals and 24 hours for standard appeals, including weekends and holidays.
- We may request copies of medical records from you in connection with our utilization management/care management, quality assurance and improvement processes, claims payment and other administrative obligations, including reviewing your compliance with the terms and provisions in your agreement with us and with appropriate billing practice. If we request medical records, you will provide copies of those records free of charge unless your participation agreement provides otherwise.

- In addition, you must provide access to any medical, financial or administrative records related to the services you provide to our members within 14 calendar days of our request or sooner for cases involving alleged fraud and abuse, a member grievance/appeal or a regulatory or accreditation agency requirement, unless your participation agreement states otherwise. These records must be maintained and protected for 7 years or longer if required by applicable statutes or regulations. For example, for Medicare Advantage benefit plans, you must maintain and protect the confidentiality of the records for at least 10 years or longer if there is a government inquiry/investigation. You must provide access to medical records, even after termination of an agreement for service provided during the period in which the agreement was in place.
- All encounter data submitted to Optum Care Network is subject to federal audit. We have the right to perform routine medical record chart audits on any or all of the medical group's/IPA's participating care providers at such time or times as we may reasonably elect to determine completeness and accuracy of encounter data ICD and CPT coding. The medical group/IPA shall be notified in writing of audit results pertaining to coding accuracy. As outlined in your participation agreement, the medical group/IPA may be subject to financial consequences if it or another submitting entity fails to submit or meet the encounter data element requirements. In addition, the medical group/IPA may be required to perform a complete medical record chart audit of its participating practitioners with notice from Optum.
- In addition, you must comply with the Medicare Advantage Regulatory Requirements Appendix (MARRA)

Health Equity in MA and Cultural Competency

This Optum network expects you to provide services in a culturally competent manner. CMS expects MA organizations to ensure equitable access to Medicare Advantage services. This includes:

- People with limited English proficiency and reading skills
- People of ethnic, cultural, racial, or religious minorities
- People with disabilities
- People who identify as lesbian, gay, bisexual, or other diverse sexual orientations
- People who identify as transgender, nonbinary, and other diverse gender identities, or people who were born intersex
- People who live in rural areas and other areas with high level of deprivation
- People otherwise adversely affected by persistent poverty or inequality

Medical records standards

In an effort to promote the optimal health of each patient through complete and accurate medical record documentation, Optum has a standard set of guidelines for patient medical records. The guidelines have been established by the National Committee of Quality Assurance (NCQA) and state and federal regulators, for medical record documentation (protected- health information or PHI).

- **Patient identification**: Each page in the record will contain the patient name and/or patient ID number
- **Personal/biographical data**: Each record will have the patient's address, employer, home and work phone numbers, marital status, date of birth, emergency contact, and phone number
- **Patient language**: Each patient's health record will include the patient's primary language, as well as any linguistic services needed for non- or limited-English proficient or hearing-impaired persons. Use and/or refusal of interpreters will be documented
- **Practitioner identification**: All entries will be identified as to the author. It is suggested that this is by full signature (first and last name, and title), but electronic identifier or initials are acceptable. Further, all physician assistant (PA) and/or nurse practitioner (NP) signatures must be cosigned by the supervising physician.
- **Entry date**: All entries will be dated
- **Legible**: The record will be legible to someone other than the writer. Any record judged illegible by one practitioner reviewer may need to be evaluated by a second reviewer before it is deemed illegible.
- **Working diagnoses**: Working diagnoses are consistent with findings
- **Problem list**: Significant illnesses and medical conditions will be identified on the problem list. If the patient has no known medical illnesses or conditions, the medical record will still include a flow sheet for health maintenance.
- **Allergies**: Medication allergies, adverse reactions, and/or the absence of allergies (NKA) will be noted on the front of the chart. A stamp, with red ink, may be provided to each primary care physician office, if requested.
- **Advance directives**: Presence of an advance directive or evidence of education about advance directive of patients over the age of 18 must be noted. Patients will be provided information as to making their own health decisions. Advance directives supplied to the practitioner must be included in the medical record.
- **Medical records**: Patient charts will be maintained in an area secure from public access, located for easy retrieval of both active and inactive charts. Each chart should be well organized in a standard format with the contents fastened and/or secured and containing only one individual's information.
- **Past medical history (for patient seen 3 or more times)**: Past medical history will be easily identified, including serious accidents, operations, and illnesses. It is recommended to include sexual activity and mental health status, if applicable. For children and adolescents (18 years or younger), past medical history will be noted as above and will include childhood illnesses, immunizations, and prenatal care and births, if applicable.
- **Smoking/ETOH/substance abuse**: Medical records for patients who are 14 years of age and older must contain a notation that the patient has been asked about depression, violence, alcohol, substance and cigarette use, and counseled as necessary.
- **History and physical**: Appropriate subjective and objective information will be obtained for the presenting complaints.
- **Appropriate use of lab and other studies**: Laboratory and other studies ordered will be noted, as appropriate.
- **Risk factors**: Possible risk factors for the patient relevant to the particular treatment will be noted.
- **Plan/treatment**: Treatment plans are consistent with diagnoses.
- **Return visit**: Progress notes will have a notation concerning follow-up care, calls, or visits. A specific time to return for an appointment will be noted in weeks, months, or as needed.
- **Follow-up**: Encounter forms or notes will have a notation, when indicated, regarding follow-up care, calls, or visits. Missed appointments will be noted in the medical record, including outreach efforts. Unresolved problems from previous office visits will be addressed in subsequent visits. Follow-up of referrals with any lab or test results should be maintained as well.
- **Appropriate use of consultants**: Review for under- and over-utilization will be noted. For example, repeated visits with a PCP for an unresolved problem might lead to a request for consultations with a specialty physician.
- **Continuity of care**: For example, if a consultation is requested, a note from the consultant, after the visit, must be documented in the record. If the visit does not occur (e.g., failed visit by the patient) the failure to visit should be documented as well.
- **Consultants/X-rays/lab and imaging report initials**: Consultations, lab and X-ray reports filed in the chart will have the primary care physician's initials and date signifying review. Consultation and abnormal results will have an explicit notation in the record of follow-up plans. Recommendation that date report/results received will be noted.
- **Medication documentation**: Current medication is documented, including complete dosage information, dates, and refill information.
- **Immunization record**: For adult immunization, physicians will follow the guidelines from the United States Preventive Services Task Force. For pediatric records, there will be a completed immunization record or a notation that "immunizations are up-to-date."
- **Preventive services**: There will be evidence that preventive screenings and services are offered. A suggested checklist may be provided to each office for use and inclusion in the medical record.
- **Addendum to record**: Any adult patient who inspects their record will have the right to provide to the physician a written addendum with respect to any item or statement in the record that the patient believes to be incomplete or incorrect. The addendum, which should be written on a separate page and include all applicable requirements (such as patient name, ID number, etc.) will be limited to 250 words per alleged incomplete or incorrect item and will clearly indicate, in writing, that the patient wished the addendum to be a part of the record. The physician will attach the addendum to the record and will include the addendum whenever the physician makes a disclosure of the alleged incomplete or incorrect portion of the record to any third party. The receipt of information in an addendum that contains defamatory or otherwise unlawful language, and the inclusion of this information in the record, will not, in and of itself, subject the physician to liability in any civil, criminal, administrative, or other proceeding.

Appointment wait standards

CMS requires MA organizations to continuously monitor access to care and member services. This Optum network may need to take corrective action, as necessary, to ensure that appointment wait times in the provider network comply with the CMS standards. The minimum standards for appointment wait times for primary care and behavioral health services are as follows for appointments:

- (A) Urgently needed services or emergency—immediately;
- (B) Services that are not emergency or urgently needed, but the enrollee requires medical attention—within 10 business days; and
- (C) Routine and preventive care—within 30 business days

If a member calls your office after hours, we ask that the recording played, or individual answering provides emergency instructions. Tell callers with an emergency to do one of the following:

- Hang up and dial 911 or local equivalent
- Go to the nearest emergency room

When it is not an emergency, but the caller cannot wait until the next business day, advise them to do one of the following:

- Go to a network urgent care center
- Stay on the line to connect to the physician on call
- Leave a name and number with your answering service (if applicable) for a physician or qualified health care professional to call back within specified timeframes
- Call an alternative phone or pager number to contact you or the physician on call

Substitute coverage

If you are unable to provide care and are arranging for a substitute, we ask that you arrange for care from other in-network practitioners and health care professionals so that services may be covered under the patient's network benefit. Review the most current directory of our network practitioners and health professionals at our website.

Access the provider lookup tool to find the current directory of our network practitioners and health professionals:
professionals.optumcare.com

After-hours access for behavioral health care

All behavioral health providers are required to utilize an automated answering system 24 hours a day, 7 days a week, to direct members to call 911 or to go to the nearest emergency room for any life-threatening medical or psychiatric emergencies.

Appointment access criteria

PCP and specialty access standards

Access type	Standard
Access to non-urgent appointments for primary care-regular and routine care (with a PCP)	Within 10 business days of request
Access to urgent care services (with a PCP or SCP) that do not require prior authorization	Within 48 hours of request
Access to urgent care (specialist and other) services that require prior authorization	Within 96 hours of request
Access to after-hours care (with a PCP)	Ability to contact on-call health care professional after hours within 30 minutes for urgent issues (appropriate after-hours emergency instructions)
Access to non-urgent appointments with a specialist	Within 15 business days of request
In-office wait time for scheduled appointments (PCP and specialist)	Not to exceed 15 minutes
Access to preventive health services	Within 30 days of initial request
Non-urgent appointments for ancillary services for the diagnosis or treatment of injury, illness, or other health condition	Within 15 business days of request
Appointment rescheduling	The provider must promptly reschedule the appointment in a manner that is appropriate for the patient's health care needs

Appointment access standards behavioral health

Access type	Standard
Access to non-urgent appointment with health care professional for routine care	Within 10 business days of request
Non-urgent appointments with a non-physician behavioral health care provider	Within 10 business days of request
Access to urgent care	Within 48 hours of request
Access to non-life-threatening emergency care	Within 6 hours of request
Access to life-threatening emergency care	Immediately
Access to follow-up care after hospitalizations for mental illness	Within 7 business days of request (initial visit); within 30 business days of request (second visit)

Appointment access standards exceptions

Access type	Exception to standard
Extending appointment waiting time	May extend waiting time for an appointment if the appropriate health care provider has determined and noted in the relevant record that a longer waiting time will not have a detrimental impact on the health of the member
Advance access	Implementation of standards, processes, and systems providing same or next business day appointments from the time an appointment is requested will demonstrate compliance for a PCP practice (includes advance scheduling of appointment at a later date if the member prefers not to accept the appointment offered within the same or next business day)
Advance scheduling	Preventive care services and periodic follow-up care may be scheduled in advance consistent with professionally recognized standards of practice as determined by the treating licensed health care provider

Preventive care recommendations for men and women ages 50 and older

Immunizations	Standard
Flu, annual	Recommended
Hepatitis A	For individuals with risk factors; for individuals seeking protection
Hepatitis B	For individuals with risk factors; for individuals seeking protection
Pneumococcal (pneumonia)	Recommended for individuals 65 and older and individuals under 65 with risk factors
Td booster (tetanus, diphtheria)	Recommended once every 10 years
Varicella (chicken pox)	Recommended for adults without evidence of immunity; should receive 2 shots
Zoster (shingles)	Recommended for all adults 50 and older

Screenings/counseling/services	Standard
AAA (abdominal aortic aneurysm)	For men ages 65 to 75 who have ever smoked; one-time screening for AAA by ultrasonography
Alcohol misuse	Behavioral counseling
Aspirin	Visit to discuss potential benefit of use
Blood pressure, depression, height, weight, BMI, vision and hearing	At wellness visit, annually
Breast cancer	Recommended mammogram every 1 to 2 years for women ages 40 to 74
Breast cancer chemoprevention	Covered for women at high risk for breast cancer and low risk for adverse effects from chemo prevention
Cervical cancer	At least every 3 years if cervix present. After age 65, pap tests may be discontinued if previous test results normal
Colorectal cancer	Recommended for adults 45 to 75
Depression	For all adults
Diabetes	Recommend Type 2 diabetes screening for individuals who are overweight, obese, have sustained blood pressure greater than 135/80 mm Hg, or diagnosed HTN
Domestic violence and abuse	Screening and counseling for interpersonal and domestic violence
Gonorrhea	Recommended for all sexually active women who are at increased risk for infection
HIV	For all adults at increased risk for HIV infection
HPV	Recommended for all sexually active women 65 and younger
Lipid disorder	Screening periodically
Obesity	Screening, counseling, and behavioral interventions
Osteoporosis	Recommend routine screening for women 65 and older; routine screening for women under age 64 if at increased risk
Prostate cancer	Men 55–69 should have a discussion with their PCP to determine if screening is appropriate for them
Sexually transmitted infections	Medical intervention and behavioral counseling as needed
Syphilis	Recommended for individuals at increased risk for infection
Tobacco use and cessation	Screening for tobacco use and cessation intervention

Heart health

For heart health, adults should exercise regularly (at least 30 minutes a day on most days), which can help reduce the risks of coronary heart disease, osteoporosis, obesity, and diabetes. Patients should consult a health care professional before starting a new vigorous physical activity.

Other topics to discuss with patients

- Overall physical and emotional health*
  - Compared to one year ago, how would you rate your physical health in general now?
  - Compared to one year ago, how would you rate your emotional problems in general now? *This includes feeling anxious, depressed or annoyed.*
- Fall risk prevention*
  - Have you fallen or do you think that you are at risk of falling?
  - Do you have problems with your balance or walking?
- Urinary incontinence*
  - Have you experienced any leaking of urine?
  - Do you have concerns about bladder control?
- Exercise*
  - For heart health, adults should exercise regularly, at least 30 minutes a day on most days. This can help lower the risks of heart disease, brittle bones, obesity and diabetes.
  - Patients should talk to a doctor before starting a new intense exercise.
  - Food
  - Eat a healthy diet. Limit fat and calories. Eat fruits, vegetables, beans and whole grains every day.
  - The best calcium intake is around 1, 500 mg/day for post-menopausal women not on estrogen therapy.
  - Vitamin D is important for bone and muscle development, roles and safety.
- Sexual health
  - Sexually transmitted infection (STI)/HIV prevention, practice safer sex (use condoms) or abstinence.
- Substance use disorders
  - Stop smoking. Limit alcohol consumption. Stay away from alcohol or drug use while driving.
- Dental health
  - Floss and brush with fluoride toothpaste daily. Seek dental care regularly.
- Other topics
  - Possible risks and benefits of hormone replacement therapy (HRT) for post-menopausal women
  - Risk of prostate cancer and benefits of screening in men to determine what is best for you
  - The dangers of drug interactions
  - Glaucoma eye exam by an eye care professional for adults age 65 and older

** Patients are asked in the Health Outcomes Survey (HOS) if these 4 topics were discussed. Reference the Health Outcomes Survey information of the Quality section of this guide for more information.*

Service standards

Care coordination

All providers will work with this Optum network and with other providers of Optum network patients to effectively collaborate and manage care of members and to actively implement best clinical practices and clinical pathways as set forth by our Optum network policies and procedures.

The PCP is responsible for providing or overseeing comprehensive healthcare services for members. The PCP is the manager and medical home of a member's total health care needs. This includes:

- Providing care services and authorizing referrals for consultation, specialty and hospital services
- Having 24-hour call coverage for the medical care of assigned members
- Coordinating the entire spectrum of care to their assigned members including direct provision of all primary healthcare services, including preventive services

When tests, labs, or x-rays are ordered, it is the responsibility of the ordering provider, along with the primary care provider, to educate the patient on how and when results will be communicated, as well as to explain the meaning of the results. If follow-up is required, appointments should be scheduled and completed in a timely manner.

Office availability and wait times

We encourage providers to implement procedures and make reasonable efforts to ensure that:

- Members are seen by a clinician within 15 minutes of the member's appointment time
- Telephone hold times are less than 15 minutes
- Back-office lines are provided for network communication

The following information delineates the access standards for availability of services to members including primary care, specialty care, after-hours care, emergency services, waiting times for appointments, and proximity of specialists and hospitals to primary care (definitions of types of visits, access standards for behavioral health and recommended preventative care services are provided in Appendix).

Patient Eligibility

Verification of eligibility

When a patient visits their health care professional, the patient's eligibility should be verified at each visit before rendering covered services to ensure timely and appropriate claims payment for patients who are eligible with health care coverage. The health care professional should verify eligibility with the patient's health plan no more than 48 hours prior to providing covered services and again on the date of service. Eligibility may be accessed at **onehealthport.com**.

The patient's member ID card and verification of eligibility with the patient's health plan is not a guarantee of coverage. The health care professional should maintain a copy of the eligibility verification in the patient's file in case of retroactivity or eligibility disputes for payment purposes. In the event such activity or dispute occurs, the health care professional may be required to provide proof of the eligibility verification transaction to receive payment for covered services rendered.

Disclaimer: Please check the health plan's website for the most up to date member eligibility information as the data provided above is not a guarantee of payment or eligibility. For members with coverage in a UHC Medicare Advantage Health plan and where the member has selected a health care professional within OCN you can access UHC's member eligibility tool to verify member eligibility and benefits and to view the member's ID card.

Online with provider portal: onehealthport.com

Online with health plan:

- UHC: **uhcprovider.com/eligibility**
- Humana: **availity.com/**
- Coordinated Care members*: **coordinatedcarehealth.com/providers**

** Providers can accept verification of enrollment in Coordinated Care from the Recipient Eligibility Verification System (REVS) system in lieu of the ID card. Check online through our secure provider portal or use our IVR System.*

Example ID cards

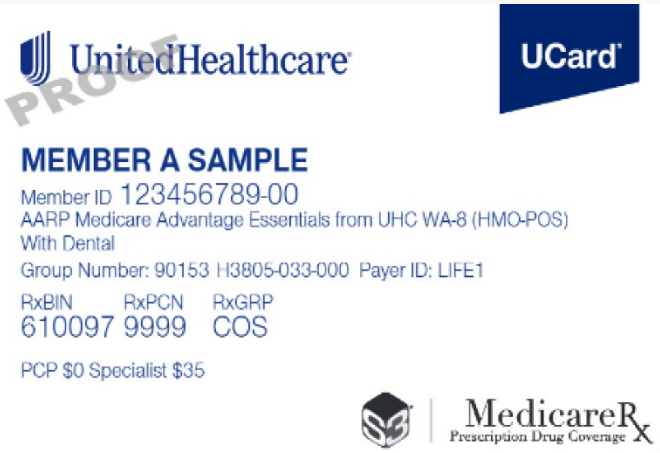
The member identification card will include the payer ID LIFE1, the Optum network claims address and health care professional services phone number.

Participating plans and sample of their member ID cards

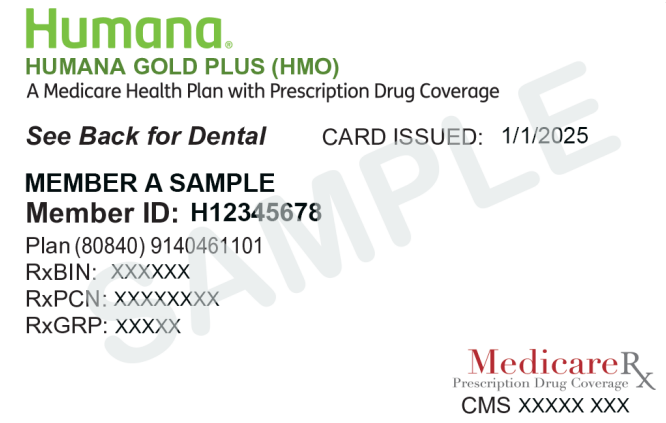
The cards represent the plans Optum manages in this Optum network. You can confirm the plan is managed by Optum by identifying the Payer ID of LIFE1.

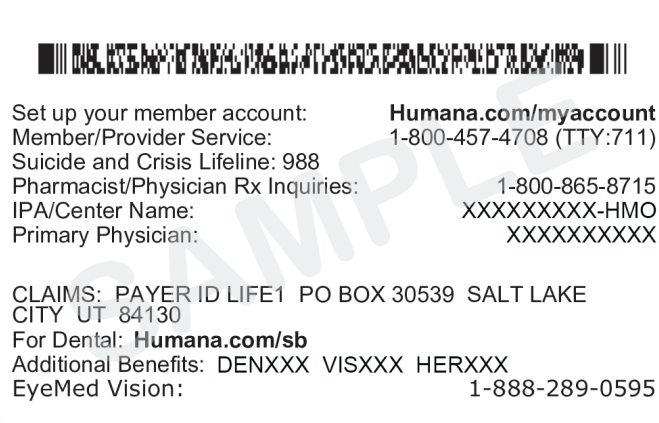
These member ID cards are samples for illustration only; actual information varies depending on payer, plan and other requirements.

Sample ID Card Front

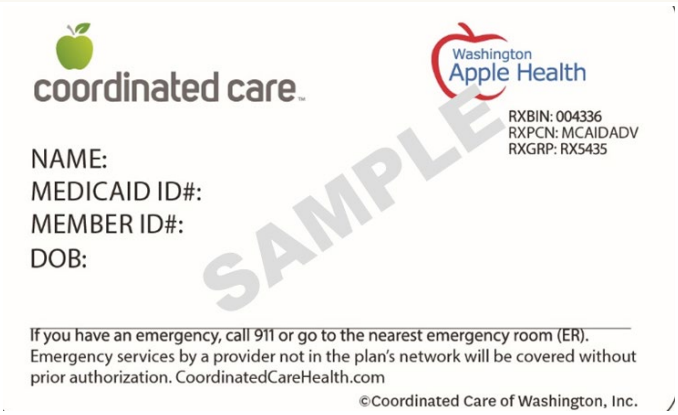


Sample ID Card Back

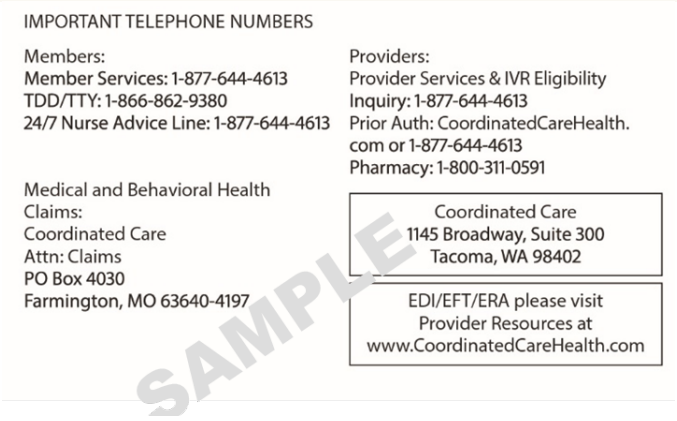




Sample ID Card Front



Sample ID Card Back



Claims

Claims overview

Optum is delegated to adjudicate and pay claims for selected health plans. Health care professionals and facilities are responsible for verifying patient eligibility, benefits and obtaining referrals/authorizations, if applicable, prior to services being rendered. Please refer to the table below:

Plan name and type	CMS contract	Group #	Type
AARP® Medicare Advantage	H3805	90890	HMOPOS
	H3805	91651	
	H3805	91647	
	H3805	92118	
AARP® Medicare Advantage Patriot	H4604	90912	HMOPOS
AARP® Medicare Advantage Plan 1	H3805	90902	HMO
	H3805	91656	
AARP® Medicare Advantage Plan 2	H4604	90913	HMOPOS
	H4604	90432	
AARP® Medicare Walgreens	H3805	90894	HMOPOS
	H3805	90409	
Humana Gold Diabetes	H5619	076/832	HMO
Humana Gold Plus	H2486	076/549	HMO
	H2486	076/550	
Humana Gold Plus	H5619	076/570	HMO
	H5619	076/118	
	H5619	076/616	
	H5619	076/112	
	H5619	076/833	
	H5619	076/542	
	H5619	076/156	
	H5619	076/113	
	H5619	076/545	
	H5619	076/617	
	H5619	076/114	
	H5619	076/116	
	H5619	076/530	
	H5619	076/537	
	H5619	076/541	
	H5619	076/536	
Humana Gold Plus	H1036	076/662	HMO
	H1036	076/346	
	H1036	076/596	
UHC AARP® Medicare Advantage	H3805	90910	HMO
	H3805	90907	
	H3805	90288	
UHC AARP® Medicare Advantage	90288	90291	HMO
UHC AARP® Medicare Advantage	H2001	90391	PPO
	H2001	90393	
	H2001	90376	
	H2001	90378	
	H2001	90389	
UHC AARP® Medicare Advantage	H2406	90799	PPO
	H2406	90858	
	H2406	92127	
	H2406	90797	
	H2406	90819	
	H2406	90818	
	H2406	90821	
	H2406	90797	
	H2406	90819	
	H2406	90818	
	H2406	90821	
UHC AARP® Medicare Advantage	H1278	90744	PPO
	H1278	90746	

Plan name and type	CMS contract	Group #	Type
UHC AARP® Medicare Advantage Choice	H1278	90738	PPO
	H1278	90361	
UHC AARP® Medicare Advantage Choice Plan 1	H1278	90742	PPO
	H1278	90740	
UHC AARP® Medicare Advantage Choice Plan 2	H1278	90750	PPO
	H1278	90369	
UHC AARP® Medicare Advantage Extras	H3805	90427	HMOPOS
	H3805	90294	
	H3805	90423	
UHC AARP® Medicare Advantage Patriot	H3805	90156	HMO
UHC AARP® Medicare Advantage Patriot	H1278	90748	PPO
UHC AARP® Medicare Advantage Plan 1	H3805	92117	HMOPOS
UHC AARP® Medicare Advantage Plan 1	H3805	90153	HMO
	H3805	90415	
UHC AARP® Medicare Advantage Plan 2	H3805	90155	HMO
UHC Medicare Advantage	H4604	90911	HMOPOS
UHG Medicare Advantage Cement Masons	H3805	92149	HMO
UHG Medicare Advantage City of Seattle	H3805	92210	HMO
UHG Medicare Advantage Harrison Electrical	H3805	92133	HMO
UHG Medicare Advantage HMO UFCW Local 555	H3805	92204	HMO
UHG Medicare Advantage Machinist H&W Trust	H3805	92169	HMO
UHG Medicare Advantage Pacific Coast Shipyards	H3805	92176	HMO
UHG Medicare Advantage Retirees Wellfare Trust	H3805	92190	HMO
Coordinated Care			

Please refer to the information below for claims submission information by health plan.

Plan name and type	OCN electronic claims	OCN paper claims
UnitedHealthcare Medicare Advantage (HMO and PPO)	Claims should be submitted electronically to **LIFE1.** OCN Electronic Claims Payor ID#: LIFE1 Clearinghouse: Optum360	Paper claims, though not preferred, can be mailed to: OCN Paper Claims Optum Care Network Claims PO Box 30788 Salt Lake City, UT 84130-0788
Humana Gold Plus (HMO)	Claims should be submitted electronically to **LIFE1.** OCN Electronic Claims Payor ID#: LIFE1 Clearinghouse: Optum360	Paper claims, though not preferred, can be mailed to: OCN Paper Claims Optum Care Network Claims PO Box 30788 Salt Lake City, UT 84130-0788
Humana (PPO)	Claims should be submitted electronically to **61101.** Humana Electronic Claims Payor ID#: 61101 Clearinghouse: Availity	Paper claims, though not preferred, can be mailed to: Humana Paper Claims PO Box 14601 Lexington, KY 40512
UnitedHealthcare Dual Complete (DSNP)	Claims should be submitted electronically to **95959.** UHC Electronic Claims Payor ID#: 95959	Paper claims, though not preferred, can be mailed to: UHC Paper Claims See back of member ID card for mailing address
Humana Gold Plus (DSNP)	Claims should be submitted electronically to **LIFE1.** OCN Electronic Claims Payor ID#: LIFE1 Clearinghouse: Optum360	Paper claims, though not preferred, can be mailed to: OCN Paper Claims Optum Care Network Claims PO Box 30788 Salt Lake City, UT 84130-0788
UnitedHealthcare Medicaid Advantage (Apple Health)	Claims should be submitted electronically to **LIFE1.** OCN Electronic Claims Payor ID#: LIFE1 Clearinghouse: Optum360	Paper claims, though not preferred, can be mailed to: OCN Paper Claims Optum Care Network Claims PO Box 30788 Salt Lake City, UT 84130-0788

Please do not submit duplicate claims unless you haven't received payment or an explanation of payment within 45 days of submission.

Reimbursement

Reimbursement for services is defined in your practice/facility participation agreement. However, your reimbursement is affected not only by the terms of your Agreement, but also the following:

- Patient's eligibility at the time of the service
- Whether services provided are covered benefits under the patient's health plan
- Whether services are medically necessary as required by the patient's health plan
- Whether services were without prior approval/authorization if authorization is required
- Patient copayments, coinsurance, deductibles and other cost-share amounts due from the patient and coordination of benefits with third-party payors as applicable
- Adjustments of payments based on coding edits described above

All services must comply with all federal laws, rules and regulations applicable to individuals or entities receiving federal funds, including without limitation Title VI of the Civil Rights Act of 1964, Age Discrimination Act of 1975, Americans with Disability Act and Rehabilitation Act of 1973. Please refer to your Provider/Facility Agreement for additional terms.

Nothing contained in the agreement or health care professional guide are intended to be a financial incentive or payment which directly or indirectly acts as an inducement for care providers/facilities to limit medically necessary services.

Charging members

Practices and facilities are responsible for verifying patient eligibility and benefits prior to services, including, but not limited to, obtaining authorization for services. Practices and facilities are responsible for the collection of copays, co-insurance and/or deductibles as applicable. Please refer to CMS guidelines for additional details.

Additionally, per your Optum participation agreement, practices and facilities shall not charge a Medicare Advantage patient for non-covered services under the patient's plan unless the patient has received a pre-service organization determination notice of denial from Optum or health plan before any such services are rendered. Please refer to your participation agreement for complete language.

Electronic data interchange (EDI)

An additional preferred method of claim submission is the Electronic Data Interchange (EDI). EDI is the computer-to-computer transfer of data transactions and information between payers and providers. Electronic claims submission allows the provider to eliminate the inconvenience and expense of printing and mailing claims to the network. It substantially reduces the delivery, processing, and payment time of claims. EDI is a fast, inexpensive, and safe method for automating daily business practices.

EDI claim submissions
Payer ID: LIFE1

There is no charge from Optum for submitting claims electronically to the network. Providers may use any major clearinghouse. Claim submissions must be in a HIPAA-compliant 837 I or P format.

Payer ID: **LIFE1**

Benefits of EDI

- Reduces costs
  - No more handling, sorting, distributing or searching paper documents
  - Keeps health care affordable to the end customer
- Reduces errors
  - Improves accuracy of information exchanged between health care participants
  - Improves quality of health care delivery and its processes
- Reduces cycle time
  - Enhanced information is available quicker
  - Ensures fast, reliable, accurate, secure and detailed information

EDI format

EDI has a standardized format, which ensures that data can be sent quickly and is interpreted on both sides. EDI transactions adhere to HIPAA regulations and American National Standards Institution (ANSI) standards. The EDI specifications are like blueprints for the data that guide the data to make the transitions between different data trading partners as smooth as possible.

Paper claims, reconsideration and refund submission

Optum prefers to receive claims electronically. However, claims submitted on paper are also accepted. If necessary, paper claims and correspondence may be submitted to the following addresses dependent upon member location:

Washington

Mail claims to:

Optum
P.O. Box 30788
Salt Lake City, UT
84130-0539

Paper submission

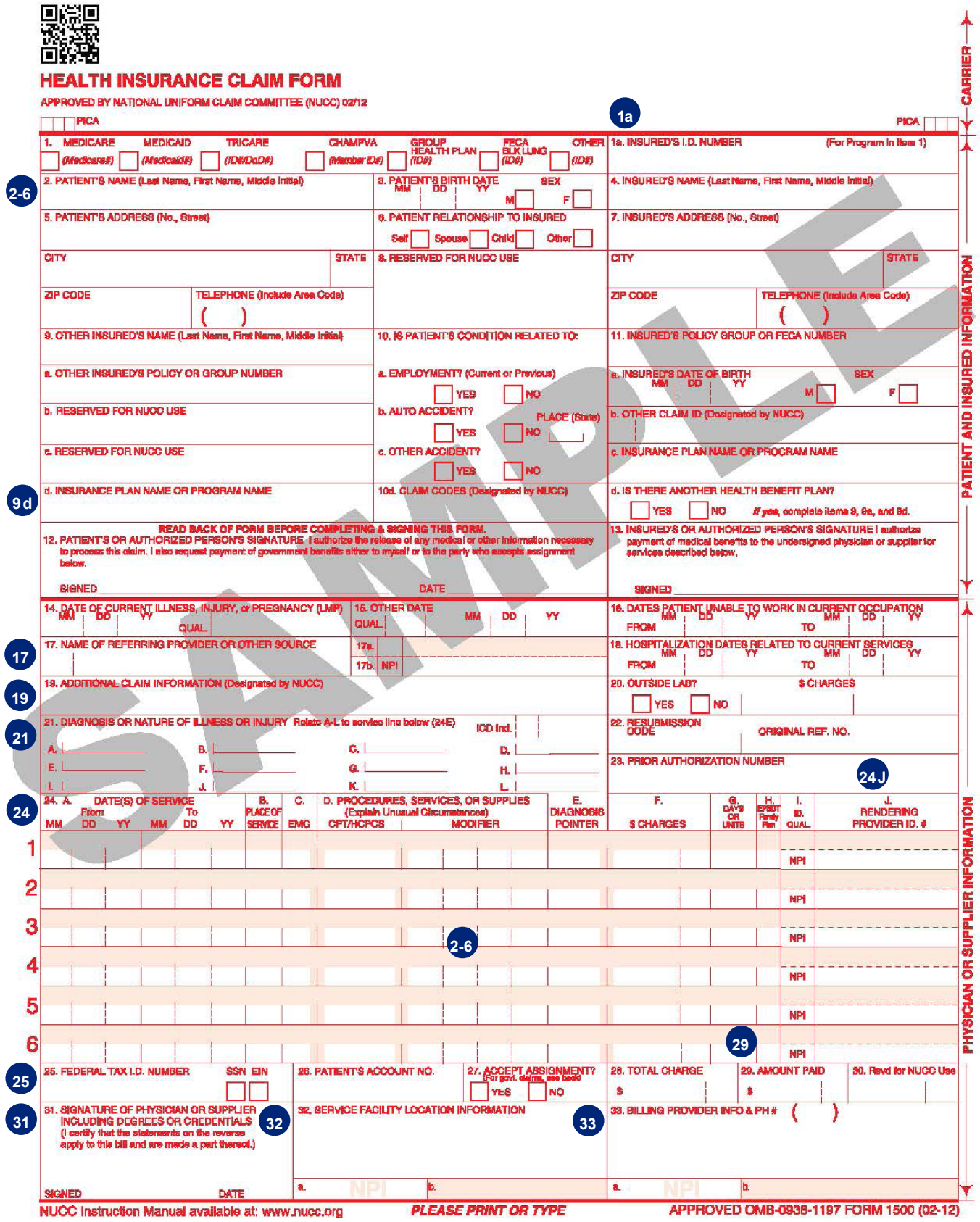
For paper submissions, please review the following to ensure that your claim is received and processed accordingly.

- Professional vendors must submit on a CMS 1500
- Ambulatory surgery centers preferred method of billing CMS 1450 with appropriate modifiers SG or TC
- Hospital and facility vendors must submit on a CMS 1450

How to complete the 1500 claim form

- Patient information
  - Box 1a: Member's External ID
  - Box 2-6: Member demographics including name, DOB, address, and gender Box 9D: Other insurance information (i.e., another primary payer)
- Provider/line-item details
  - Box 17: Referring provider
  - Box 19: Provider comments (i.e., corrected claim, 911)
  - Box 21: Diagnostic codes
  - Box 22: Resubmission code (if 7 in box, claim is a correction of a previously submitted claim)
  - Box 24A-G, 28, 29: Line-item details/charges about services rendered by provider
  - Box 24J, 25, 31: Rendering provider information
  - Box 32: Location services were rendered
  - Box 33: Billing provider (sometimes provider group information)

1500 claim type image



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code)

ZIP CODE TELEPHONE (Include Area Code)

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY | B. PLACE OF SERVICE | C. EMG | D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER | E. DIAGNOSIS POINTER | F. $ CHARGES | G. DAYS OR UNITS | H. EPSDT Family Plan | I. ID. QUAL. | J. RENDERING PROVIDER ID. #

1 NPI

2 NPI

3 NPI

4 NPI

5 NPI

6 NPI

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

1a 2-6 9d 17 19 21 24 2-6 29 25 31 32 33 24J

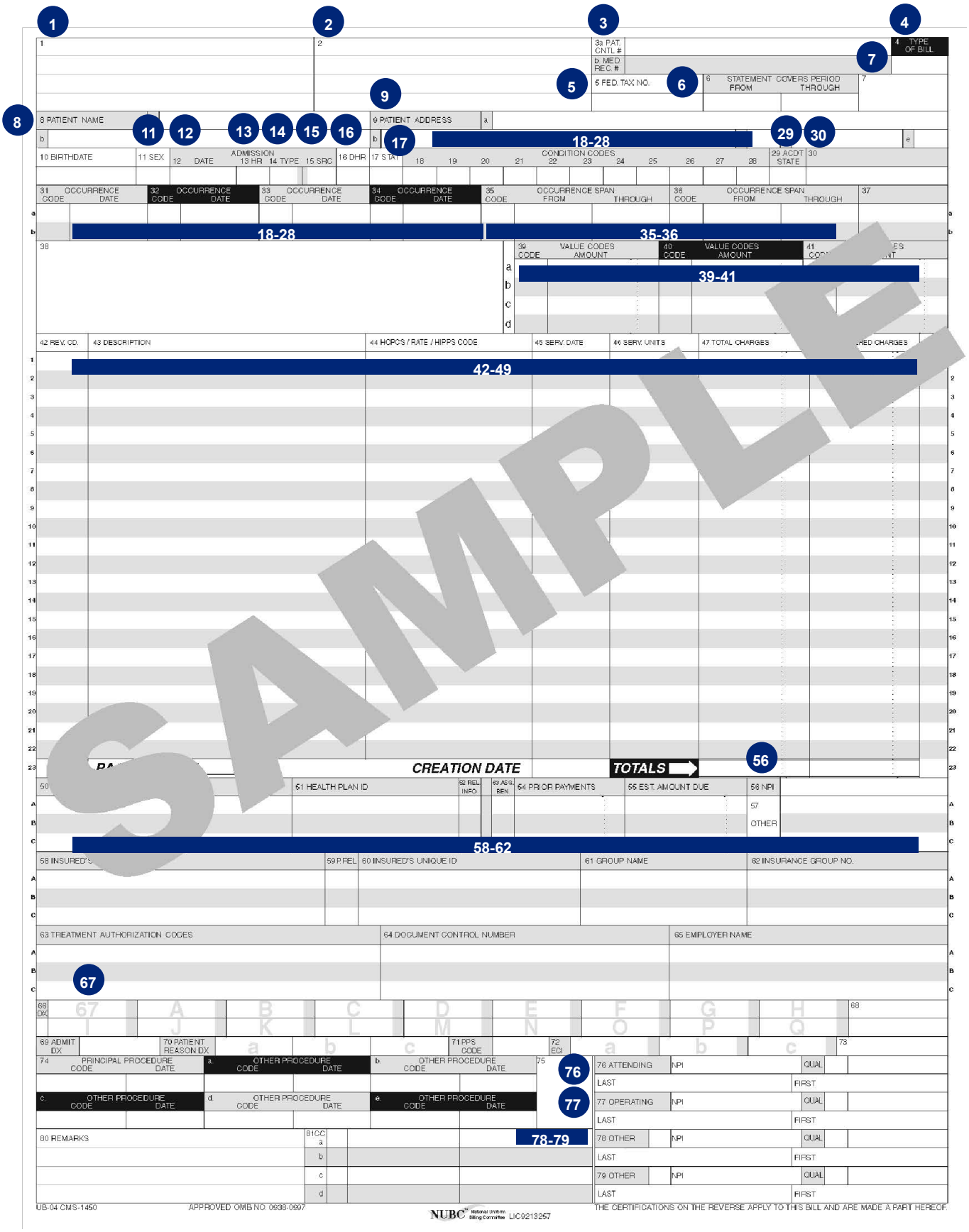
SAMPLE

How to complete the UB04 (1450) claim form

- Provider information
  - Box 1: Provider name and address
  - Box 2: Pay-to name and address (if different from Box 1)
  - Box 3a/b: Patient control number, medical record number
  - Box 4: Bill type
  - Box 5: Facility tax ID
  - Box 6: Statement covers period (DOS)
  - Box 7: Administrative necessary days
- Member validation
  - Box 8a-b: Patient name
  - Box 9a-d: Patient address
  - Box 10: Patient DOB
  - Box 11: Patient gender
- Admission information
  - Box 12: Admission date
  - Box 13: Admission hour
  - Box 14: Admit type (reason for admission)
  - Box 15: Source of admission
  - Box 16: Discharge hour
  - Box 17: Patient discharge status
  - Box 18-28: Condition codes
  - Box 29: Accident state (State in which accident occurred) Box 30: Accident date
  - Box 31-34: Occurrence codes and dates
  - Box 35-36: Occurrence span
  - Box 39-41: Value codes
- Line items
  - Box 42-49: Claim lines with information on services and charges provided
  - Box 56: Facility NPI
- Patient insured information
  - Box 58-62: Any additional information such as External
  - ID listed which can be used to validate the member
  - Box 67 A-Q: Diagnosis Codes
- Other providers
  - Box 76: Attending (admitting) name
  - Box 77: Operating ID
  - Box 78-79: Other provider ID

Click here for additional information regarding completing and processing the Form CMS-1450 Data Set.

UBO4 (1450) claim type image



Billing

Complete (clean) claims are those claims and attachments or other documentation that include all reasonably relevant information necessary to determine payer liability. To be considered a complete claim, the claim should be prepared in accordance with the National Uniform Billing Committee standards and should include, but not be limited to, the following information:

- A description of the service rendered using valid CPT, ICD-10, HCPCS, and/or revenue codes, the number of days or units for each service line, the place of service code/bill type and the type of service code
- Patient demographic information
- Provider of service name, address, National Provider Identifier (NPI) number and tax identification number
- Date(s) of service
- Amount billed
- Signature of person submitting the claim
- Other documentation necessary in order to adjudicate the claim, such as medical reports, claims itemization or detailed invoice, medical necessity documentation, other insurance payment information, referring provider information, attending provider information and associated NPI as applicable

Incomplete claims or claims requiring medical records in order to make a determination of payer liability will be contested back to the provider via EOB with a descriptive reason code informing the provider what additional information is needed. Medicare claims will be developed in accordance with CMS regulations. Any claims submitted with invalid codes or claims missing required billing elements will be mailed back to the provider with reason codes attached requesting a corrected claim.

All payments and copayments are subject to the benefit information as defined by the patient's specific health plan benefit plan. Claims payment is always dependent on patient eligibility status on the date of service as determined by the health plan.

Claims and encounter submissions

For proper payment and application of copayment, deductible and coinsurance, it is important to accurately code all diagnoses and services in accordance with national coding guidelines. It is particularly important to accurately code because a patient's level of coverage under his or her benefit plan may vary for different services. You must submit a claim and/or encounter for your services, regardless of whether you have collected the copayment, deductible or coinsurance from the patient at the time of service. All claims are validated using clinical editing software to check for coding accuracy.

Anesthesia

Anesthesia is processed following the American Society of Anesthesiologists (ASA) guidelines:

- One (1) unit = fifteen (15) minutes of anesthesia time
- All anesthesia time is prorated and rounded to the nearest tenth
- 5010 EDI transactions must be reported in minutes. Should the procedure code have minutes in the description, then units are still acceptable

Immunizations and injectable medications

- Must include the appropriate National Drug Code (NDC) number and the corresponding quantity for each NDC unit dispensed
- Must include the appropriate HCPCS/CPT code and corresponding quantity for each HCPCS/CPT unit dispensed
- Reimbursement is based upon CMS payment methodology for Part B drugs

DRG/APC reimbursements

DRG/APC reimbursement is validated using Optum Rate Manager files maintained by CMS to verify DRG grouping and provide appropriate CMS pricing. DRG claims may be reviewed, post-payment, to determine necessity for DRG validation, which include complete review of medical records. If the provider does not have an accurate rate file with CMS, then DRG/APC pricing may be affected.

Fee schedules

Reimbursement is based on the current Medicare fee schedule for the appropriate geographical area unless otherwise stated in the provider's contract.

Modifiers

The AMA industry standard modifiers are acceptable for billing. The Correct Coding Initiative (CCI) guidelines for claims payment and use of modifiers are used when adjudicating claims. CPT defines the standard, acceptable modifiers to be used for professional claims. HCPCS also includes acceptable modifiers for services not defined by CPT. Optum accepts modifiers published by CPT and HCPCS.

Multiple procedures

Multiple surgeries performed by the same health care professional on the same patient during the same operative session are reimbursed in accordance with Medicare guidelines, unless otherwise stated in the provider's contract.

Claims status

The fastest and most efficient way to check a claim's status for contracted health care professional is to utilize the provider portal at **onehealthport.com**. Care providers may view detailed claims information associated with their tax ID number. Most claim inquiries can be researched at **onehealthport.com**.

You can also call to check a claim status at **877-836-6806**, 8 a.m.–5 p.m. PT, Monday-Friday.

Claim receipt verification

- For verification of receipt of paper claim by OCN within 15 working days of receipt, you may access **onehealthport.com**. Please contact your OCN Practice Engagement Manager (PEM) representative for information about access to this website.
- You may verify the receipt of your electronic claims by contacting your clearinghouse directly.

Timely filing submissions

Submission timeframes

All parties must adhere to required timeframes when submitting claims, regardless of submission method (electronic or paper).

If you dispute a claim that was denied due to timely filing, you must show proof you filed your claim within your timely filing limits. Please see the provider dispute section of this manual for the required supporting documentation.

Examples of claims that may be denied as untimely include:

- Claims resubmitted because the original claim was denied for additional information or was processed incorrectly
- Corrected claims resubmitted for reprocessing (e.g., additional/ reduced charges, updated fee schedule)
- Claims with outdated member insurance information where Optum was either the primary or secondary payer

Submissions timeframe

Timely filing limit is 90 days or per the provider contract

Reconsideration and payment disputes

The timely filing limit is 365 days or per the provider contract. A request submitted after this timeframe may be denied. In the event of a conflict or inconsistency between this administrative guide and your network contractual agreement or applicable federal and state statutes and regulations, the terms of the contractual agreement (along with federal and state statutes and regulations) shall prevail.

Reconsideration or dispute timeframe

Timely filing limit is 365 days or per the provider contract

Common billing errors

Corrected claims

- Include all codes for rendered services that should be considered for payment
- Follow the billing terms of the contractual agreement, if applicable, along with federal and state statutes and regulations
- The appropriate claim change reason code is required on corrected or voided claims. Any facility claim billed with bill type XX7 must contain a “claim change reason” Condition Code i.e. D0-D9, E0
- Be sure to reference the original Optum claim ID when submitting your corrected claims

Professional (1500) bill type

- Resubmission code of 7 required in box 22/CLM05-3 with original Optum reference/claim number
- Resubmission code of 8 required in box 22/CLM05-3 for a voided claim

Facility (1450) bill type

- Frequency code of 7/CLM05-3 required in box 4

Optum claim IDs are formatted in the following 2 formats:

- YYESSSSSSSXX where YY = Year, E = alpha character/EDI indicator, SSSSSSS = numerical sequence, XX = numerical segment (i.e., ##A#########, 12 characters all numeric, with an alpha in the third position)
- YYJJJSSSSSXX where YY = Year, JJJ = Julian date, SSSSS = numerical sequence, XX = numerical segment (i.e., ############, 12 characters all numeric)

ABN modifiers

On May 5, 2014, CMS released that Advance Beneficiary Notice modifiers GA, GX, GY and GZ are to be used only for Medicare beneficiaries and not to be used for members of **Medicare Advantage** plans. As such, claims appended with GA, GX, GY, or GZ Modifiers on any claim line are invalid, and the claim will be denied for a corrected claim.

Contracted providers are expected to follow the organizational determination (prior authorization) process before rendering services that potentially could be non-covered. This process gives the member and provider appeal rights. Following an adverse determination of a non-covered service, if the member still wants to go forward with the procedure that is non-covered, contracted providers should enter a self-pay agreement with the member and not bill Optum for the services.

Provider fields in 837p

Use the correct fields to report various providers on an 837p transaction:

- Provider groups should be billed in 2010AA and 2010AB as needed
- Referring providers should be billed in 2310A
- Individuals rendering services should be billed in 2310B if not listed in 2010AA (be sure to include the provider's taxonomy)
- Facility where services are provided should be billed in 2010C

Helpful billing and claim tips

- EDI submission is the preferred method of claims submission: it's fast, easy and cost-effective
- Always verify the patient's eligibility at the time of service
- Submit the most current information to support accurate payment processing
- Provide accurate data and complete all required fields on the claim
- Be sure all billing staff is familiar with current billing and contract requirements and submit claims in accordance with any provider time limits for claims submission outlined in the contract

Common denial codes

Reading the provider remittance advice (PRA)

Information is listed on the PRA in addition to the amount paid. Denied claims are listed on the PRA with a detailed denial reason or reasons; these are helpful to refer to when submitting a provider dispute, correcting a claim or contacting the service center with questions regarding a claim.

Code	Definition	Healthcare claim adjustment reason code (CARC) and descriptions	Remittance remark codes (RARC) and descriptions
CDD/0FC	Duplicate of service previously submitted	18 - Exact duplicate claim/ service	Not applicable
ST/S16/S23	Claimant not effective or terminated for this date of service	109 - Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor	N418 - Misrouted claim; see the payer's claim submission instructions
TF1	Claim not received within the timely filing limit	29 - The time limit for filing has expired	Not applicable
H31	Category II Reporting Code(s) and/or Category III Emerging Technology Codes(s)	246 - This non-payable code is for required reporting only	Not applicable
0IT/0EK	Not a clean claim; billed information not complete or inconsistent with level of service; please resubmit corrected billing	16 - Claim/service lacks information or has submission/billing error(s)	N380 - The original claim has been processed, submit a corrected claim
WFL	Not a credentialed provider with this group on the date of service	B7 - This provider was not certified/eligible to be paid for this procedure/service on this date of service	Not applicable
z88	LCD/NCD: Missing or invalid Part B diagnosis	50 - These are non-covered services because this is not deemed a “medical necessity” by the payer	N115 - This decision was based on Local Coverage Determination (LCD)
CBI/ 0FF/ OPM/ OPQ/ OPS	COB information not received; resubmit with all other carrier’s EOBs	22 - This care may be covered by another payer per coordination of benefits	MA04 - Secondary payment cannot be considered without the identity of or payment information from the primary payer. The information was either not reported or was illegible. N479 - Missing Explanation of Benefits (Coordination of Benefits or Medicare Secondary Payer)
p09	Non-covered, restricted or bundled code	246 - This non-payable code is for required reporting only	Not applicable

Reconsideration requests

Provider dispute resolution process: Submit a reconsideration request

The Optum goal is to provide affiliated health care professionals and providers with readily accessible information that works to expedite interaction with our organization and will assist providers in their managed care and business operations.

Definition of a provider claim reconsideration request

A provider reconsideration request is a provider's written notice challenging and requesting the reconsideration of a claim (or a bundled group of substantially similar multiple claims that are individually numbered) that has been denied, adjusted or contested, or disputing a request for reimbursement of an overpayment of claims.

Examples of types of reconsideration requests

- Underpayment and/or overpayment
- Denials
- Provider contracts
- Provider credentialing
- Eligibility

Provider reconsideration request submission requirements

Each provider reconsideration request must contain the following information:

- Member demographic information
- Provider name, TIN and contact information

Provide the following to dispute a claim or reimbursement of an overpayment of a claim from Optum:

- Clear identification of the disputed item, such as the claim number(s), medical records, and invoices if applicable
- Date of service
- Clear description of the dispute

For provider reconsideration requests not concerning a claim, include a clear explanation of the issue along with provider's position on the issue. If there is a claim dispute/reconsideration process established in a provider's contract, the contract and state/federal regulations will govern the decision.

Helpful provider reconsideration request submission tips

- Complete and submit the provider reconsideration request form in full. Incomplete requests are returned to the submitter.
  - To submit a provider dispute, follow the dispute language on the Explanation of Payment (EOP). Refer to the Provider Claim Reconsideration form which can be found at **Optum.com** > Business > Providers > Resources > Forms and resources
- Please submit the reconsideration request as indicated on the form

Claim appeal by contracted Optum provider

Following completion of a claim reconsideration, providers contracted with Optum may submit a second-level appeal using the same process used for reconsiderations. Submit your appeal and indicate that this second-level request is an appeal. After the appeal has completed, providers may contact **opshelp@optum.com** for escalation of any unresolved claim issues. If the portal is unavailable, claim appeals from a contracted provider may be submitted to:

Attn: Optum Care Claims
PO Box 30539
Salt Lake City, UT 84130-0539

Dispute escalations

If a timely or reasonable resolution on a submitted reconsideration request has not been achieved, escalate to Optum Market Operations Research and Escalation department at **opshelp@optum.com** for triage and intervention. For example:

- Resolution is not being met and/or additional research is required
- Complexity of the issue requires cross-functional teams to drive resolution
- Level of provider escalation requires urgent action and/or resolution

Provider escalation process

1. Market Operations receives provider and claim escalation disputes via email from internal and external customers; examples may include incorrect rates, provider contract status, and incorrect claim denials
2. Research Analysts triage and research inquiries to determine root cause and identify potential trends
3. After the root cause is identified the Research Analyst engages the appropriate operational team to assist with resolution. The submitter receives communication notifying them of findings and next steps for resolution
4. After confirming resolution, the Research Analyst validates that the issue has been remediated and documents findings
5. The Research Analyst communicates resolution to the submitter

Past due payments

If the contracted provider dispute or amended contracted provider dispute involves a claim and is determined in whole or in part in favor of the provider, OCN, as agent for the health plan, will pay any outstanding monies determined to be due, and all interest and penalties required by law, within 5 working days of the issuance of the written determination.

Dispute resolution process for non-contracted providers

- Definition of Non-Contracted Provider Dispute: A non-contracted provider dispute is a non-contracted provider's written notice to OCN challenging, appealing, or requesting reconsideration of a claim (or a bundled OCN of substantially similar claims that are individually numbered) that has been denied, adjusted, or contested or disputing a request for reimbursement of an overpayment of a claim. Each non-contracted provider dispute must be submitted on a completed Provider Dispute Resolution Form and:
  - If the non-contracted provider dispute concerns a claim or a request for reimbursement of an overpayment of a claim from OCN to provider the following must be provided: A clear identification of the disputed item, the date of service, and a clear explanation of the basis upon which the provider believes the payment amount, request for additional information, contest, denial, request for reimbursement for the overpayment of a claim, or other action is incorrect.
  - If the non-contracted provider dispute involves an enrollee: The name and identification number(s) of the enrollee or enrollees, a clear explanation of the disputed item including the date of service, provider's position on the dispute, and an enrollee's written authorization for provider to represent said enrollees.
- Dispute Resolution Process: The dispute resolution process for non-contracted providers is the same as the process for contracted providers detailed previously in this guide.

Misrouted claims

If claim is misrouted to OCN that is not part of payer group that OCN processes, OCN shall either forward claims to appropriate payer for processing or send the provider a denial, notifying the provider that the claim was sent to OCN in error.

Electronic funds transfer (EFT)

Optum processes payments through the Optum Financial online tool, Optum Pay. Health care professionals enrolled in Optum Pay will receive electronic payments. Health care professionals not enrolled in Optum Pay will receive payments in the form of a paper check or virtual card payment (VCP) mailed to the address on file with Optum until Optum Pay enrollment has been activated. Access Optum Pay at **optumproportal.com**: Select *Payments* from the navigation ribbon on your portal dashboard.

About Optum Pay

- Secure, easy access to claims payment data
- Data download options drive efficiencies
- Flexible administrative management options

Optum Pay enrollment

Enroll online in Optum Pay automated clearing house (ACH) to receive electronic payments. Access Optum Pay enrollment at **myservices.optumhealthpaymentservices.com**. The following information is required to complete your enrollment:

- Current bank account information (account number and routing number)
- A copy of a voided check
- A W-9 or bank letter

Once you have submitted your Optum Pay enrollment, it may take up to 10 business days for your enrollment to be activated.

Note: To receive electronic remittance advice (ERA), i.e. 835, through a clearinghouse, please contact Payment Services Support for more information at **888-477-0256**, 6 a.m.–6 p.m. MT, Monday–Friday.

For more details, please review the below helpful links/videos:

- **How to enroll in Optum Pay**
- **Frequently asked questions**
- **Learn more about Optum Pay (benefits, resources, and videos)**

Need help getting an ERA?

Contact Optum Payment Services Support at **888-477-0256**, 6 a.m.–6 p.m. MT, Monday–Friday

Optum Pay support

If you have questions regarding your Optum Pay account, please contact **877-620-6194**, 8 a.m.–5 p.m. PT, Monday–Friday.

Medical records requests

An Optum health care professional may receive a request to submit medical records in response to an Optum team. Please note the request type and submission details. The following request type submission processes are detailed in this guide:

- Medical Claim Review (MCR) medical records request
- Claim denial letter resulting in provider submission of Reconsideration Request
- Pend response from Optum Prepayment Review System (OPRS)
- Optum Care Payment Integrity medical records request

Medical Claim Review response

The Optum Care Medical Claim Review (MCR) team reviews readmissions for a similar or related condition (same or similar DRG) that occurs 30 days following a prior discharge, from the same hospital to determine whether the readmission was preventable.

Why are medical records requested?

Claims are identified by Optum Payment Integrity as readmission claims. Once the claims are identified, the Medical Claim Review (MCR) team requests medical records from the facility for both the readmission claim and the previous inpatient stay. Providers are encouraged to fulfill all medical record requests within the designated timeline communicated within the request.

Please provide all information relevant to the claim and dates of service requested. Failure to provide all essential documentation may delay the review or denial of the claim line charges due to services not being supported.

You may receive a medical record request for a procedure that was previously authorized. MCR requests are separate from prior authorization reviews and are an attempt to verify services billed and documented.

How to submit medical records

Medical records may be submitted by paper copy. Instructions on how to submit by each method is included with each medical record request.

Optum Care Claims
P.O. Box 30539
Salt Lake City, UT 84130-0539

What happens next?

If the determination is that the readmission was unpreventable, the claim is processed accordingly. If the determination is that the readmission was preventable, the readmission claim is denied. The facility may submit one claim and receive one combined DRG payment for both admissions because both are for the treatment of the same episode of illness.

Need help?

Contact the Provider Inquiry Resolution Team (PIRT) to discuss a medical record request or review findings.

- Phone: **800-940-5732**, 8 a.m.–6 p.m. ET, Monday - Friday

Claim denial letter response

If a claim is denied and medical records must be submitted in the dispute/reconsideration, please submit the medical records using the Reconsideration Request process.

Optum Prepayment Review System (OPRS) pend recommendation response

As detailed in the Payment Integrity section of this administrative manual, a provider may receive an OPRS review response pending medical records. Pend recommendations will trigger a medical record request from OptumInsight. All reviews are validated by Optum Care Payment Integrity. Providers are encouraged to fulfil all medical record requests within the designated timeline communicated within the request.

Please provide all information relevant to the claim and date of service requested. Failure to provide all essential documentation may delay the review or denial of the claim line charges due to services not being supported. Unless otherwise stated in your agreement, supply records to Optum free of charge.

At times there may be a medical record request for a procedure that was authorized prior. OptumInsight requests are separate from prior authorization reviews, as these reviews are an attempt to verify services billed and documented.

How to submit medical records

Medical records may be submitted by secure online upload, paper copy or CD/DVD. Submission instructions will be included with each medical record request. *Online submission is preferred for accuracy, speed and security.*

Online: sftp.databankimx.com/form/RecordUploadService?ID=0031

Mail (USPS):
Optum
PO Box 51056
Philadelphia, PA 19115

Delivery Service (FedEx, UPS):
Optum
458 Pike Road
Huntingdon Valley, PA 19006

Do not submit medical records to Optum Care directly. Requested medical records are submitted to OptumInsight directly via the above submission options to ensure delivery to the correct department and assigned reviewer.

Initial review findings

After medical record review completion, the health care professional will receive an initial review findings letter from OptumInsight if any part of the associated claim is denied. This letter will state the reason for denial and provide instructions for filing an appeal, if the submitter chooses to appeal.

Corrected claims submission

Upon receiving a medical record request, you may also realize that you would like to submit a corrected claim in lieu of medical records. Corrected claims appropriately billed should follow the normal claim resubmission process to Optum via Payor ID: LIFE1 or the Optum claims address.

Provider Inquiry Resolution Team (PIRT)

- Should you need to call and discuss an OPRS medical record request or review findings, please contact OptumInsight
- **Phone: 800-940-5732**, 8 a.m.–6 p.m. ET, Monday - Friday

Optum Care Payment Integrity FWA/ANA/DRG* medical records response

In the case of a medical records request from Optum Care Payment Integrity (PO Box 30773), the health care professional will receive a letter requesting to submit medical records. You will receive a medical record request letter for all reviews conducted by Optum Payment Integrity. In response, please follow instructions detailed in the request letter. Providers are encouraged to fulfill all medical record requests within the designated timeline communicated within the request. Please provide all information relevant to the claim and date of service requested. Failure to provide all essential documentation may delay the review or potentially deny the claim due to documentation not received. A copy of the request letter from Optum Care FWA/ANA/DRG should be included in your response submission. You may send records either electronically through the PCH Global portal using the reference guide as instructions or by mail.

At times there may be a medical record request for a procedure that received prior authorization. Optum requests are separate from prior authorization reviews, as these reviews are an attempt to verify that services billed are supported by documentation.

Initial review findings

If the medical record review results in any part of the associated claim being denied, you will receive an initial review findings letter from Optum. This letter states the reason for denial and provides instructions for filing a reconsideration, should you so choose. If you are an out-of-network provider and no payment has been made, appeal information is found on the EOP/ERA sent from the payment vendor.

How to submit medical records

Medical records may be sent by paper copy or CD/DVD. Instructions on how to submit by each method is included with each medical record request.

- Online: Begin with **this guide** to access **PCH Global (exelatech.com)**
- Mail (USPS):
  Optum Care – Payment Integrity
  PO Box 30773
  Salt Lake City, UT 84130-0773

Should you disagree with the overpayment notification, please submit your payment dispute via provider claim reconsideration request as indicated in this guide.

**FWA: Fraud, Waste & Abuse; ANA: Analytic; DRG: Diagnosis Related Grouping*

Type	Records	Mail	Delivery (FedEx/UPS ground)	Phone
DRG Coding and Compliance	Email: **recordsintake@ optum.com** Fax: **646-349-2406**	Optum DRG Validation PO Box 31338 Salt Lake City, UT 84131	Optum DRG Validation 1355 S 4700 West Salt Lake City, UT 84104	**877-787-2310**
DRG Appeals	Fax: **781-240-0509**	Optum Attn: DRG Appeal Dept PO Box 31338 Salt Lake City, UT 84131	Optum Attn: DRG Appeal Dept 1355 S 4700 West Salt Lake City, UT 84104	**877-787-2310**
Itemized Bill Review	Email: **mca@optum.com** Fax: **800-435-2049**	Optum – IBR Medical Claims Analyst – Admin PO Box 1090 Draper, UT 84020-1090	Optum – IBR Medical Claims Analyst – Admin 12921 S Vista Station Blvd Draper, UT 84020	**800-304-5649**
Itemized Bill Review Appeals	Email: **reconsiderations@ optum.com** Fax: **866-700-5769**	Optum - IBR IBR Claims Disputes PO Box 1090 Draper, UT 84020-1090	Optum - IBR 12921 S Vista Station Blvd Draper, UT 84020	**888-895-2254**
Outpatient Facility	Email: **recordsintake@ optum.com** Fax: **646-349-2406**	Optum Outpatient Validation PO Box 31338 Salt Lake City, UT 84131	Optum Outpatient Validation 1355 S 4700 West Salt Lake City, UT 84104	**877-787-2310**
Outpatient Facility Appeals	Email: **recordsintake@ optum.com** Fax: **646-349-2406**	Optum Outpatient Validation PO Box 31338 Salt Lake City, UT 84131	Optum Outpatient Validation 1355 S 4700 West Salt Lake City, UT 84104	**877-787-2310**
Short Stay Bill Validation	Email: **recordsintake@ optum.com** Fax: **646-349-2406**	Optum SSBV Appeal Dept PO Box 31338 Salt Lake City, UT 84131	Optum SSBV Appeal Dept 1355 S 4700 West Salt Lake City, UT 84104	**877-787-2310**
Hospital Bill Audit	Email: **schedulers@ optum.com** Fax: **800-861-9361**	Optum HBA Validation PO Box 31338 Salt Lake City, UT 84131		**800-777-5589**
Hospital Bill Audit Disputes	Email: **schedulers@ optum.com** Fax: **800-861-9361**	Optum HBA Validation PO Box 31338 Salt Lake City, UT 84131	Optum Attn: HBA Claims Disputes 1355 S 4700 West Salt Lake City, UT 84104	**800-777-5589**

OON appeals and disputes

UnitedHealthcare appeal language

Pursuant to federal regulations governing the Medicare Advantage program, non-contracted providers may request reconsideration (appeal) of a Medicare Advantage plan payment denial determination including issues related to bundling or down coding of services. To appeal a claim denial, submit a written request within 65 calendar days of the remittance notification date and include at a minimum:

- A statement indicating factual or legal basis for appeal
- A signed waiver of liability form (**cms.gov/medicare/appeals-grievances/managed-care/notices-forms**)
- A copy of the original claim
- A copy of the remittance notice showing the claim denial
- Any additional information, clinical records or documentation that supports the argument for reimbursement

Humana appeal language

Appeals process for non-contracted Medicare providers

Pursuant to federal regulations governing the Medicare Advantage program, non-contracted providers may request reconsideration (appeal) of a Medicare Advantage plan payment denial determination. To appeal a claim denial, submit a written request within 65 calendar days of the remittance notification date and include at a minimum:

- A statement indicating factual or legal basis for appeal
- A signed waiver of liability form (**provider.humana.com/coverage-claims/payment-integrity/reconsiderations-appeals**)
- A copy of the original claim
- A copy of the remittance notice showing the claim denial
- Any additional information, clinical records, or documentation

Payment dispute process for non-contracted Medicare providers:

Pursuant to federal regulations governing the Medicare Advantage program, non-contracted providers may file a payment dispute for a Medicare Advantage plan payment determination. A payment dispute may be filed when the provider disagrees with the amount paid, including issues related to bundling of services. To dispute a claim denial, submit a written request within 120 calendar days of the remittance notification date and include at a minimum:

- A statement indicating factual or legal basis for the dispute
- A copy of the original claim
- A copy of the remittance notice showing for the claim payment
- Any additional information, clinical records, or documentation to support the dispute

For additional information on the non-contracted appeal and dispute processes including a form that may be used to facilitate your request for appeal or dispute, please go to **humana.com**.

We're here to help

If you have additional questions relating to a dispute decision made, you may contact your Optum Service Center.

Payment integrity programs

Payment Integrity

Optum Payment Integrity services ensures that the right payment is made to the right person at the right time.

Claims Editing System (CES)

Optum CES uses logic to check each claim for errors, omissions, and questionable coding relationships by testing the data against an expansive database containing industry rules, regulations and policies governing health care claims. Services identified to be out of required coding compliance are administratively denied. Should you disagree with the administrative denial, please submit your payment dispute via the options identified.

Refer to the Provider Claim Reconsideration Request process to submit a payment dispute.

Coordination of benefits (COB)

Coordination of Benefits (COB) post-pay program

If a patient presents current proof multiple health plans, coordination of benefits is the process the health plans use to decide which plan pays first for covered medical services or prescription drugs and what the second plan pays after the first plan has paid. Health plans coordinate benefits for several reasons:

- To avoid paying twice for the same covered service
- To determine which plan is primary, which means the insurer pays for covered services first according to the benefits provided by the plan; the other insurer pays secondary, which means it pays the remaining unpaid balance according to the benefits provided by its plan
- To help keep health and prescription drug costs affordable

When Optum is not the primary payer

If a patient presents current proof of other primary insurance making Optum the secondary payer, the provider has the right to bill the primary insurance and collect the applicable co-pays from the patient. The provider should bill the network following receipt of the primary payer's claim. Be sure to include a copy of the primary payer's remittance advice that shows the payment or denial by the other payer. Benefits will be coordinated with other carriers when Optum is notified that the patient has other insurance.

COB process for submitting overpayment refunds

You may satisfy the overpayment by sending your check and the signed letter to the Optum Claims Investigation and Recovery Department within 30 days. You may choose to initiate the debit process. This process applies future claims payment against the amount owed until the debt is satisfied. Please sign the letter and return it to the address listed here.

Please be advised that if a refund is not received within 30 days, future payments made to you for covered services may be reduced by the overpayment amount to recover overpayments.

Coordination of benefits (COB): Medicaid

Our Medicaid benefits contracts are subject to coordination of benefits (COB) rules:

- **COB:** We coordinate benefits based on the member's benefit contract and applicable regulations. We do this during claims adjudication.

All other health insurance, including Medicare and Tricare, are primary over Medicaid. Medicaid is only primary to any Tribal Health coverage unless the member is employed by a tribe and is self-insured. When billing UnitedHealthcare Community Plan, submit the primary payer's explanation of benefits (EOB) or remittance advice with the claim.

HCA enrolls some fee-for-service Medicaid members who have other primary health insurance.

The HCA covers some members under the fee-for-service Apple Health program, such as dual-eligible members whose primary insurance is Medicare. This means:

- Affected members will have 3 ID cards: a ProviderOne card, a primary insurance card and a UnitedHealthcare Community Plan card
- You must verify eligibility: Please verify member COB with UnitedHealthcare, not ProviderOne
- If OCN is billed as a secondary payer, OCN will not require prior authorization. However, if the member's primary health insurance does not cover the service, you must follow OCN requirements.
- When COB payment is equal to or more than the allowable rate, the primary insurance has no patient responsibility, and the claim is paid in full, OCN requires no additional payment
- When COB payment is equal to or less than allowable rate with a patient responsibility from the primary insurance, OCN reimburses the patient responsibility up to the allowable rate
- When the COB payment is less than primary's allowable rate for services performed, OCN pays for the difference between the primary payment and the OCN allowable rate
- Claims received with pediatric preventive, private duty nursing procedure codes and ABA procedure codes follow OCN Pay & Chase policy
- OCN may bill or adjust claims with COB within 30 months of the initial process date

Subrogation

Auto Accidents (and other accidental occurrences)

If services rendered are related to an automobile accident or another party at-fault occurrence, claims are generally paid by Optum via pay and chase.

Optum will work to recover dollars from at-fault party.

Workers' compensation

If services rendered are workers' compensation related, the provider is authorized to bill the appropriate carrier. If the claim is denied by the carrier, submit confirmation and bill to Optum for processing.

Data mining

Data mining is an analytic program which identifies aberrant payments due to various root causes. Services identified as overpayment are administratively denied.

Process for submitting overpayment refunds

You may satisfy the overpayment by sending your check and the signed letter within 30 days.

You may choose to initiate the debit process. This process applies future claims payment against the amount owed until the debt is satisfied. Please sign the letter and return it to the address listed here.

Please be advised that if a refund is not received within 30 days, future payments made to you for covered services may be reduced by the overpayment amount to recover overpayments.

Payment Integrity review

Payment Integrity review is a PI Operations program designed to detect, prevent, and recover funds for services deemed ineligible for payment due to policy and coding non-compliance. The program is comprised of three types of reviews:

- Post payment review – Professional and Facility
- Pre-payment review – Professional and Facility
- Provider education – Professional and Facility

Should you disagree with the overpayment notification, please submit your payment dispute according to instructions for a Provider Claim Reconsideration Request as detailed in this guide.

Optum Prepayment Review System (OPRS)

OPRS is a predictive analytic tool for professional and institutional medical claims. The OPRS review identifies aberrant behavior requiring additional review prior to payment. Post-adjudication, pre-pay claims are reviewed by the OPRS coding review team. OPRS returns a process recommendation for each service line. One of four recommendations are applied:

- Allow
- Deny
- Pend (for medical records)
- Hold (48-hr hold for additional internal review)

OPRS is managed by Optum Insight, a vendor partner to the Optum Payment Integrity (OCPI) program.

Optum Insight

Optum Insight is a vendor partner to the Optum Payment Integrity program, providing pre- and post-pay reviews on DRG Coding and Compliance™, Outpatient Facility™, Itemized Bill Review™, Short Stay Hospital Bill Validation™ and Hospital Bill Audit™.

DRG Coding and Compliance™

DRG Coding and Compliance™ is a coder-driven, post-claim-payment process of reviewing claims and matching to medical records to ensure the DRG, diagnosis and procedures are aligned with the services rendered.

Outpatient Facility™

Outpatient Facility™ is a post-claim-payment process of reviewing claims and matching to medical records to ensure the billed services are aligned with the services rendered.

Itemized Bill Review (IBR)™

Itemized Bill Review (IBR)™ are pre-pay claim reviews for DRG claims that have hit an outlier status. Optum works directly with the Facility providers to obtain the itemized bill and ensures all outlier charges are billed appropriately.

Short Stay Hospital Bill Validation™

Short Stay Hospital Bill Validation™ (SSBV) is a nurse-driven, post-claim payment audit to determine if an inpatient intensity was provided appropriately. The nurse auditor compares the medical record against the claim submission.

Hospital Bill Audit™

Hospital Bill Audit™ (HBA) is the post-claim-payment process of reviewing claims and matching to medical record to ensure physician orders, nursing documentation, provider contracts and payments are aligned and consistent with CMS guidelines. Registered nurses are responsible for the review of these audits and use historical data to conduct focused reviews.

Payment Resolution Services (PRS)

Payment Resolution Services is a recovery team within Optum tasked to pursue overpayment recovery efforts for unsatisfied overpayment balances within 150 days of the initial requests for refund.

These efforts may be in the form of phone calls or letter correspondence on behalf of Optum to reach overpayment recovery resolution.

Advanced Communication System (ACE)

The Advanced Communication System is an EDI capability that identifies potential billing errors within a claim and allows care providers the opportunity to review and repair the claim before it is processed.

ACE program overview

ACE Edits are sent within 24 hours of a claim submission, so problematic claims may be reviewed in a matter of hours instead of formerly resulting claims denials days later.

- ACE edits are designed to identify the specific error that triggered the edit.
- A message on the 277CA clearinghouse rejection report will explain why the claim was flagged and provide direction on how to update and resubmit the claim, or if any future action needs to be taken. An informational banner is exhibited on all claims receiving ACE edits. The intent of the banner is to provide resources for further information on ACE edits and the associated policies at a claim level – see example to the right.

ACE edit types

- **Return edit:** Sent when the claim in question is likely to result in a denial, reduce potential medical record requests or reduce potential future overpayment requests if it continues into the Optum claims processing system. This edit is found at the line level of the claim.
- **Rejection edit:** Sent when the claim is automatically returned and needs immediate attention. If no action is taken to correct the claim, it will not enter the Optum claims processing system. This edit is found at the line level of the claim.
- **Documentation edit:** Will notify you when a claim requires additional information. Supporting documentation can be submitted through the provider portal. This edit is found at the line level of the claim.
- **Information edit:** Message notifies you of key information in the claim submission process or about upcoming events that require your attention. Informational Edits are found at the line level of the claim and do not impact the specific claim.

Z-Code assigned molecular tests

Optum requires health care providers to include the appropriate DEX™ Z-Code™ for molecular diagnostic test services when submitting Medicare Advantage claims. The DEX Z-Code is required in addition to the CPT® code, and this requirement applies to both facility and professional claims.

DEX Z-Code registration

If you haven't already obtained a DEX Z-Code for your test, please register by visiting **dexzcodes.com** to prepare for this upcoming change and help ensure there's no disruption in your payment.

What to expect after you complete your registration

- The initial review for Z-Code assignment takes approximately 2 weeks from test submission
- The Z-Code can be submitted on claims once you have received email notification that the test has been assigned a recommended CPT® code and the assessment is complete
  - This typically occurs within 60 days from Z-Code assignment
- You will be notified by email if additional documentation is required dependent on test complexity
- For further guidance on the timeline for the registration of your tests, refer to **DEX Diagnostics Exchange Test Registration**

Why this is important

- Providing the Z-Code on a claim, with the appropriate CPT® code, will clearly identify the test being performed and eliminate some of the administrative burden you may encounter surrounding billing for these services. This requirement applies to both facility and professional claims.
- Claims for molecular pathology services will be denied if the DEX Z-Code information is missing, invalid or does not match the service represented by the CPT® code reported on the claim. Claims denied for missing or invalid information may be resubmitted with the required information.

For additional information regarding the technical assessment, please refer to the **frequently asked questions**. If you have questions about this new Optum claim requirement, please contact **opshelp@optum.com**.

Credit Balance Resolution (CBR) program

The Credit Balance Resolution (CBR) program is a complimentary service offered to our providers and facilities, designed to alleviate the administrative burden associated with self-auditing and reporting of overpayments, as mandated by the Centers for Medicare & Medicaid Services (CMS). By participating in the CBR program, providers can significantly reduce staffing expenses related to these tasks, ensuring compliance with CMS regulations while allowing you to focus more on delivering high-quality patient care. Our vendor partners manage the entire process end to end, providing a seamless and efficient solution for handling credit balances on file.

Program overview

Upon identifying overpayments, the vendor will submit all findings for provider approval and package all relevant documents for submission to this Optum network for processing. Providers can choose their preferred method of reimbursement directly to the vendor, whether it be by check or requesting offset against future payments, to streamline the process. For more information on enrolling in the CBR program, please contact Optum network provider services.

Initial identification and review findings

- Credit Balance Resolution (CBR) will research and resolve credit balance accounts to facilitate claim adjudication for both the health plan and Provider. Overpaid claims are identified by both the Provider (solicited) and the CBR Contractor (unsolicited), then run through our business intelligence logic to determine likely payer refund
- The claims are then reviewed by assigned CBR Contractor Regional Account Manager (RAM) and resolved, bringing the account to a zero balance
  - Outcomes include payer refunds, patient refunds, or adjustments. These refunds or adjustments will be deposited into the account of the market/region where the overpayment was made
  - In addition, CBR Contractor will assign a dedicated claims manager to help research and resolve overpaid claims to 100% resolution
- CBR Contractor will provide monthly invoice including claims that were paid or offset throughout the monthly invoice cycle
- Upon Request, the RAM (Auditor) needs to provide Optum network documentation (EOB's, Explanation of Payment, etc.) as proof of valid recovery

To access a list of partnerships offering CBR services, you may contact your Optum Service Center.

Medical Management

Utilization management

The Optum Care Network of Washington (OCN) Utilization Management (UM) team works in concert with PCPs, specialists, and ancillary providers of care around the appropriate and efficient use of healthcare resources. The UM team also works collaboratively with discharge planners in hospitals and skilled nursing facilities to ensure positive patient outcomes.

OCN is not delegated for Utilization Management for all plans. Please refer to the Delegation by Plan table in the Appendix.

Referrals/prior authorizations

Prior authorizations are not required for office visits, when referring to a specialist or facility that is directly contracted with OCN or the patient's health plan.

If your patient requires a specialist or facility that is not within OCN or the member's health plan, a prior authorization is required. An authorization request form can be found on the Optum Care Provider Center and submitted online (at **onehealthport.com**) or faxed to **855-402-1684**.

- **Contracted OCN and/or Health Plan Providers**: Follow Health Plan Prior Authorization requirements for services/CPT codes requiring a Prior Authorization
- **Non-Contracted Providers**: Prior Authorization is required for all services, excluding emergencies, dialysis and urgently needed services when the network is not available

Prior authorizations

Prior authorization requirements can be accessed at **onehealthport.com** or by calling OCN at **877-836-6806**, 8 a.m.-5 p.m. PT, Monday-Friday. Additionally, Medicare Advantage prior authorization requirements can be found on the Provider Portal at **UHCprovider.com**.

Prior authorization requirements

Servicing provider	OCN contracted/plan contracted (Provider is contracted with OCN or the health plan)	Non-contracted/non-par (Provider is not contracted with OCN or the health plan)
UnitedHealthcare (Medicare PPO/HMO and Medicaid)	Follow UHC PA Guidelines UHC PA List Applies	All services provided by non-contracted providers require prior authorization (except for emergencies, urgently needed services when the network is not available, and dialysis).
Humana	Follow Humana PA Guidelines Humana PA list applies	

Please note: Not all plans have out-of-network benefits.

Requesting prior authorization

To submit a prior authorization notification, log in to **onehealthport.com**. If online is not available, call **877-836-6806**, 8 a.m.-5 p.m. PT, Monday-Friday, or fax your notification to:

- New Authorization (General): **855-402-1684**
- Part B New Authorization: **855-402-1684**
- Clinicals Submission for Authorization: **855-402-1684**

Submitting a prior authorization request online for Medicare Advantage members who have an OCN network PCP

Log in to **onehealthport.com** to start a new request and select submit. For urgent requests call: **877-836-6806**. Urgent requests will be addressed within 72 hours of online submission. An urgent request is defined as a request for a patient that meets one or more of the following conditions:

- Imminent, serious threat to his/her health
- Potential loss of life, limb or other major bodily function(s)
- The timeframe for routine decisions could be detrimental to the patient

Prior authorization provider notification process

When a prior authorization request is approved, OCN will notify the provider and enrollee so the provider may proceed with the service delivery.

When an adverse determination is made, OCN will notify both the provider and enrollee with a formal written notification that includes member appeal rights and next steps. The provider may also log in to **onehealthport.com** and access the referrals and prior authorizations to view the status of a prior authorization request.

Prior authorization time frames

The department strives to process each request as expeditiously as an enrollee's condition requires. According to CMS regulations for organizational determinations, the determination must be rendered within the following time frames:

Type of request	Turn-around time
Expedited or urgent pre-service requests	72 hours
Standard or non-urgent pre-service requests	14 calendar days
Part B Drug Expedited or urgent pre-service requests	24 hours
Part B Drug Standard or non-urgent pre-service requests	72 hours

Prior authorization status

A health care professional may log in to **onehealthport.com** and access referrals and prior authorizations to view the status of a prior authorization request or by call **877-836-6806**.

Out of network services

All out-of-network hospitalizations, surgeries, procedures, referrals, evaluations, services and treatment require prior authorization. All out-of-network providers require prior authorization for any service rendered. Please refer to the Prior Authorization Grid at **Optum.com** > Business > Providers > Resources > **Forms and resources.**

Utilization management annual criteria notification

The following is informational only and is required to be sent annually to all providers.

The Optum Care Network (OCN) Utilization Management Department is provided with nationally established criteria for the range of services and procedures that we examine for an appropriate use of resources. Upon request, the specific criterion used to make a decision is available for both the provider and the patient.

OCN Utilization Management decision making is based only on medical necessity, efficiency and appropriateness of healthcare services and treatment plans required by member benefit plans and protocols. OCN employees and vendors are not rewarded either financially or in non-monetary items of value ("Incentives") for issuing denials of coverage or care. Incentives for UM decision-makers do not encourage decisions that result in under-utilization and do not encourage creating barriers to care and service and Decisions to hire, promote or terminate OCN employees and vendors are not based upon the likelihood or the perceived likelihood that the individual will support or tend to support the denial of coverage.

All providers have the opportunity to discuss any utilization management denial decision with an OCN Medical Director.

Home health prior authorization

Prior authorization (PA) is required for all home health services after the initial start of care (SOC) and subsequent visits through day 14 during the 60-day certification period. Notification of admission to services is required (48-72 hours – verify by market).

- New home health care prior authorization: **877-836-6806**

Note: Start of Care (initial visit) does not require prior authorization. You can perform a comprehensive evaluation during the initial visit. and are required to provide notification only to Optum Care. After day 14 of episode within first certification period, prior authorization is required. If you do not obtain authorization before services are rendered when required, claims may be denied.

Home health prior authorization will be required for:

- Initial certification period on day 15-60
- Continuation of care
- Resumption of care (ROC)
- Additional visits
- Recertification for all subsequent 60-day episodes

Medicare home health HCPCS: G Codes

To request home health visits, the home health agency must use one of the Medicare appropriate HCPCS codes to represent each visit by each home health care discipline. S Codes will be denied/rejected for incorrect coding. Please refer to the below resources which include a link to the CMS manual on appropriate coding.

HCPCS Code	Description
G0299	Direct skilled nursing services of a registered nurse (RN) in the home health or hospice setting, each 15 minutes
G0300	G0300 Direct skilled nursing services of a license practical nurse (LPN) in the home health or hospice setting, each 15 minutes
G0151	G0151 Services performed by a qualified physical therapist in the home health or hospice setting, each 15 minutes
G0152	G0152 Services performed by a qualified occupational therapist in the home health or hospice setting, each 15 minutes
G0152	G0153 Services performed by a qualified speech-language pathologist in the home health or hospice setting, each 15 minutes
G0155	G0155 Services of clinical social worker in home health or hospice settings, each 15 minutes
G0156	G0156 Services of home health/hospice aide in home health or hospice settings, each 15 minutes
G0157	Services performed by a qualified physical therapist assistant in the home health or hospice setting, each 15 minutes
G0158	Services performed by a qualified occupational therapist assistant in the home health or hospice setting, each 15 minutes
G0159	Services performed by a qualified physical therapist, in the home health setting, in the establishment or delivery of a safe and effective physical therapy maintenance program, each 15 minutes

Understanding Optum home health approval with the G codes

All home health cases need to be submitted with the appropriate G code for discipline. Each G code will be equivalent to 1 visit. Although the G code is to be used and stated as 15 minutes, billing should be done where one unit corresponds to one visit in its entirety.

Example: G0299 X 9. This means Optum has approved 9 skilled nursing visits.

Home health denials: Peer-to-peer requirement

Peer-to-peer can only occur with ordering physician and Optum Medical Director.

Criteria used for home health medical necessity reviews

Optum uses Medicare criteria to facilitate medical necessity reviews for home health.

- Medicare Manual for Home Health requirements: **Medicare Benefit Policy Manual Chapter 7 Home Health Services**

Medicare home health conditions coverage

The following criteria for initial and subsequent home health visits will be reviewed and member must meet all 3 conditions with a Medicare certified agency for initial and subsequent home health visits:

- Member is homebound. This means needs assistance of another person or of a supportive device. Leaving home requires a considerable and taxing effort
  - There is a normal inability to leave the home.
- A physician's order
  - A physician or a recognized non-physician health care professional, had a face-to-face meeting with the member prior to certifying the individuals need for home care.
- Member requires skilled nursing care on an intermittent basis, or skilled physical/occupational therapy, and speech therapy.

How to request a home health prior authorization

Please submit for prior authorization 7 days prior to your first visit after Start of Care in order to ensure time for medical necessity review of the authorization. To submit a home health prior authorization notification, log in to **onehealthport.com**. If online is not available, call **877-836-6806**, 8 a.m.-5 p.m. PT, Monday-Friday, or fax your notification to:

- New Authorization (Home Health): **855-402-1684** (PA fax cover sheet and all documentation)

Initial authorization process

Regardless of the method of submission, you will be required to submit the following information upon review:

- Ordering Provider demographic information, TAX ID, NPI and office contact name, phone, and fax number
- Servicing Provider (Home Health Agency) demographic information, TAX ID, NPI and office contact name, phone, and fax number.
- Member demographic information
- Attestation to member meeting Centers for Medicare & Medicaid Services (CMS) criteria for home health eligibility
- Home Health Discipline (SN, PT, OT, SP, AIDE) and number of visits requested (Using G codes)
- Member primary diagnosis and secondary diagnosis's
- CMS-485 form/signed plan of care by ordering physician (or verbal start of care order is accepted)
- Start of Care OASIS will be required within 7 days of initial authorization to support the authorization request
- Initial therapy evaluation within 7 days of the initial authorization request
- Face-to-face encounter

Recertification: Completing request process

All recertifications require prior authorization for the 60-day increment and can be submitted using the same methods as listed above. Regardless of method of submission, you will be required to submit clinical documentation to support medical necessity criteria. This documentation includes:

- 485 form and/or start of care OASIS (if not already submitted)
- Home Health Discipline (SN, PT, OT, SP, AIDE) and number of visits requested (Using G codes)
- Last 2 visit notes per discipline involved
- Any other relevant clinical documentation

Additional discipline visit vs. add new discipline for certification period

If there is any modification to member's care plan the home health agency is required to submit prior authorization for additional visits or add-on discipline prior to requested service date. The home health agency must submit the following documents: documentation of Physician's order (verbal order accepted), clinical documentation as applicable to support request RN/LPN notes, Physical Therapy notes, Occupational Therapy notes, Speech Therapy notes, Home Health Aid notes and Medical Social Worker notes.

Compliance: Notice of Medicare Non-Coverage (NOMNC) – preparation and delivery

- Home Health agency must prepare and deliver the NOMNC
- Use the most current Medicare NOMNC (CMS-10123) form
- NOMNC must be delivered at least 2 calendar days before Medicare covered services end or the second to last day of service if care is not being provided daily
  - Note: Optum Prior Authorization Department can provide the current NOMNC form.
- Provider can type or write in the required fields:
  - The patient's name
  - The Medicare patient number
- The type of coverage (SNF, Home Health, CORF, or Hospice)
- The effective date (last day of coverage), which is always the last day beneficiaries will receive coverage for their services

If you have questions, please call Optum Care Service Center at **877-836-6806**.

Additional resources

- **Medicare Claims Processing Manual: Chapter 10- Home Health Agency Billing**
- **Benefit Policy Manual, Chapter 7 Home Health Services**

Referrals

Medicare Advantage members who have selected an OCN PCP will need to coordinate services with their network PCP for specialists, ancillary care providers, facilities and hospitals. The PCP will be the member’s first and foremost source of care. They can best refer the member to other network health care professionals or specialists when additional care is needed.

Specialty care

We have a large network that includes skilled medical professionals in almost every specialty. The specialists we contract with are carefully chosen and will work closely with you to provide the patient with what is needed.

Hospital admission notification requirements

Facilities are responsible for admission notification for the following types of admissions:

- All planned/elective admissions for acute care
- All unplanned admissions for acute care
- All post-acute care admissions:
  - Skilled nursing facility (SNF)
  - Long-term acute care (LTAC)
  - Acute inpatient rehab (AIR)
- All admissions following outpatient surgery
- All admissions following observation stay
- All admissions for observation

Unless otherwise indicated, admission notification must be received within 24 hours after actual weekday admission. For weekend and federal holiday admissions, notification must be received by 5 p.m. local time on the next business day.

Admission notification by the facility is required even if the health care professional supplied advance notification and a pre-service coverage approval is on file.

Receipt of an admission notification does not guarantee or authorize payment. Payment of covered services is contingent on coverage within an individual patient's benefit plan, the facility's eligibility for payment, any claim processing requirements and the facility's participation agreement with Optum.

Admission notifications must contain the following details regarding the admission:

- Patient name and health care ID number
- Facility name and National Provider Identifier (NPI) or Tax Identification Number (TIN)
- Admitting/attending health care professional name and TIN or NPI
- Description for admitting diagnosis or ICD-10-CM (or its successor) diagnosis code
- Actual admission date
- Inpatient or observation status

For emergency admissions when a patient is unstable and not capable of providing coverage information, the facility should notify Optum via phone or fax within 24 hours (or the next business day, for weekend or federal holiday admissions) from the time the information is known and communicate the extenuating circumstances. We will not apply any notification-related reimbursement deductions.

Reimbursement reductions for failure to timely provide admission notification

If a facility does not provide timely admission notification, the service may not be paid by Optum.

How to submit admission notifications

To notify OCN of hospital admissions no later than 24 hours after admission and 24 hours post discharge, log in to **onehealthport.com**.

If online is not available, notifications can be submitted:

- Phone: **877-836-6806**
- Fax: **253-627-4708**

Submit clinical Information for hospital admissions

- Online: **onehealthport.com**
- Fax: **253-627-4708**

Referral vs. prior authorization vs. advanced notification

The **referral** process, advance notification process and prior authorization processes are separate processes.

A referral is required for a member to see a specialist and is originated by the assigned PCP through the provider portal. While a referral is required by the health plan to see a specialist, it is not an authorization for payment for services. While a referral is considered a pre-approval to see a specialist, it does not require authorization from OCN. In simple terms, a referral can be considered as a warm hand-off from the PCP to the specialist to ensure communication of medical intent and patient history, appropriate care and ease of access for the member. The health plan uses the referral process to ensure that this process is followed.

A **prior authorization** is payment approval sought by a health care professional from the member's health plan for specific procedures, admissions, medical devices, medications, etc. The prior authorization process is a means of managing costs and the management of overall patient care based on evidence-based practices.

An **advanced notification** is notification to the health plan that an inpatient procedure or admission will occur, and a period of 5 days is recommended prior to the service delivery. A prior authorization request is often submitted at the same time the advance notification is done.

Prior authorization and hospital admission peer-to-peer process

The peer-to-peer process may be initiated before an adverse determination has been communicated to the member. The OCN nurse or coordinator will contact the ordering physician to make them aware that the request may be denied. If the ordering physician has additional clinical information that may help the request meet medical necessity criteria, the ordering physician is encouraged to contact the OCN medical director to provide such information. The peer-to-peer conversation gives the treating provider the opportunity to discuss the OCN determination before an actual denial has occurred and before the initiation of the appeals process.

Please call **877-836-6806** for a peer-to-peer discussion during the hours of 8 a.m.-5 p.m. PT, Monday-Friday.

The opportunity to discuss the determination is provided with the OCN medical director making the initial determination or a covering Optum Care medical director if the original OCN medical director is not available. If the peer-to-peer discussion does not result in the authorization of the request, OCN informs the provider and enrollee of their appeal rights during the notification.

NOTE: The peer-to-peer conversation may occur after the date/time provided during the notification call, however, once the adverse determination has been issued to the member, the initial adverse determination cannot be changed. If the peer-to-peer discussion does not result in the authorization of the request, OCN informs the provider of the appeal rights.

For Prior authorization only, Part B, Expedited and aged cases day 10 and greater are eligible for a peer-to-peer post decision discussion. A determination change is not available due compliance on case turnaround times. For a final determination change OCN informs the provider of the appeal rights.

Health improvement

Optum Care affirmative statement: Our principles of ethics and integrity code of conduct serves as a guide to acceptable and appropriate business conduct by the company's employees and contractors.

- Utilization Management (UM) decision-making is based only on medical necessity, efficiency or appropriateness of health care services and treatment plans required by provider contractual agreement and the patient's benefit plan
- Practitioners or other individuals are not rewarded for issuing denials of coverage or care
- Financial incentives for UM decision-makers do not encourage decisions that result in under- utilization nor are incentives used to encourage barriers to care and service
- Hiring, promoting, or terminating practitioners or other individuals is not based upon the likelihood or the perceived likelihood that the individual will support or tend to support the denial of benefit.

Optum Care uses standardized, objective and clinically valid criteria that are compatible with established principles of health care and flexible enough to allow for variations. These criteria are based on reasonable medical evidence and acceptable medical standards of practice (i.e. applicable health plan benefits and coverage documents, national and local coverage determinations, CMS guidelines and Milliman Care Guidelines), The criteria are applied in a flexible manner based on currently accepted medical or health care practices, consideration of patients with specialized needs (including, but not limited to, patients with disabilities), acute conditions or life-threatening illness and an assessment of the local delivery system.

Upon request from a patient, a patient's representative, the public or a health care professional, the relevant criteria used to support the UM decision-making process may be released. Patients are instructed in their adverse determination letters that they may call the UM department to make a criteria request.

Health care professionals may contact the Optum Care UM department to obtain UM policy or criteria used in making medical decisions.

Optum Care Management programs

This Optum network has care management resources at no extra cost to your patient. The care management programs focus on high-risk patients, provides care coordination through a variety of programs to assists throughout their health care journey. The programs aid in delivering high quality outcomes. The care management program works in collaboration with the patient, the family/support system, providers and key stakeholders.

To refer to Optum Care Management, submit a completed form found on Optum Pro via secure email to **CMintake@optum.com**.

We offer several programs to help members with their needs such as:

Transitional care management (post-discharge follow up)

- Dedicated nurse case manager
- Telephonic support
- Health goal development
- Coordinate access to community resources and services
- Disease management education and medication review
- Post-discharge 30-day follow-up from inpatient or skilled nursing facility

Complex and high-risk case management

- Dedicated nurse case manager
- Telephonic support
- Patient centered plan of care
- Longitudinal management/coordination of care for medical issues
- Health goal development
- Coordinate access to community resources and services
- Disease management education and medication review

Disease management (focus on Diabetes, Congestive Heart Failure (CHF) and Chronic Obstructive Pulmonary Disease (COPD))

- Dedicated nurse case manager
- Telephonic support
- Disease specific treatment assessment
- Patient centered plan of care
- Coordination with PCP and specialist
- Coordinate access to community resources and services
- Evaluate and manage health risk factors
- Disease education (diet, medication management, complications, exercise and self-management techniques)
- Self-monitoring and intervention follow-up

Social work support

- Collaborates with all case management programs as well as stand-alone referrals
- Coordination of community resources to address social determinants of health
- Provide education with advance directives and living will documents
- Support with financial resources, housing, transportation, placement and meal assistance

Behavioral health

OCN manages behavioral health authorizations and adjudicates claims for some payers. Please refer to Delegation by Plan table in the Appendix for additional information.

Mobile Urgent Care Visit

DispatchHealth is a mobile acute care service that offers same day appointments for patients with the goal of preventing unnecessary visits to the emergency room and reducing avoidable hospital admissions and readmissions. Consider DispatchHealth for patients with an acute, not immediately life-threatening medical need who:

- Are unwilling or unable to come in
- Have difficulty with transportation
- May not come in otherwise

Contact:

- Snohomish County Direct Line: **425-372-5441** Pierce County
- Direct Line: **253-666-9459**
- For more information: **dispatchhealth.com**

Embedded Nurse Practitioner Program

OCN is focused on supporting clinics on their valued-based care journey. Consequently, OCN offers an embedded nurse practitioner program to see patients either virtually, in-home, at an Optum site, or, with clinic permission, at an OCN clinic. Patients in scope for the program are called and offered visits with the OCN nurse practitioners throughout the year.

Opportunities and services:

- OCN will contact all targeted patients for visits either in-home, virtually, or at an Optum site
- Visits will focus on care gap closure, medication reconciliation, and connection to patient support offered by OCN (e.g. case management).
- OCN will fax the results of these visits to the patient's assigned PCP and may outreach via phone if follow-up needs are urgent
- OCN will come onsite to see patients if a clinic is interested in bringing the program to their clinic
- OCN will compensate clinics $100 per onsite visit to account for the loss of use of space

Additional resources

- Optum behavioral health
  - For direct referrals regarding behavioral health needs. Call behavioral health number on the back of member's card
- Optum nurse line
  - A 24-hour access hotline for member to reach a nurse to answer questions regarding health concerns. Members can call the number on the back of their insurance card.

Quality

Population health

OCN has developed programs and resources in concert with health plans to support your practice around population health management. These resources include, but are not limited to, complex care management, clinical education, Electronic Medical Record (EMR) optimization, and programs supporting quality, accurate documentation and coding, and patient experience.

These are the 4 guiding principles of OCN's population health programs:

- Promoting activities that drive quality outcomes
- Focusing on prevention and early detection of conditions which may negatively impact the health or wellbeing of individuals
- Expanding team-based care to include the broader health care continuum
- Improving clinical outcomes while lowering the total cost of care

Quality and risk adjustment

OCN is committed to supporting our partners in delivering the highest quality of care. To that end, tools and resources (as referenced in the Medical Management section of this guide) are available to help providers identify quality care gaps and outreach to patients to close these gaps. OCN also offers education around best practices and tactical support to help practices meet requirements in accordance with Medicare's quality standards.

To ensure all data is captured and reported to health plans, OCN performs chart reviews through remote EMR access, fax, and site visits. Only data for your OCN attributed patients is reviewed and processed. The purpose of the chart abstraction process is to capture documentation to close care gaps and to identify potential coding trends, which contribute to Quality Incentive Program (QIP) performance. Practices can support quality initiatives and clinical documentation accuracy by granting OCN remote access to their Electronic Medical Record (EMR).

What does this mean for your practice?

- OCN will deploy chart abstractors to facilitate the capture of clinical documentation to close quality care gaps
- OCN will work with your practice to collect records either directly via fax or EMR, or through a third party to facilitate accurate capture of quality care gaps and conditions
- Your Practice Engagement Manager and Network Medical Director will provide tools, resources, and information on best practices to help you achieve quality goals

Risk Adjustment Factor

Risk Adjustment Factor (RAF) is a numeric measurement based on a patient's chronic health conditions (specifically those that fall within a CMS-assigned Hierarchical Condition Category or HCC) as well as demographic factors such as Medicaid status, gender, age/disabled status, and whether the patient has resided in an institution for longer than 90 days.

RAF is a relative measure of probable costs to meet the healthcare needs of the individual. RAF is used by Centers for Medicare and Medicaid Services (CMS) to adjust capitation payments to payors and thus to OCN for each Medicare Advantage (MA) member. As such, complete and accurate reporting of patient data is critical.

CMS requires providers to identify and document all conditions that may fall within an HCC at least once each calendar year at a qualified visit. Documentation in the patient's medical record must support the presence of the condition and indicate the provider's assessment and treatment plan. OCN supports an accurate RAF score for your practice through in-home assessments, chart review, outreach support, provide education, and attestation forms.

Ongoing education

OCN is focused on capturing whole-person health through accurate documentation and coding. OCN has a team of clinical educators that can help your practice stay up to date on coding and documentation so that you can provide the most accurate and complete status for each of your patients.

Opportunities and services

- OCN will perform reviews of medical documentation to ensure that practices accurately capture chronic hierarchical condition categories (HCCs) that impact quality performance, and patient outcomes.
- OCN also analyzes data from inpatient hospitalizations, diagnostic testing, outpatient procedures and services, home health care services, rehabilitative therapies, and pharmacy reviews for the possibility of chronic codes that have not been addressed in the calendar year.
- OCN will prepare feedback and training materials to educate providers and staff on any audit outcomes and will help with accurate documentation procedures.
- OCN will communicate coding and documentation trends to providers and staff and help implement correct diagnosis reporting.
- OCN will perform routine audits of documentation and coding in accordance with compliance policies and procedures and communicate the results to practices.
- OCN will follow up with written and verbal education regarding coding and compliance to physicians, clinical staff, and non-clinical staff. You may also request OCN educators to come to your clinics and help with any coding or documentation issues.
- OCN educators will remain apprised of the latest coding guidelines and relay that information to clinics and staff. OCN will send emails with webinars, coding materials, and any other education needed.

What does this mean for your practice?

- OCN can provide consultation and education to help network partners improve their patient outcomes and systems and processes to ensure complete, accurate, and compliant documentation and coding.
- Our educators can evaluate documentation and coding behavior and identify areas for improvement.

Provider attestations

An Attestation is a point of care tool used during a patient encounter to identify and address current chronic conditions and evaluate potential new chronic conditions. Attestations are electronic and paper forms customized to each patient that list known chronic conditions and suspected chronic conditions based on prior years claims, pharmacy data, lab data, and clinical chart reviews. Each condition is either listed by the ICD-10-CM code or by the appropriate Hierarchical Condition Category (HCC).

Attestations help clinicians quickly identify important patient conditions that require action and a plan of care. Accurate identification of conditions for each patient coupled with supporting clinical documentation in clinician chart notes ensures applicable resources are available and appropriately allocated to manage the needs of the patient throughout the year in order to improve patient outcomes. Practices receive payment for completed Attestations through the Quality Incentive Program (QIP).

Quality improvement committee mission

The QI/UM committee supports the QI, UM and credentialing programs to promote measurable quality improvement reviews and ensure the performance of UM activities is in accordance with applicable regulatory entities. The members of the QI/UM committee have the responsibility to create a quality improvement culture throughout the organization. The QI/UM committee systematically oversees the continuous improvement in the quality of care and services delivered to Optum Care patients. The committee also monitors and oversees the utilization of services to enrolled members to ensure the delivery of care is medically necessary, appropriate, and provided in the most cost-effective setting. The committee is accountable for the implementation of the UM program plan and medical management plan. The committee meets quarterly to discuss and adopt policies and procedures and to initiate and review quality initiatives that impact care and service delivery.

The QI/UM committee may appoint, at any time, a sub-committee or ad hoc team to conduct a focus review, investigation or to monitor a specific process. Any such sub-committee or ad hoc team shall be documented through the QI/UM committee meeting minutes.

Committee objectives

The committee shall oversee the following functions:

- Review and adoption of QI Program and related policies and procedures
- Review and adoption of the UM, PHM-DM and CCM Program, policies and procedures, annual UM, PHM-DM and CCM work plan and program evaluation in compliance with Health Plan, accreditation and regulatory standards
- Review and approve practice protocols and guidelines related to the use of non-physician practitioners such as nurse practitioners
- Review and adoption of UM Clinical Criteria and regulatory Guidelines
- Oversight of clinical care and services to include but not be limited to the following delegated and subdelegated functions:
  - Patient Safety reviews (such as Medication Reconciliation)
  - Utilization Management
  - Quality of Care Concerns
  - Coordination with Care Management to assist with discharge planning and transition of care issues
- Conduct an annual evaluation of the UM and QI programs to assess accomplishments and barriers and to establish goals for the next year's program
- Quality of clinical care and service monitoring and evaluation activities include but may not be limited to the following activities and outcomes:
  - Prior authorization
  - Medical claims review
  - Concurrent review
  - Patient safety
  - UM timeliness of decisions
  - Oversight of delegated functions

Committee goals

At least annually, the QI/UM committee shall objectively and systematically monitor and evaluate quality of care and services delivered to our members, identify opportunities for improvement through ongoing monitoring, recommend, implement and monitor changes to assess the effectiveness of the changes related to the delivery of quality of care and services.

The CDQI (clinical documentation and quality improvement) department oversees risk adjustment and quality-based activities. This team provides education, training and feedback on provider performance against regulatory, risk and quality standards and initiatives. CDQI oversees and manages the applications and tools that are designed to assist in closing gaps in care and ensure complete and accurate coding. These tools are deployed to the providers and designed to be used by the provider and/or support staff. These tools will:

- Provide evidence-based guidance for tests and procedures based on a member's current and past health history to ensure UM decisions are consistent and based on medical necessity, appropriateness, and availability of resources and benefits
- Enable providers to close both risk and quality-based gaps in care, at the point of care while improving diagnosis capture and reporting
- Connect members to case management services when appropriate
- Support submission of quality performance measures such as HEDIS®-Stars

CMS quality measure overview

Several industry quality programs, including the Centers for Medicare & Medicaid Services (CMS) Star Ratings, provide external validation of Medicare Advantage and Part D plan performance and quality progress. Quality scores are provided on a 1- to 5-star scale, with 1 star representing the lowest quality and 5 stars representing the highest quality. Star ratings scores are derived from 5 sources:

- Consumer Assessment of Healthcare Providers and Systems (CAHPS®) or patient experience data
- Health Care Effectiveness Data and Information Set (HEDIS®) or medical record and claims data
- Health Outcomes Survey (HOS) or patient health outcomes data
- CMS administrative data on plan quality and customer satisfaction
- PQA (Pharmacy Quality Alliance) (examples are the medication adherence measures, SUPD)

To learn more about Star Ratings and view current Star Ratings for Medicare Advantage and Part D plans, go to the CMS consumer website at **cms.gov**.

CPT® Category II codes

Use to help achieve better outcomes for your patients and your practice.

CPT® Category II codes make it easier for you to share data quickly and efficiently with Optum. When you add them for certain preventive care services and test results, we can get a more complete picture of our plan members' health—and help you address care opportunities tied to Healthcare Effectiveness Data and Information Set (HEDIS®) quality measures.

Using CPT® Category II codes may also offer these benefits:

- Fewer medical record requests: When you add CPT® Category II codes, we won't have to request charts from your office to confirm care you've already completed
- Enhanced performance: With better information, we can work with you to help identify opportunities to improve patient care. This may lead to better performance on HEDIS® measures for your practice
- Improved health outcomes: With more precise data, we can refer plan members to our programs that may be appropriate for their health situation to help support your plan of care
- Less mail for members: With more complete information, we can avoid sending reminders to patients to get screenings they may have already completed

List of CPT Category II codes to report

The following chart shows which measures are tracked and which codes to use for each measure. For a complete a list of CPT® Category II codes, please access **ama-assn.org** > Practice Management > CPT® (Current Procedural Terminology) > **Need Coding Resources**

Measure	CPT Category II code descriptor	Code
Advance Care Planning	Advance care planning discussed and documented—advance care plan or surrogate decision-maker documented in medical record (DEM) (GER, Pall Cr)	1123F
	Advance care planning discussed and documented in medical record—patient didn't wish to or was unable to name a surrogate decision maker or provide an advance care plan (DEM) (GER, Pall Cr)	1124F
	Advance care plan or similar legal document in medical record	1157F
	Advance care planning discussion documented in the medical record	1158F
Care of Older Adults – Medication Review	Medication List documented in medical record	1159F
	Review of all medications by a prescribing practitioner or clinical pharmacist (e.g. prescriptions, OTCs, herbal therapies and supplements) documented in the medical record	1160F
Care of Older Adults - Functional Assessment	Functional status assessed	1170F
Eye Exam for Patients with Diabetes (EED) –formerly CDC EYE	Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed; with evidence of retinopathy	2022F
	Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed; without evidence of retinopathy	2023F
	7 standard field stereoscopic retinal photos with interpretation by an ophthalmologist or optometrist documented and reviewed; with evidence of retinopathy	2024F
	7 standard field stereoscopic retinal photos with interpretation by an ophthalmologist or optometrist documented and reviewed; without evidence of retinopathy	2025F
	Eye imaging validated to match diagnosis from 7 standard field stereoscopic retinal photos results documented and reviewed; with evidence of retinopathy (DM)	2026F
	Eye imaging validated to match diagnosis from 7 standard field stereoscopic retinal photos results documented and reviewed; without evidence of retinopathy	2033F
	Diabetic eye exam without evidence of retinopathy in prior year	3072F
Glycemic Status Assessment for Patients with Diabetes (GSD) – formerly CDCA1C9, CDCA1C8 Diabetes Monitoring for People with Diabetes and Schizophrenia (SMD)	HbA1c level < 7.0%	3044F
	HbA1 c level > 9.0%	3046F
	HbA1c level ≥ 7.0% & < 8.0%	3051F
	HbA1 c level ≥ 8.0% & ≤ 9.0%	3052F
	Most recent LDL-C 100-129 mg/dL (CAD) (DM)	3049F
	Most recent LDL-C greater than or equal to 130 mg/dL (CAD) (DM)	3050F
	Most recent LDL-C less than 100 mg/dL (CAD) (DM)	3048F
Blood Pressure Control for Patients with Diabetes (BPD) -formerly CDCBP Controlling High Blood Pressure-(CBP)	Systolic less than 130	3074F
	Systolic between 130 to 139	3075F
	Systolic greater than/equal to 140	3077F
	Diastolic less than 80	3078F
	Diastolic between 80 to 89	3079F
	Diastolic greater than/equal to 90	3080F
Medication Reconciliation Post-Discharge	Discharge medications reconciled with current medications in outpatient record	1111F
Postpartum Care	Postpartum care visit	0503F
Prenatal Care	Initial prenatal care visit	0500F
	Prenatal flow sheet	0501F
	Subsequent prenatal care	0502F

Reporting reminders by measure

- COA Medication Review: Document both medication list and medication review and report both CPT II codes. Medication review must be completed by a prescribing care provider or clinical pharmacist.
- EED: Any provider can report the appropriate CPT II code for the eye exam results. It does not have to be reported by only the ophthalmologist or optometrist.
- GSD: Report the appropriate CPT II code for the A1c result value with the date of test, not the date of the office visit when the test was reviewed.
- BPD & CBP: Report 2 CPT II codes. One for the lowest systolic value and the one for the lowest diastolic value measured during the encounter.
- SMD: Report the appropriate CPT II code for the A1c result value with the date of test, not the date of the office visit when the test was reviewed. Report the appropriate CPT II code for the LDL-C result value.
- TRC: Report the medication reconciliation post-discharge when performed either via a telephone call or during the Transitional Care Management office visit.

CPT Category II codes can be reported alone on a claim with $0.00 value (or $0.01 value if your system requires it in order for the codes to populate on a claim).

CPT tips for success

- A CPT-II code can be billed on the claim by itself
- A diagnosis code that pertains to the service being rendered is required when billing CPT-II codes
- A servicing provider is required when billing CPT-II codes
- CPT Category II codes can be submitted by whichever provider performs the service/measurement unless there are specific reporting requirements for the measure (e.g., COA Medication Review must be completed by a prescribing practitioner or clinical pharmacist)
- CPT Category II codes can be submitted on both UB (837I), and HCFA (837P) claim types
- A denial on the Category II code in my remittance does not mean anything was billed incorrectly. Optum assigns a payment reason code to indicate why payment is not made, but it is not a denial, since the codes are for reporting purposes only.

If you have additional questions, please visit the CMS website pertaining to **HCPCS Level II Coding Process & Criteria**.

Health Outcomes Survey measures

The Medicare Health Outcomes Survey (HOS) is an outcomes measure reported by patients. The goal is to gather valid, reliable and clinically meaningful health status data from the Medicare Advantage (MA) program. The data is then used in quality improvement activities. The Medicare HOS looks at the following:

- Improving or Maintaining Physical Health (PCS) (Physical Component Summary)
- Improving or Maintaining Mental Health (MCS) (Mental Component Summary)
- Management of Urinary Incontinence in Older Adults (MUI) (Improving Bladder Control)
- Physical Activity in Older Adults (PAO) (Monitoring Physical Activity)
- Fall Risk Management (FRM) (Reducing the Risk of Falling)

The Centers for Medicare and Medicaid Services (CMS) uses HOS to evaluate patients' perceptions of their physical and mental health status over time. Additionally, the survey assesses patients' recall of conversations with their health care providers on key aspects of health in aging.

Each year, a small, random sample of patients with Medicare Advantage plans are selected to participate. The survey is typically administered from July through October by CMS-approved vendors. HOS is the first patient-reported outcomes measure in Medicare-managed care and is a critical part of assessing the quality of care for its members.

Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey

Each year, the Centers for Medicare & Medicaid Services (CMS) distributes the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey and Healthcare Outcomes Survey (HOS) to Medicare Advantage (MA) plan members. This survey gathers insights from MA patients to learn how they feel about their patient experience. The goal is to gather valid, reliable and clinically meaningful data from the Medicare Advantage (MA) program. The data is then used in quality improvement activities.

CAHPS looks at the following:

- Getting Needed Care (GNC)
- Getting Appointments and Care Quickly (GCQ)
- Coordination of Care (COC)
- Flu Vaccine
- Getting Needed Prescription Drugs (GNPD)
- Overall rating measures

Why this is important
The CAHPS and HOS surveys are heavily weighted in the overall CMS Stars calculations for quality and performance tracking each year, accounting for approximately 40% of overall Star ratings. **Star ratings can increase performance-based payments for health plans, which can improve physician/provider group compensation through better contracting and increased revenue growth.** Achieving high performance in CAHPS and HOS patient experience surveys are an important part of how we achieve our quadruple aim of patient satisfaction, high-quality health outcomes, clinician well-being and affordable health care for patients.

Resources for you
We've created a series of 3 patient experience videos that provide best practices and tactics to support the top 3 measures included in the upcoming Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey:

1. Coordination of Care (COC)
2. Getting Needed Care (GNC)
3. Getting Care Quickly (GCQ)

We encourage you to watch these videos to learn:

- Why patient experience is important
- How to improve your patience experience scores in the 2025 CAHPS survey
- How to address the topics covered in each video with your patients
- How to create specific action plans for your clinics

Explore the patient experience video series

- **Video 1: Caring Through Coordination, Collaboration, and Experience (27 mins) – Watch this video**
  - What you'll learn:
    - How Medicare Advantage plans measure patient experience through the COC measure (6 questions)
    - What the CAHPS COC questions mean
    - What success looks like for each CAHPS COC question
    - Activity: CAHPS COC action plan worksheet
- **Video 2: Practical CAHPS Tips for the Busy Primary Care Team (22 minutes) – Watch this video**
  - What you'll learn:
    - How Medicare Advantage plans measure patient experience through the CAHPS access measures: GCQ and GNC (4 questions)
    - What the CAHPS access questions mean
    - What success looks like for each CAHPS access question
    - Activity: CAHPS GCQ and GNC action plan worksheet
- **Video 3: Goal Planning & Tracking (29 minutes) – Watch this video**
  - What you'll learn:
    - How do patients share their experience openly and confidentially?
    - Utilizing scorecards to assist in action plan development
    - Setting SMART goals
    - How to use scoreboards
    - Activity: The "return to clinic" plan

Learn more about the CAHPS survey

Each year from March through June, the Centers for Medicare & Medicaid Services (CMS) sends the **CAHPS survey** to a random sample of Medicare Advantage plan members. The survey results provide valuable insights into how consumers perceive their experience with their health care providers and health plans.

CMS uses a Star Ratings program to help consumers understand a practice and health plan's performance.

Together, we can use these insights to identify areas of improvement and drive better health outcomes.

We're here to help you

For more information about the patient experience education resources available to you, please contact **cpqeducation@optum.com**.

Glossary: Definitions and Terminology

Glossary: Definitions and Terminology

Admission notification: A notice to Optum Care that a patient has been admitted to any inpatient setting, including hospitals, skilled nursing facilities, home health, etc. The facility is required to report within 1 business day after actual admission date. For weekend and federal holiday admission, notification must be by 5 p.m. local time on the next business day.

Advance notification: The first step in the process of making a coverage determination and for referrals to case and condition management programs.

Allowed charges: Charges for services rendered or supplies furnished by a health provider, which would qualify as covered expenses and for which the program will pay in whole or in part; subject to any deductible, co-insurance or table of allowance included in the program.

ASC—Ambulatory Surgery Center: Used for payments to a surgery center. Billed charges: The dollar amount billed by a provider as their usual and customary charge.

ASC—Ambulatory Surgery Classification: used for outpatient hospital claims, paid at OPPS (outpatient perspective payment system).

Capitation: Method of payment for health services in which a provider or hospital is paid a fixed amount for each person served regardless of the actual number or nature of services provided each person. This is a per-patient-per-month (PMPM) payment to a provider/provider organization that covers contracted services and is paid in advance of delivery of any services. The rate can be fixed or adjusted by age/sex of enrollees; percent of premium based on severity ratings.

Case rate: A fixed dollar amount established as payment for a service.

Centers for Medicare & Medicaid Services (CMS): A federal agency within the U.S. Department of Health and Human Services.

Clean claim: A complete claim or itemized bill that doesn't require any additional information to process the claim for payment.

Coinsurance: The member's share of the costs of a covered health care service, calculated as a percent (for example, 20 percent) of the allowed amount for the service. Members may pay coinsurance plus any deductibles owed.

Coordination of benefits (COB): Allows benefit plans that provide health and/or prescription coverage for a person with Medicare to determine their respective payment responsibilities (i.e., determine which insurance benefit plan has the primary payment responsibility and the extent to which the other benefit plans will contribute when an individual is covered by more than one benefit plan).

Copayment: A fixed amount members may pay for a covered health care service, usually upon receiving the service.

Covered services: Medically necessary services included in the member's benefit plan. Covered services change periodically and may be mandated by federal or state legislation.

Credentialing: The verification of applicable licenses, certifications and experience to assure that provider status is extended only to professional, competent providers who continually meet the qualifications, standards and requirements established by UnitedHealthcare and Optum Care.

Current procedural terminology (CPT) codes: American Medical Association (AMA)-approved standard coding for billing of procedural services performed.

Discharge planning: Process of screening eligible candidates for continuing care following treatment in an acute care facility and assisting in planning, scheduling and arranging for that care.

DRG: Diagnosis Related Group: A patient classification scheme that categorizes patients who are medically related with respect to diagnoses and treatment and are statistically similar in their lengths of stay.

DRG payment method: An approach to paying for hospital inpatient acute services that bases the unit of payment on the DRG system of classifying patients. Primarily used for Medicare patients. DRG rate: A fixed dollar amount based on the average of all patients in that DRG in the base year, adjusted for inflation economic factors and bad debts.

Electronic data interchange (EDI): The process of electronically submitting data to payers, including but not limited to claims, electronic eligibility and pre-authorization requests.

Electronic funds transfer (EFT): The electronic exchange of funds between 2 or more organizations.

Electronic health records – EHR/Electronic medical records - EMR: A digital version of a normal patient medical records that providers store and access via computer rather than papers and manila folders.

Encounter: An interaction between a patient and health care providers, for the purpose of provider health care services or assessing the health status of a patient.

Evidence of coverage (EOC): Document that describes in detail the health care benefits covered by the health plan.

Explanation of benefits (EOB): Statement or document from the health insurance company to covered individuals explaining what medical treatments/services were paid on their behalf.

Explanation of payment (EOP): Document available to providers of details on claims that have been paid, denied, or adjusted.

Fee-for-service (FFS): A traditional means of billing by health providers for each service performed, referring payment in specific amounts for specific services rendered.

Glossary: Definitions and Terminology

Fee schedule: Any list of professional services and the rates at which the payer reimburses the services.

Fraud: Health care fraud is a crime that involves misrepresenting information, concealing information, or deceiving a person or entity to receive benefits, or to make a financial profit. (18 U.S.C.§1347)

Global period: A time set aside before and after a surgical procedure is done. This includes the initial visit and any follow up visits. Per CMS claims processing manual, section 40; including but not limited to minor surgery, endoscopies and global surgical packages.

Health Insurance Portability and Accountability Act (HIPAA) of 1996: A federal legislation that provides data privacy and security provisions for safeguarding medical information.

Maximum out-of-pocket (MOOP): Out-of-pocket expenses are co-pays, deductibles and co-insurance. The health plan caps the out-of-pocket expenses, meaning when the patient reaches the maximum out-of- pocket costs, the health plan takes over and provides coverage for rest of year.

Medical necessity: Medical service or procedure performed for treatment of an illness or injury not considered investigational, cosmetic, or experimental.

Misdirected claim: A claim that is submitted to the incorrect payer; required to be forwarded to the appropriate entity.

Net promotor score (NPS): A management tool that can be used to measure of the loyalty between a company and its consumer. It is an alternative to traditional customer satisfaction surveys. It is claimed to be correlated with revenue growth and is used by organizations across all industries. It has become “the” standard in measuring loyalty and commitment to a brand.

Non-covered service: Item or service that is not covered by the health plan’s benefit plan.

Out-of-pocket (OOP): Refers to any portion of payment for medical services that are the patient’s responsibility.

Per diem: A flat amount paid for each day the patient is hospitalized regardless of the services rendered.

Prior authorization: Approval to receive medical treatment or equipment. For example, surgeries, in home care, medical tests, medical equipment, etc.

Provider remittance advice (PRA): Detailed explanation received from payee regarding the payment or denial of benefits billed.

Quality management program: The policies and procedures adopted by Optum Care or plan and designed to monitor and ensure the quality of covered services provided to Optum Care members.

Referral: When a provider suggests a patient receive additional care from another provider such as a specialist or facility.

Risk: A method by which costs of medical services are shared or assumed by the health plan and/or medical group.

Risk adjustment factor (RAF) score: Used by CMS and insurance companies to represent a patient’s health status. RAF scores are used to predict the cost for a health care organization to care for a patient.

Service area: Geographic area serviced by an Optum Care contracted provider, as stated in the provider’s agreement with us

Un-bundling: Refers to the practice of separating a surgical procedure into multiple components and charging for each component when there is a procedure code that would group them together, resulting in lower global rate.

Unclean claim: An incomplete claim or a claim that is missing required information/documentation that is needed to process the claim for payment.

Utilization management (UM): The process of evaluating and determining the coverage for and the appropriateness of medical care services, as well as aiding a clinician or patient in cooperation with other parties, to help ensure appropriate use of resources. UM includes prior authorization, concurrent review, retrospective review, discharge planning and case management.

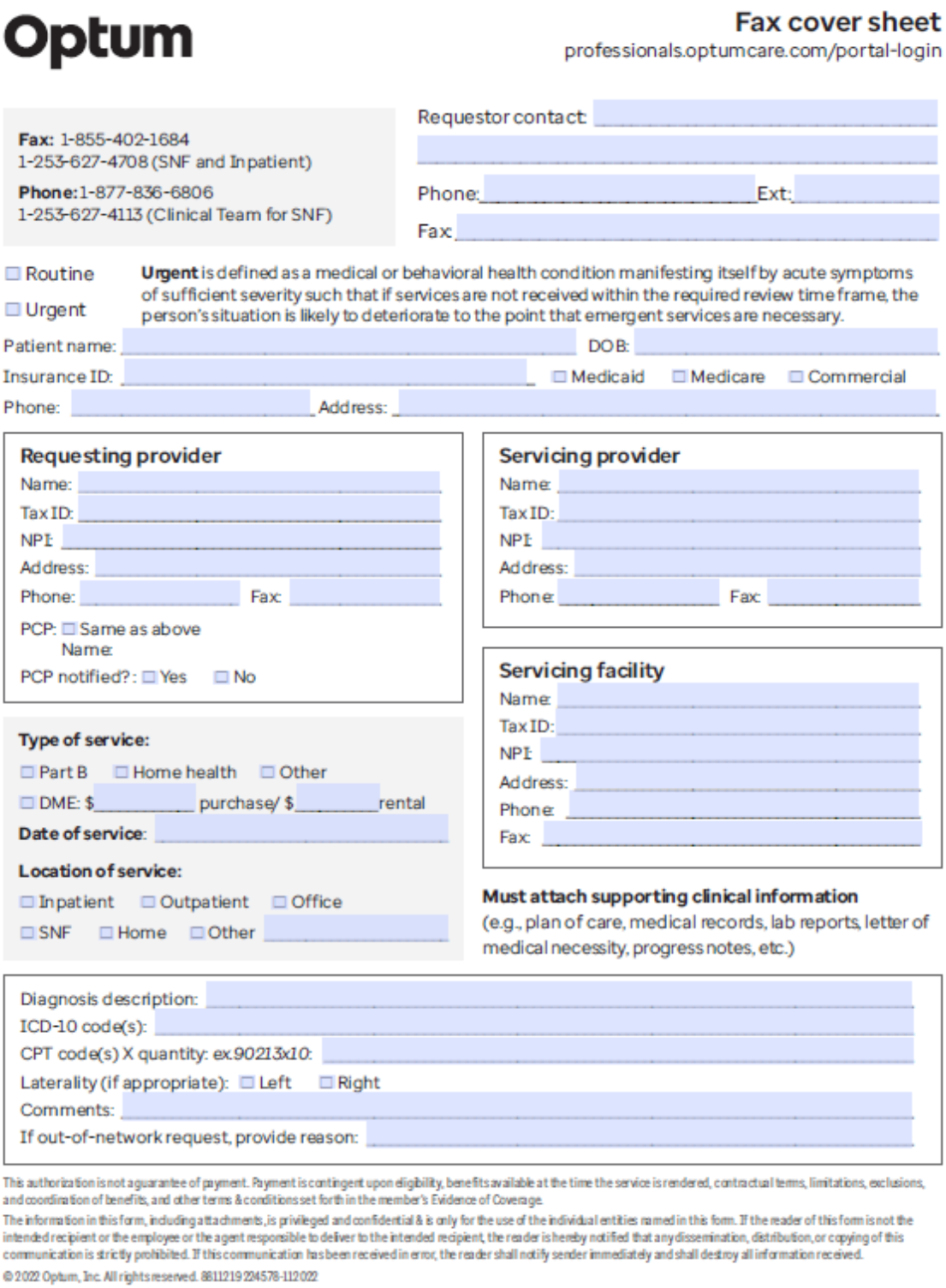
Workers’ compensation: Workers’ compensation is a form of insurance providing wage replacement and medical benefits to employees injured in the course of employment in exchange for mandatory relinquishment of the employee’s right to sue their employer for the tort of negligence.

Appendix

Prior Authorization Request Form

The current form may be accessed online: **Prior Authorization Form for Washington**.

Sample form:



Optum

Fax cover sheet
professionals.optumcare.com/portal-login

Fax: 1-855-402-1684
1-253-627-4708 (SNF and Inpatient)
Phone: 1-877-836-6806
1-253-627-4113 (Clinical Team for SNF)

Requestor contact:
Phone: Ext:
Fax:

☐ Routine
☐ Urgent

Urgent is defined as a medical or behavioral health condition manifesting itself by acute symptoms of sufficient severity such that if services are not received within the required review time frame, the person's situation is likely to deteriorate to the point that emergent services are necessary.

Patient name: DOB:
Insurance ID: ☐ Medicaid ☐ Medicare ☐ Commercial
Phone: Address:

Requesting provider
Name:
Tax ID:
NPI:
Address:
Phone: Fax:
PCP: ☐ Same as above
Name:
PCP notified?: ☐ Yes ☐ No

Servicing provider
Name:
Tax ID:
NPI:
Address:
Phone: Fax:

Servicing facility
Name:
Tax ID:
NPI:
Address:
Phone:
Fax:

Type of service:
☐ Part B ☐ Home health ☐ Other
☐ DME: $_____ purchase/ $_____ rental
Date of service:

Location of service:
☐ Inpatient ☐ Outpatient ☐ Office
☐ SNF ☐ Home ☐ Other

Must attach supporting clinical information
(e.g., plan of care, medical records, lab reports, letter of medical necessity, progress notes, etc.)

Diagnosis description:
ICD-10 code(s):
CPT code(s) X quantity: ex.90213x10:
Laterality (if appropriate): ☐ Left ☐ Right
Comments:
If out-of-network request, provide reason:

This authorization is not a guarantee of payment. Payment is contingent upon eligibility, benefits available at the time the service is rendered, contractual terms, limitations, exclusions, and coordination of benefits, and other terms & conditions set forth in the member's Evidence of Coverage.

The information in this form, including attachments, is privileged and confidential & is only for the use of the individual entities named in this form. If the reader of this form is not the intended recipient or the employee or the agent responsible to deliver to the intended recipient, the reader is hereby notified that any dissemination, distribution, or copying of this communication is strictly prohibited. If this communication has been received in error, the reader shall notify sender immediately and shall destroy all information received.

Care Management Referral Form

The current form may be accessed online: **Care Management Referral Form for Washington**.

Sample form:

Optum

Optum Care Network
17930 International Blvd #1000
SeaTac, WA 98188
optum.com

CARE MANAGEMENT REFERRAL FORM

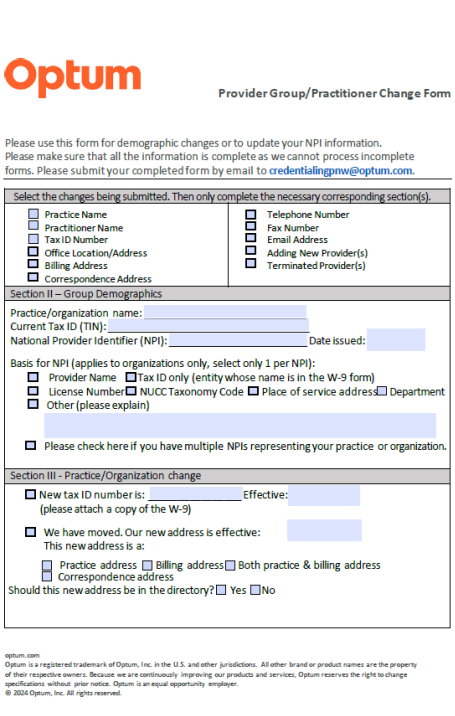
Date: Click or tap to enter a date.			
MEMBER INFORMATION			
Member Name: Click or tap here to enter text.	**Member DOB:** Click or tap here to enter text.	**Member Health Plan ID:** Click or tap here to enter text.	**Member Phone:** Click or tap here to enter text.
If primary contact is not the member, provide the following:			
Contact Name: Click or tap here to enter text.	**Relationship to Member:** Click or tap here to enter text.		**Contact Phone:** Click or tap here to enter text.
REFERRED BY			
Name: Click or tap here to enter text.	**Title:** Click or tap here to enter text.		**Phone:** Click or tap here to enter text.
LINE OF BUSINESS			
Choose an item.	**If Other, please specify:** Click or tap here to enter text.		
PRIMARY CARE PROVIDER INFORMATION (OPTIONAL)			
PCP Name: Click or tap here to enter text.	**PCP Office Address:** Click or tap here to enter text.		**PCP Phone:** Click or tap here to enter text.
DIAGNOSIS AND REASON FOR CARE MANAGEMENT REFERRAL			
Diagnosis(s): Click or tap here to enter text.	**Reason or Need for Assistance:** Click or tap here to enter text.		
PROJECTED OUTCOME FROM CARE MANAGEMENT (OPTIONAL)			
Reason or Need for Assistance: Click or tap here to enter text.			

INSTRUCTIONS FOR REFERRAL SUBMISSION:
Complete this referral form and fax to
253-356 5778

Provider Group/Practitioner Change Form

The current form may be accessed online: **Provider Change Form for Washington**.

Sample form:



Optum

Provider Group/Practitioner Change Form

Please use this form for demographic changes or to update your NPI information.
Please make sure that all the information is complete as we cannot process incomplete forms. Please submit your completed form by email to credentialingpnw@optum.com.

Select the changes being submitted. Then only complete the necessary corresponding section(s).

- ☐ Practice Name
- ☐ Practitioner Name
- ☐ Tax ID Number
- ☐ Office Location/Address
- ☐ Billing Address
- ☐ Correspondence Address
- ☐ Telephone Number
- ☐ Fax Number
- ☐ Email Address
- ☐ Adding New Provider(s)
- ☐ Terminated Provider(s)

Section II – Group Demographics

Practice/organization name:
Current Tax ID (TIN):
National Provider Identifier (NPI): _____ Date issued:

Basis for NPI (applies to organizations only, select only 1 per NPI):

- ☐ Provider Name ☐ Tax ID only (entity whose name is in the W-9 form)
- ☐ License Number ☐ NUCC Taxonomy Code ☐ Place of service address ☐ Department
- ☐ Other (please explain)

☐ Please check here if you have multiple NPIs representing your practice or organization.

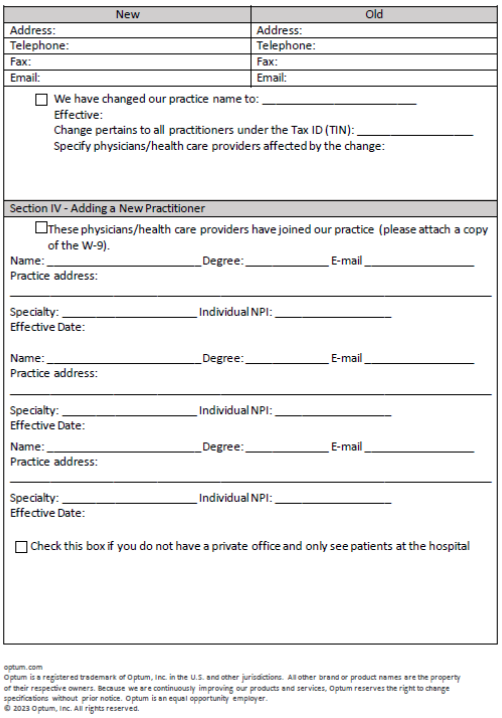
Section III - Practice/Organization change

☐ New tax ID number is: _____ Effective:
(please attach a copy of the W-9)

☐ We have moved. Our new address is effective:
This new address is a:

☐ Practice address ☐ Billing address ☐ Both practice & billing address
☐ Correspondence address

Should this new address be in the directory? ☐ Yes ☐ No



New	Old
Address:	Address:
Telephone:	Telephone:
Fax:	Fax:
Email:	Email:

☐ We have changed our practice name to: _____
Effective:
Change pertains to all practitioners under the Tax ID (TIN): _____
Specify physicians/health care providers affected by the change:

Section IV - Adding a New Practitioner

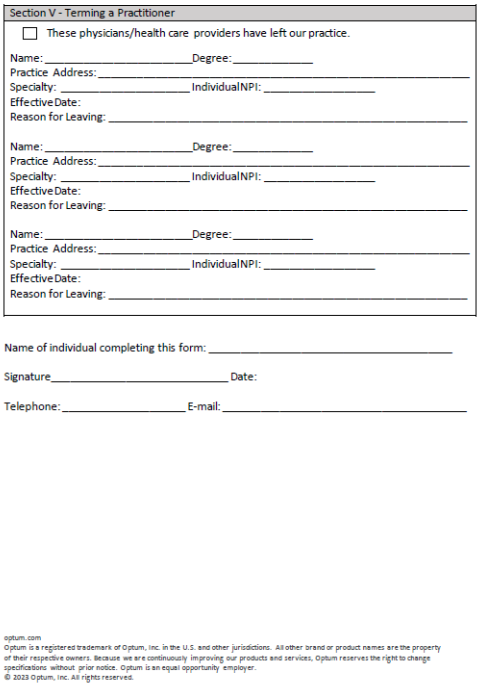
☐ These physicians/health care providers have joined our practice (please attach a copy of the W-9).

Name: _____ Degree: _____ E-mail _____
Practice address:
_____
Specialty: _____ Individual NPI: _____
Effective Date:

Name: _____ Degree: _____ E-mail _____
Practice address:
_____
Specialty: _____ Individual NPI: _____
Effective Date:

Name: _____ Degree: _____ E-mail _____
Practice address:
_____
Specialty: _____ Individual NPI: _____
Effective Date:

☐ Check this box if you do not have a private office and only see patients at the hospital



Section V - Terming a Practitioner

☐ These physicians/health care providers have left our practice.

Name: _____ Degree: _____
Practice Address: _____
Specialty: _____ Individual NPI: _____
Effective Date:
Reason for Leaving: _____

Name: _____ Degree: _____
Practice Address: _____
Specialty: _____ Individual NPI: _____
Effective Date:
Reason for Leaving: _____

Name: _____ Degree: _____
Practice Address: _____
Specialty: _____ Individual NPI: _____
Effective Date:
Reason for Leaving: _____

Name of individual completing this form: _____

Signature _____ Date:

Telephone: _____ E-mail: _____

Behavioral health: Plan resources

- UnitedHealthcare Medicare Advantage
  - **Website**: Enter patient zip code on Provider Listing Page > select *Medicare*
  - Behavioral Health Claims and Authorizations: **866-673-6315**
- Humana Medicare Advantage
  - Behavioral Health provider assistance: **866-900-5021**, 8 a.m.–6 p.m., ET
  - Patients may call the number on the back of their Humana member ID card
  - Behavioral Health Claims and Authorizations - OCN Utilization Management
- UnitedHealthcare Medicaid
  - Behavioral Health Claims and Authorizations **800-711-4577**
- Coordinated Care
  - Behavioral Health provider assistance: **877-644-4613**

Delegation Contact Tree

Optum

Delegation contact tree

Behavioral Health

Claims

Credentialing

Pop Health:
Quality & Risk Adj

Pop Health:
Care Management

Utilization Management

Who to contact with questions

Choose an area of concern on the right, then locate the contact associated with the health plan and type.

Optum

Delegation contact tree

Behavioral Health

Claims

Credentialing

Pop Health:
Quality & Risk Adj

Pop Health:
Care Management

Utilization Management

Locate the health plan and plan type on the right to determine who to contact.

UHC

Medicare Advantage HMO	Contact UHC
Medicare Advantage PPO	

Humana

Medicare Advantage HMO	Contact Optum Health
Medicare Advantage PPO	

Optum

Delegation contact tree

Behavioral Health

Claims

Credentialing

Pop Health:
Quality & Risk Adj

Pop Health:
Care Management

Utilization Management

Locate the health plan and plan type on the right to determine who to contact.

UHC

Medicare Advantage HMO	Contact Optum Health
Medicare Advantage PPO	

Humana

Medicare Advantage HMO	If the provider is contracted, contact Optum Health. If not, contact Humana
Medicare Advantage PPO	Contact Humana

Optum

Delegation contact tree

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Pop Health:
Quality & Risk Adj

Pop Health:
Care Management

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UHC

Medicare Advantage HMO	Contact UHC
Medicare Advantage PPO	

Humana

Medicare Advantage HMO	Contact Optum Health
Medicare Advantage PPO	Contact Humana

Optum

Delegation contact tree

Behavioral Health

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Pop Health:
Care Management

Utilization Management

Locate the health plan and plan type on the right to determine who to contact.

UHC

Medicare Advantage HMO	Contact Optum Health
Medicare Advantage PPO	

Humana

Medicare Advantage HMO	Contact Optum Health
Medicare Advantage PPO	

Optum

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Optum

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Medicare Advantage PPO	

Humana

Medicare Advantage HMO	Contact Optum Health
Medicare Advantage PPO	