



2021 provider guide

Optum Care Network–Utah





As a health care provider, you know that the care delivery environment is changing — rapidly. Significant challenges and market pressures are at play on all fronts.

- Benefit plan sponsors are coping with cost pressures and demanding more for less.
- Patients are seeking education, value, simplicity and a better experience.
- Care providers are expected to deliver greater value, assume more risk and take on more responsibility.

We believe that Optum Care Network–Utah is uniquely positioned to help make the health system work better for everyone. We empower high-performing providers through new clinical insights and connections, while creating practice efficiencies and supporting financial stability.

Through this guide, we give you support and tools to improve patient care and clinical quality while reducing administrative burdens. The result? More time to focus on what you value most — caring for your patients.

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Purpose

The purpose of this guide is to provide key information to our contracted network providers and give you the tools necessary to deliver effective care to our patient population and ultimately improve the health and well-being of your patients.

In Utah, we strive to give selflessly, innovate endlessly and always collaborate. We take responsibility and demand quality. Above all else, we care about people, their health and their happiness.

This guide is not intended to be exhaustive nor contractually binding. The terms of the contractual agreement along with federal and state statutes and regulations shall control.

Business overview

Who is Optum?

Optum Care Network–Utah is a network of providers. We offer a full range of services to assist physicians and other providers in their managed care and business operations. You'll discover a group of like-minded clinicians who share a vision for better health care. Our success starts with investing in strong partners who aim to keep patients healthy and living long, productive lives.

Optum Care Network–Utah contracted providers represent a network of primary care and specialty providers.

Optum is a fully delegated entity, assuming both institutional and professional financial risk which allows us to enhance the coordinated care model. We are delegated by insurance plans to manage the medical services for their Medicare Advantage patients.

Mission

To help people live healthier lives and to help make the health system work better for everyone.

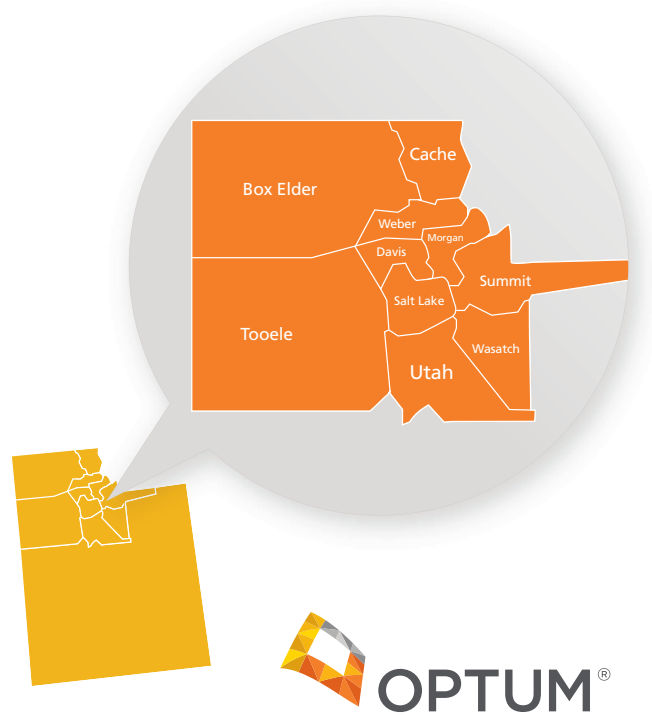
Vision

To improve lives by transforming health care in Utah: one patient, one family, one community at a time.

Values

Integrity. Compassion. Relationships. Innovation. Performance.

Service area



Optum Community Center locations:

Layton Community Center

2146 N. Main Street
Suite 514
Layton, Utah 84041
1-385-423-3585

Monday–Friday, 8 a.m.–5 p.m.

optumcare.com/utcenters

Sandy Community Center

1403 E. Sege Lily Drive
Suite 100
Sandy, UT 84092
1-801-982-3882

Monday–Friday, 8 a.m.–4 p.m.

optumcare.com/utcenters

West Valley Community Center

4071 S. 4000 West
Suite 1B
West Valley City, UT 84120
1-801-982-3178

Monday–Friday, 8 a.m.–4 p.m.

optumcare.com/utcenters

Optum contact information

Network contact information

Optum service center

Call [1-877-370-2845](tel:1-877-370-2845) or visit us online:

professionals.optumcare.com/resources-clinicians/utah-clinician-resources.html

Service advocates are available to answer questions Monday through Saturday, 8 a.m. to 8 p.m.

Network management team

Optum assigns a provider relations representative to each practice, in order to give you personal service. They will get to know your business needs, make sure your practice understands the network's best practices and assist with your questions and requests. If you need to reach your network manager, please email:

providerservices.ut@optum.com.

Prior authorization (urgent and routine)

For urgent and routine prior authorization/referrals and admission notification, please use the listed resources below to request prior authorization:

Phone: 1-877-370-2845, opt 2

Fax: 1-888-992-2809

Online: optumcare.com/provider-login

**Please see page 6 for user instructions or contact your network manager for assistance with the online tool.*

Prescriptions (Rx) prior authorization for UnitedHealthcare patients

Phone: 1-800-711-4555

Fax: 1-800-527-0531

Online: optumcare.com/provider-login

A prior authorization process is in place to provide for coverage of select formulary and non-formulary medications. Depending on the patient's plan, you can access the Medicare Advantage prescription drug formulary online and the drugs requiring prior authorization at the plan's website.

Transplant prior authorization

Phone: 1-888-936-7246

Referral policy

The primary care physician is responsible for coordinating all referrals. Refer to the front bottom right of the member's plan ID card for referral requirements. Refer to lookup.optumcare.com/utah/find-doctors/ for a complete provider directory with eligible specialists.

Claims from specialists who provide services to Optum patients without a referral will be denied. The specialist may not bill members for these denied services.

When is a referral required?

Refer to lookup.optumcare.com/utah/find-doctors/ for a complete provider directory with eligible specialists. The primary care physician is responsible for coordinating all referrals. No written referral is required. Refer to the front bottom right of the member's plan ID card for referral requirements.

How to complete a referral

Our online portal makes it quick and easy. To see if a specialist is contracted with Optum Care Network–Utah or to complete a referral, please go to providers.optumcaremw.com/.

Referrals to specialists will be auto approved if completed on our web portal.

Prior authorization is required for any out-of-network services

Please note that a specialist referral does not supersede the need for prior authorization for treatment or equipment. If you have completed a referral for services that require prior authorization, you will be notified if further information is required.

How long are patient referrals valid?

- Evaluation and treatment referrals are valid for six months from the date of issue.
- At the end of the six-month period, re-evaluation by the patient's PCP and a second referral is required. If you have any questions, please call the Optum service center at: [1-877-370-2845](tel:1-877-370-2845).

For more information, visit:

professionals.optumcare.com/resources-clinicians/utah-clinician-resources.html

Preferred providers

Preferred specialty groups

In an ongoing effort to provide our patients with the highest level of service, Optum has established preferred or exclusive arrangements with certain specialty groups. Preferred and exclusive specialists were chosen based on quality, performance metrics, geographic location and availability of clinical services. Please direct all patient referrals within these specialties to the groups listed below.

For information on additional Optum specialists and facilities, please contact our service center:

Optum service center

Phone: 1-877-370-2845

Online: Use the provider lookup at

professionals.optumcare.com/resources-clinicians/utah-clinician-resources.html

Home health care:

Rocky Mountain Care

Phone: 1-801-397-4600

Fax: 1-801-397-4606

Email: admissions@rmcare.com

Atlas Homecare:

Phone: 1-801-771-9099

Fax: 1-888-859-5658

Email: info@atlashomecareandhospice.com

Outpatient physical, occupational, speech language therapy and covered chiropractic:

Optum Physical Health

Phone: 1-800-873-4575

Optum behavioral health:

Phone: 1-800-579-5222

- Consultations
- Placement support
- Urgent prescriber program

Woundtech:

- Provides comprehensive wound care to patients in their place of residence
- No copay in most instances
- Referral process:
Email: intake@woundtech.net
Fax: 1-888-770-5056
Woundtech portal submission:
regusa.woundtech.net/
Fax: 1-888-770-5056
- For additional questions, contact the patient care coordinators
Phone: 1-866-986-2263

Optum NurseLine:

24-hour access hotline for patient to reach a nurse to answer questions regarding health concerns.

Phone: 1-877-365-7949, TTY 711

Patient enrollment and assignment

UnitedHealthcare plan ID card

The card below represents one example of an Optum member's Medicare Advantage health plan ID card through UnitedHealthcare. You can confirm the UnitedHealthcare® Medicare Advantage® plan is managed by Optum by locating the Optum logo on the ID card, as shown below.

Beginning in January 1, 2021, Optum will not manage the care of the UnitedHealthcare Medicare Advantage patients assigned to an Intermountain Healthcare provider.

Here are the UnitedHealthcare Medicare Advantage plan numbers managed by Optum.

UnitedHealthcare® MedicareAdvantage® H4604-003 (Group# 42000)

UnitedHealthcare® MedicareAdvantage® H4604-005 (Group# 42004 and 42009 essential)

UnitedHealthcare® MedicareAdvantage® H4604-011 (Group# 42022 and 42026)

UnitedHealthcare® MedicareAdvantage® H4604-017 (Group# 90055)

UnitedHealthcare® MedicareAdvantage® H4604-018 (Group# 42030)

UnitedHealthcare® MedicareAdvantage® H0271-003 (Group# 42027)

UnitedHealthcare® MedicareAdvantage® H7404-021 (Group# 90034 and 90033)

AARP Medicare Advantage
through UnitedHealthcare

Health Plan (80840): **911-87726-04**
Member ID: 0000000000 Group Number: 90033

Member: **WALTER J SAMPLE**
Payer ID: LIFE1 UHC Dental Benefits

PCP Name: **COOK, D.O., EMILY**
PCP Phone: (888) 387-6200

Copay: PCP \$10 Spec \$45 ER \$90

AARP Medicare Advantage Choice (PPO) w/Dental Platinum
H7404-021-000 Medicare limiting charges apply.

Medicare Rx
Prescription Drug Coverage

RxBIN: 610097
RxPCN: 9999
RxGrp: COS

Customer Service Hours: 8 am - 8 pm 7 days/week Printed: 10/20/2020

For Members
Website: www.myAARPMedicare.com
Customer Service: 1-800-643-4845 TTY 711
NurseLine: 1-877-365-7949 TTY 711
Behavioral Health: 1-800-985-2596 TTY 711

For Providers
www.OptumCare.com 1-877-370-2845
Medical Claim Address: P.O. Box 30539, Salt Lake City, UT 84130
Provider Authorizations: 1-877-370-2845
UHC Dental Providers: www.UHCdental.com 1-877-816-3596

UHC **Renew Active** **NO Referral Required** **OPTUM**

For Pharmacists 1-877-889-6510
Pharmacy Claims OptumRx P.O. Box 650287, Dallas, TX 75265-0287

Optum customer service

By phone

The phone number for providers to contact customer service is [1-877-370-2845](tel:1-877-370-2845). Service advocates are available to answer questions Monday through Saturday, 8 a.m. to 8 p.m.

Online

For faster service regarding claims or authorization inquiries, access the secure provider portal at: optumcare.com/provider-login.

Experience the benefits of online access:

- No wasted time on the phone, holding for information
- Accessible 24 hours a day, 7 days a week
- Quick and easy access to view claim, authorization and eligibility information
- No additional cost/fee for this feature

Secure email

Service advocates can also be reached by secure email through the provider portal at:

providers.optumcaremw.com/. Our secure email allows contracted providers to submit questions on important topics such as correcting claims payments, submitting or inquiring about prior authorizations and more. Any provider who has access to the secure portal can use this feature. When you submit a question via the web portal, you will receive a response within 24 hours. Emails received on weekends will be responded to the following business day. All questions and replies sent through this system are encrypted to ensure safe transfer of personal health information.

Optum provider portal

About the provider portal

The Optum provider portal is designed specifically for our contracted providers. It offers provider offices access to key patient authorization and claims information online, along with other value-added services.

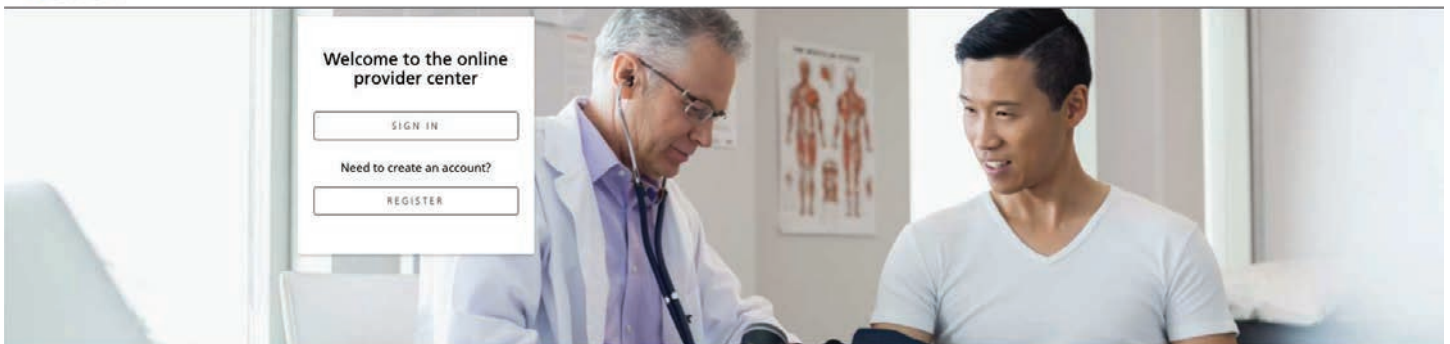
Using the provider portal, provider staff can:

- Submit referrals
- Verify patient eligibility
- Search prior authorizations and claims
- Send secure emails to our service center
- Search for contracted physicians to refer patients for services
- Submit requests for prior authorization
- Submit notification of patient hospitalization
- Select data by TIN for multi-TIN providers
- Obtain reports and helpful forms
- Update your account profile and reset your passwords

The provider portal can be a great tool to help eliminate lengthy phone calls and faxes. It can also be of assistance if you are doing paperwork before or after normal business hours.

How to get access

To gain access to the provider portal, visit providers.optumcaremw.com. If your office does not currently have portal access, you will need to designate an account administrator and have them create a new account. Once the designated account administrator fills out and submits the registration form found under the "Create Account" link, your account information will be delivered via email in about two business days. If you have questions or issues with getting access, email providerservices.ut@optum.com or their network manager for administrator access or any issues they have with the portal.



This portal is best experienced in these browsers: [Microsoft Edge](#) | [Mozilla FireFox](#) | [Google Chrome](#) | [Apple Safari](#)

NOTE: If you are using Internet Explorer, you may experience slow page loading. Also, some pages may have text or buttons not aligned properly. If you click a button and the page does not work as expected, try refreshing the page or clicking the back button. We highly recommend you use a newer, more secure

Language and hearing-impaired assistance

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

Language assistance

For patients that 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.

For more information, call Optum at [1-877-370-2845](tel:1-877-370-2845). The TTY 711 and language lines are open 24 hours a day, 7 days a week. The service center is available Monday through Saturday, 8 a.m. to 8 p.m.

Eligibility

The eligibility department receives frequent patient information from the health plans. Once this information has been received, it is loaded electronically into the system.

This information is reviewed by the eligibility department staff to ensure that the eligibility data matches the information submitted by the health plans. Information is being constantly updated and revised as it is provided to Optum by the health plans.

Claims

Attention: office managers and billing managers

Provided in the following sections is key information for claim submission and resubmission to initiate claims payment.

Topics addressed:

- Claim submission and field requirements
- EDI (electronic data interchange) claim payment policy and processing standard billing
- Reading a provider remittance advice (PRA)
- Time frames definitions helpful and hints

Corrected claims can be submitted electronically by following the guidelines:

Professional claims

1. On the CMS-1500 form, enter frequency code "7" in the **Resubmission** field (box 22). The provider can enter the claim number in the Original Ref No. field, which is also in box 22.
2. In the **Additional Claim Information** field (box 19), add a note indicating the reason for the resubmission (i.e. changed CPT code, added a modifier, corrected explanation of benefit (EOB) was received, etc.).

Facility claims

1. On the CMS-1450 form, in the **Type of Bill** field (box 4), enter frequency code "7."

This will indicate the claim is a corrected claim.

Optum preferred method of claim submission is electronic, known as electronic data interchange (EDI). EDI is the computer-to-computer transfer of data transactions and information between trading partners (payers and providers). EDI is a fast, inexpensive and safe method for automating the business practices that take place on a daily basis. There is no charge from Optum for submitting claims electronically to Optum.

Health care providers must be compliant with version 5010 of the HIPAA EDI standards. The current format that is used is 837, ANSI x12.

- 837i – Institutional claims
- 837p – Professional claims

Additional transactions performed by Optum:

- 997 – Functional acknowledgement (claim receipt acknowledgement via clearinghouse)

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

Paper submission:

- 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

Claim submission address:

Optum claims
P.O. Box 30539
Salt Lake City, UT 84130

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 claim form that contains:

- 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.

Submission time frames

Keep in mind when submitting claims, whether it is electronic or paper, there are required time frames that must be kept by all parties involved.

Submitter: Timely filing limit is 90 days or per the provider contract. A claim submitted after this time frame may be denied.

Please see provider dispute section of this manual for the necessary supporting documentation needed for proof of timely filing when filing a dispute.

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 HCPC/CPT code and corresponding quantity for each HCPC/CPT unit dispensed
- Reimbursement is based upon CMS payment methodology for Part B drugs

DRG/APC reimbursements

DRG/APC reimbursement is validated using an outside vendor 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.

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 physician on the same patient during the same operative session are reimbursed in accordance to Medicare guidelines, unless otherwise stated in the provider's contract.

Reading the provider remittance advice (PRA)

Information is listed on the PRA in addition to the amount paid. See the end of this section for a detailed explanation of each field.

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.

Electronic funds transfer (EFT)

Optum offers ERA/EFT solution through our exclusive vendor, InstaMed.

Benefits include:

- Free integrated ERA/EFT including trace number linking the ERA and EFT
- Quick registration, with only 8 to 10 business days before you receive your first payment
- No disruption to your current workflow – there is an option to have ERAs routed to your existing clearinghouse
- Viewing payments at summary and detail level with intuitive reporting
- Live InstaMed customer service support from 7–9 a.m. ET via phone, email and web.

In July 2018, Optum discontinued our relationship with Change Healthcare. Going forward, Optum will work exclusively with InstaMed as our free payer payments solution for providers. All providers still on Change Healthcare at the time of disconnect will return to paper checks. To continue receiving your Optum payments electronically, please register for free ERA/EFT through InstaMed.

To register, visit instamed.com/eraeft or call 1-866-945-7990 with any questions.

Electronic data interchange (EDI)

Optum encourages and supports electronic data interchange, particularly claims and encounters. Electronic claims submission allows the provider to eliminate the hassle and expense of printing, stuffing and mailing your claims to the network. It substantially reduces the delivery, processing and payment time of claims. There is no charge for submitting claims electronically to the network. Providers are able to use any major clearinghouse.

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.

Helpful billing and claims hints

Things to remember when billing and submitting claims:

- EDI submission is Optum's 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. This will increase the chance of accurate payment.
- Provide accurate data and complete all required fields on the claim.
- If the provider has time limits for claims submission in the contract, be sure to know what they are and submit claims accordingly.
- Know the contract(s) – be sure all billing staff is familiar with current billing and contract information.
- To verify and view claim status, go to optumcare.com/provider-login or contact the service center at 1-877-370-2845 and have a current tax ID available.

Glossary of claims terminology

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

Ambulatory surgery classification – ASC: Used for outpatient hospital claims, paid at OPPS (outpatient perspective payment system).

Ambulatory surgery center – ASC: Used for payments to a surgery center.

Billed charges: The dollar amount billed by a provider as their usual and customary charge.

Capitation: Method of payment for health services in which a physician 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 (pppm) 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, adjusted by age/gender of enrollees, percent of premium based on severity ratings.

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

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

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

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

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

Global period: A time period 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.

Maximum out-of-pocket – MOOP: Out-of-pocket expenses are copays, deductibles and coinsurance. 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 and must be forwarded to the appropriate financial entity.

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.

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

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

Unbundling: 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 a 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.

Credentialing and recredentialing

The credentialing department handles provider credentialing/recredentialing for Optum. The credentialing and recredentialing verifications are performed by the credentialing department.

Initial credentialing

The initial credentialing process takes approximately 30 to 60 days to complete, from receipt of completed credentialing application to committee approval. Once received, the credentialing process will begin. The credentialing time frame is directly dependent upon receiving verifications from the primary source verification sources in a timely manner. If receipt of those verifications is delayed in any way, it will hold up 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 the processing of the application. The credentialing department has a streamlined verification process that enables short turnaround times. An overview of the initial credentialing process is on the following page.

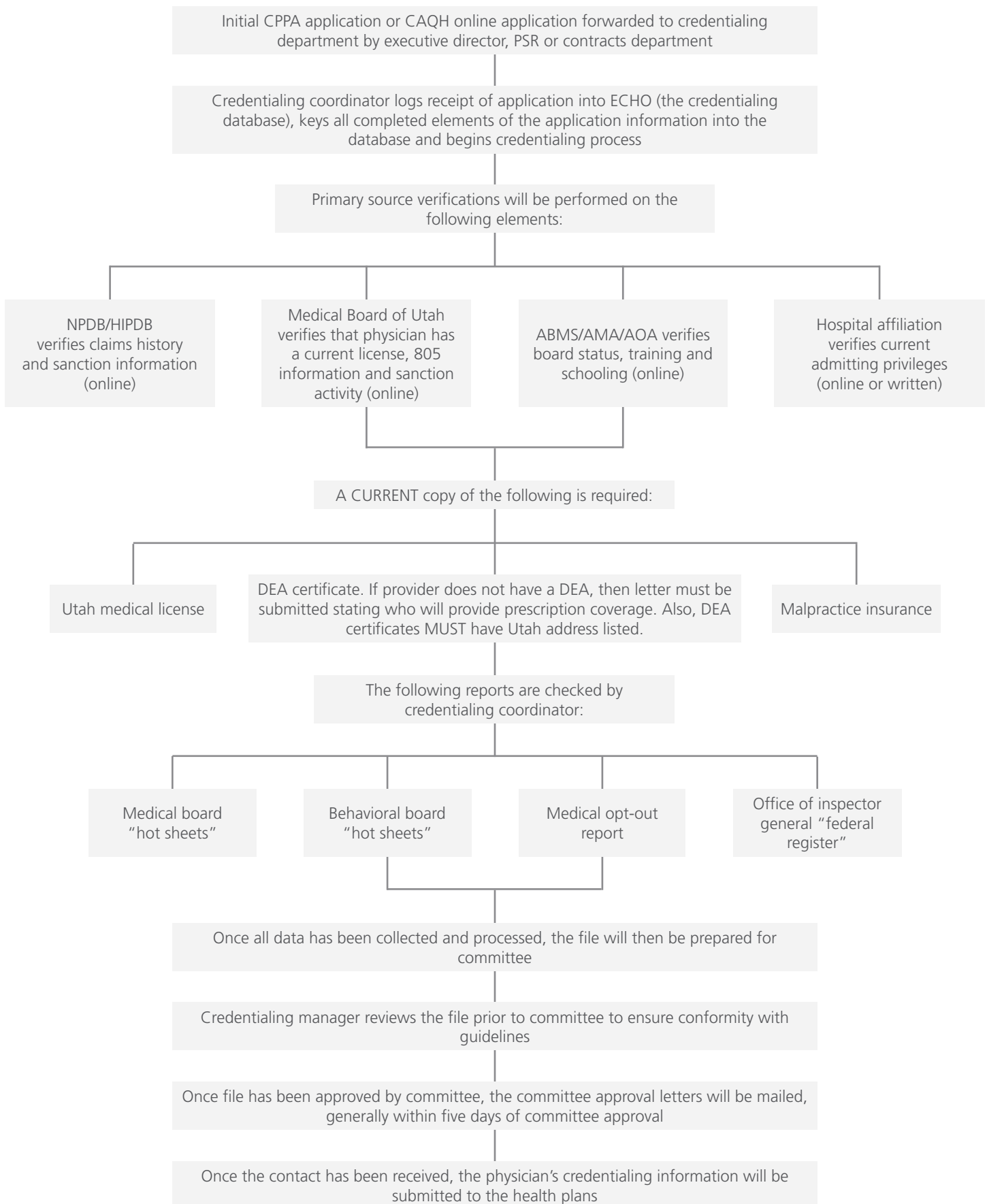
Recredentialing

Recredentialing occurs every three years. Five months prior to the three-year credentialing anniversary, the provider will receive a request to log in to CAQH, a universal provider datasource, and complete the online application, or if provider has already done so, then verify that the attestation is current and up to date. The CAQH website is proview.caqh.org/login. If you need your CAQH provider ID number, please contact CAQH at 1-888-599-1771 and they will provide it. Providers shall promptly notify Optum and credentialing department if they no longer meet the group's credentialing criteria (e.g. medical license revoked, opt-out of Medicare).

Please note: If the provider or their group is adding a physician, the credentialing must be completed and there must be an executed contract in place prior to the practitioner seeing Optum patients. It is fraudulent practice to bill under one physician when services are actually provided by another physician.

Optum has a form that can be used to report demographic changes or update NPI information for your practice. If you are adding a provider, changing address, or deleting a provider who may have left your group, please fill out this form and submit it via fax or email. The "Physician/Provider update form" can be found at professionals.optumcare.com/resources-clinicians.html.

Credentialing flow chart



Health improvement

General information

Optum 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 are not based upon the likelihood or the perceived likelihood that the individual will support or tend to support the denial of benefits.

Optum uses standardized, objective and clinically valid criteria that are compatible with established principles of health care and flexible enough to allow for variations. This criteria is based on reasonable medical evidence and acceptable medical standards of practice (i.e. applicable health plan benefit and coverage documents, national and local coverage determinations, CMS guidelines, Milliman Care Guidelines, and Hayes criteria). 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 general public, or a physician, 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 or the service center to make the request. Physicians may contact the Optum UM department to obtain UM policy or criteria used in making medical decisions.

Quality improvement

Introduction to quality improvement (QI)

Committee mission

The UM/QI committee supports the QI and UM programs to promote measurable quality improvement and recognition of both individual and team accomplishments as well as to identify opportunities for improvement. The members of the UM/QI committee have the responsibility to create a quality improvement culture throughout the organization. Optum team members use quality improvement principles and tools in everyday settings, with leadership and guidance from the senior management team.

The UM/QI committee may appoint, at anytime, 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 UM/QI committee minutes.

Committee goals

The UM/QI committee shall objectively and systematically monitor and evaluate quality of care and services delivered to our members. Opportunities for improvement maybe identified in a variety of ways including but not limited to ongoing monitoring, process changes and staff recommendations. Implemented changes will be monitored to assess effectiveness.

Committee objectives

The committee shall oversee the following functions:

- Review and adoption of QI Program and related policies and procedures
- Review and adoption of UM Program, UM Work Plan and related policies and procedures
- Review and adoption of UM Criteria and Clinical Guidelines
- Oversight of clinical care and services to include but not limited to:
 - Patient safety reviews (medication reconciliation)
 - Utilization management
 - Sub-delegated and vendor functions
- Conduct an annual evaluation of the UM and QI programs to assess accomplishments, barriers and to establish goals for the next year's program
- Quality of clinical care, service monitoring and evaluation activities include but may not be limited to the following activities and outcomes:
 - Prior authorization
 - Concurrent review
 - Patient safety
 - UM timeliness of decisions
 - Oversight of delegated functions

CMS quality measure overview

Several industry quality programs, including the Centers for Medicare and 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 four sources:

- Consumer Assessment of Healthcare Providers and Systems (CAHPS) or patient satisfaction 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
- Pharmacy Drug Event data and Pharmacy Quality Alliance (PQA) measures

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](https://www.cms.gov).

Consumer Assessment of Healthcare Providers and Systems (CAHPS) measures

CAHPS is an annual survey that asks consumers and members to report on and evaluate their experiences with health care. The CAHPS survey is administered by CMS and overseen by AHRQ. Details include:

- The survey is given annually between February and June to adults ages 18 and older who have been enrolled in a Medicare Advantage plan for six months or longer.
- Respondents are asked a core set of questions developed by AHRQ and CMS, in addition to additional questions related to the enrollee's particular plan type.
- Results are calculated and released between July and October.

Health Outcomes Survey (HOS) measures

HOS is a health plan member survey by CMS that gathers health status data specific to the Medicare Advantage program. Respondents are given a baseline survey between late April and July and then asked to complete a follow-up survey two years later between April through July.

Baseline survey results are calculated and released in May of the following year, while results for the follow-up survey are provided during the summer of the following year.

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), as well as 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.

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 three 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.

Working diagnoses

Working diagnoses are consistent with findings.

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 (for example, 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 (age 18 and under), 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 his/her 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 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 physician 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 to non-urgent appointment with physician 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 six hours of request
Access to life-threatening emergency care	Immediately
Access to follow-up care after hospitalizations for mental illness	Within seven business days of request (initial visit). Within 30 business days of request (second visit)

Exceptions

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

Preventive care recommendations for men and women ages 50 and older

Immunizations	
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 two shots
Zoster (shingles)	Recommended for all adults 60 and older

Screenings/counseling/services	
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 well visit, annually
Breast cancer	Recommended mammogram every one to two years for women ages 50 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 three years if cervix present; after age 65. Pap tests can be discontinued if previous tests have been normal
Colorectal cancer	Recommended for adults 50 to 75
Depression	For all adults

Screenings/counseling/services (continued)

Diabetes	Recommend type 2 diabetes screening for individuals with sustained blood pressure greater than 135/80 mm Hg
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	Prostate-specific antigen (PSA) test and digital rectal exam
Sexually transmitted infections	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 physician before starting a new vigorous physical activity.

Other topics to discuss with patients

Nutrition

- Eat a healthy diet. Limit fat and calories. Eat fruits, vegetables, beans and whole grains every day.
 - Optimal calcium intake is estimated to be 1,500 mg/day for post-menopausal women not on estrogen therapy.
 - Vitamin D is important for bone and muscle development, function and preservation.
-

Sexual health

- Sexually transmitted infection (STI)/HIV prevention, practice safer sex (use condoms) or abstinence.
-

Substance abuse

- Stop smoking. Limit alcohol consumption. Avoid alcohol or drug use while driving.
-

Dental health

- Floss and brush with fluoride toothpaste daily. Seek dental care regularly.
-

Other topics

- Fall prevention.
- Possible risks and benefits of hormone replacement therapy (HRT) for post-menopausal women.
- Risks for and possible benefits of prostate cancer screening in men to determine what is best for you.
- The dangers of drug interactions.
- Physical activity.
- Glaucoma eye exam by an eye care professional (an ophthalmologist, optometrist) for adults ages 65 and older.

Utilization management and prior authorization

Introduction to utilization management (UM) and prior authorization

The Optum UM team strives to offer providers and patients the most efficient service possible. Its goal is to process authorizations within the following time frames:

- Non-urgent (routine) pre-service decisions – As soon as medically indicated within a maximum of 14 calendar days after receipt of request
- Urgent pre-service decisions (expedited) – As soon as medically necessary within 72 hours after receipt of request (includes weekends and holidays)
- Urgent requests are defined as the requesting physician considers that waiting longer than 72 hours for a decision on this request could place the enrollee's life, health or ability to regain maximum function in serious jeopardy
- Part B drug requests – Urgent pre-services decisions (expedited) – As soon as medically necessary within 24 hours after receipt of request (includes weekends and holidays)
- Non-urgent (routine) pre-service decisions – As soon as medically indicated within 72 hours of receipt of request (includes weekends and holidays)

More about prior authorization

Prior (or pre-service) authorization is any case or service that Optum must approve, in whole or in part, in advance of the patient obtaining medical care or services. Prior authorization and pre-certification are pre-service decisions.

The purpose of the prior authorization process is to support a review process that promotes appropriate access to care and service. This is done to promote wellness through utilization of appropriate resources, in the most appropriate setting and in the most cost-effective manner. This is achieved through the evaluation and determination of the appropriateness of the patient's and practitioner's use of medical resources prior to services being rendered.

Instances in which prior authorization is required

The prior authorization procedure requirements and request form are posted on the professionals.optumcare.com/resources-clinicians website and are updated at least annually. You can also submit requests and check status directly in our secure provider portal.

In addition, the Optum® Cancer Guidance Program (CGP) is an evidence-based prior authorization program for outpatient oncology (intravenous /injectable) drugs rxcare.optum.com/.

Prior authorization is required for all skilled nursing facility, acute rehab and long-term acute care admissions. Requests should be submitted to the UM department (see "how to request prior authorization" below).

Instances in which prior authorization is not required

Prior authorization is NOT required for emergency care. However, notification of such services is expected within 24 hours.

How to request prior authorization

A patient, authorized representative or provider may request prior authorization. Multiple methods can be used to request prior authorization. These methods include submission via Internet, fax, phone and U.S. postal mail:

- Online: providers.optumcaremw.com
- Fax: 1-888-992-2809
- Phone: 1-877-370-2845, * Prompt 2

Coordinators are available for prior authorization calls Monday through Friday, 8 a.m. to 5 p.m. (except holidays).

Optum® Cancer Guidance Program (CGP)

- Online: mbm.linkplatform.com/home
- Phone: 1-877-454-8365



Instructions:

- Please complete the form located on page two. Fields with an asterisk (*) are required. If mandatory fields are not complete, information will not be accepted and processed.

You now have several options for submitting your prior authorization requests to Optum Care:

- Online (preferred method): professionals.optumcare.com/portal-login
- AZ/UT phone: **1-877-370-2845**
NV phone: **1-855-893-2297**
- Or mail the completed form to: **Optum Care**
Attention: Prior Authorization
P.O. Box 30539
Salt Lake City, UT 84130

All referrals should be submitted through the provider portal at professionals.optumcare.com/portal-login.

The paper form is available for use on an exception basis. If a paper form is used, please complete the form located on page two. All fields are required. Any forms with required fields missing information will be faxed back and identified as unable to process.



PLEASE MARK ONE OF THE FOLLOWING:

- ROUTINE (Normal, non urgent request completed within 14 days.)
URGENT (Urgent is defined as significant impact to health of the member if not completed within 72 hours per the requesting physician. A signed physician order and clinicals must be included.)

PATIENT INFORMATION:

LAST NAME: FIRST NAME: DOB:
PHONE: INSURED ID:
ADDRESS: CITY: STATE: ZIP:

REQUESTING PROVIDER INFORMATION:

PROVIDER NAME:
GROUP NAME:
SPECIALTY:
TAX ID #:
ADDRESS:
CITY: STATE: ZIP:
CONTACT NAME:
PHONE: EXT:
FAX:

SERVICING PROVIDER:

PROVIDER/FACILITY NAME:
GROUP NAME:
SPECIALTY:
TAX ID or NPI #:
ADDRESS:
CITY: STATE: ZIP:
CONTACT NAME:
PHONE: EXT:
FAX:

SERVICES: DOS:
TYPE OF SERVICE: OUTPT INPT Office Surgery Ctr SNF Home Other:
DIAGNOSIS CODE(S):
CPT/HCPCS CODE(S) (INCLUDE NUMBER OF UNITS PER CODE):
FOR DME ITEMS (CHECK ONE): RENTAL PURCHASE Cost:

- PLEASE ATTACH SUPPORTING CLINICAL INFORMATION (E.G., PLAN OF CARE, MEDICAL RECORDS, LAB REPORTS, LETTER OF MEDICAL NECESSITY, PROGRESS NOTES, ETC.)

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 contained in this form, including attachments, is privileged and confidential and is only for the use of the individual or entities named on 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.

Hospital admission notification

Requirements for admission notifications

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
- All admissions following outpatient surgery
- All admissions following observation
- 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 physician supplied advance notification and a pre-service coverage approval is on file.

Skilled nursing facility admission notification

Requirements for admission notifications.

Admission notification must be received within 24 hours after admission to facility.

Receipt of an admission notification does not guarantee or authorize payment. Payment of covered services is contingent upon coverage within an individual patient's benefit plan, the facility being eligible 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 TIN or NPI
- Admitting/attending physician 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.

Home health information

Initial notification

No prior authorization is required for the first 30 days of home health services

72-hour notification for start of care is required

Prior authorization

If additional home health visits are needed beyond the first 30 days, a prior authorization is required, the following must be submitted:

Clinical documents required for home health review and required for prior authorization must be submitted by Day 21:

- Request and justification for continued home health
- Face to face, if available
- Documentation of physician's verbal order or physician signed plan of care
- Comprehensive assessment including:
 - RN/LPN notes
 - Progress notes as applicable
 - Physical therapy notes
 - Occupational therapy notes
 - Speech therapy notes
 - Home health aide notes
 - Medical social worker notes

Recertification

For recertification and prior authorization, Days 61–90, the following documents must be received by Days 56–60:

- Request and justification for continued home health
- Face to face, if available
- Documentation of physician's verbal order or physician signed plan of care
- Comprehensive assessment including:
 - RN/LPN notes
 - Progress notes as applicable
 - Physical therapy notes
 - Occupational therapy notes
 - Speech therapy notes
 - Home health aide notes
 - Medical social worker notes

The pattern will repeat itself subsequently every 30 days.

Submission process

To submit a notification or prior authorization request:

Fax the request to 1-888-992-2809, utilize the provider portal or call 1-877-992-2809.

Note: If the patient is discharging from an acute facility, the hospital history and physical, as well as the discharge summary, are required to be submitted with this request.

If the patient is not discharging from an acute facility, physician clinic note relevant to home health care must be submitted with this request.

If Optum Care does not receive these required documents, the services could be denied for lack of information.

Clinical coverage review

You can review a list of required information by service on uhcprovider.com/protocols > Medical Record Requirements for pre-service reviews. If you submit required information with the advance notification/prior authorization, your review will go faster. You must:

- Return calls from our care management team and/or medical director.
- Submit the most correct and specific code available for the services.
- Comply with our request for additional information or documents and discussions, including requests for medical records and imaging studies/reports:
 - If you receive our request before 1 p.m. local time, provide the information within 4 hours.
 - If you receive our request after 1 p.m. local time, provide the information no later than 12 p.m. local time the next business day.
 - If a facility does not provide timely admission notification, the service may not be paid by Optum.

How to submit admission notifications

Multiple methods can be used to notify Optum of admissions. These methods include submission via Internet, fax, phone and U.S. postal mail.

- Online: providers.optumcaremw.com
- Fax: 1-888-992-2809
- Phone: 1-877-370-2845, opt 2

Coordinators are available to answer questions Monday through Friday, 8 a.m. to 5 p.m. (except holidays).

Coordination of benefits (COB) and third-party liability (TPL)

COB 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 copays 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.

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.

Provider dispute resolution process

Optum's goal is to provide affiliated physicians 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 dispute

A provider dispute is a provider's written notice challenging, requesting 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 over payment of claims.

Each provider dispute must contain, at a minimum, the following information:

- Provider's name
- Provider's TIN
- Provider's contact information

If the provider dispute concerns a claim or reimbursement of an over payment of a claim from Optum, the following must be provided:

- Clear identification of the disputed item, such as the claim(s) number
- Date of service
- Clear description of the dispute

If the provider dispute is not concerning a claim, the following must be provided:

- Clear explanation of the issue
- Provider's position on the issue

Things to remember when submitting a provider dispute:

- Provider dispute forms must be completed in full and included with the dispute.
- To download a copy of the Optum provider dispute resolution request, visit professionals.optumcare.com/resources-clinicians.html.
- All required information must be included. Disputes that are missing information will be returned to the submitter.



PROVIDER DISPUTE RESOLUTION REQUEST

NOTE: SUBMISSION OF THIS FORM CONSTITUTES AGREEMENT NOT TO BILL THE PATIENT

INSTRUCTIONS

- Please complete the below form. Fields with an asterisk (*) are required.
- Be specific when completing the DESCRIPTION OF DISPUTE.
- Provide additional information to support the description of the dispute. It is not necessary to resubmit the original claim.

You now have several options for submitting your requests for reconsideration to Optum:

If you have a secure system, please submit reconsideration requests to: claimdispute@optum.com.

If you do not have a secure email in place, please contact our service center at [1-877-370-2845](tel:1-877-370-2845). We will ask for your email address and will send a secure email for claim reconsideration requests.

You can fax your requests to [1-888-905-9495](tel:1-888-905-9495).

Or mail the completed form to: **Provider Dispute Resolution**
PO Box 30539
Salt Lake City, UT 84130

NOTE: This form is for claim disputes and reconsiderations only. To submit a formal appeal, please see the instructions listed on the back of your explanation of payment (EOP).

*Provider Name:	*Provider TIN:		
Provider Address:			
Provider Type:	<input type="checkbox"/> MD	<input type="checkbox"/> Mental Health Professional	<input type="checkbox"/> Mental Health Institutional
	<input type="checkbox"/> Hospital	<input type="checkbox"/> ASC	<input type="checkbox"/> SNF <input type="checkbox"/> DME <input type="checkbox"/> Rehab
	<input type="checkbox"/> Home Health	<input type="checkbox"/> Ambulance	
	<input type="checkbox"/> Other _____ (please specify type of "other")		

CLAIM INFORMATION Single Multiple "LIKE" Claims (**attach spreadsheet**) Number of claims: _____

*Patient Name:	*Date of Birth (MM/DD/YYYY):
*Member's Health Plan ID:	*Patient Account Number:
*Service From Date (MM/DD/YYYY):	*Service To Date (MM/DD/YYYY):
Claim ID Number:	(If multiple claims, use attached spreadsheet)

Please check the description that best fits: <input type="checkbox"/> Claims <input type="checkbox"/> Authorizations <input type="checkbox"/> Contract Issues <input type="checkbox"/> Medical Records	
Description of dispute:	
*Contact Name: _____	*Telephone Number (111-111-1111): _____ Ext. _____ (if applicable)
*Signature: _____	*Fax Number (111-111-1111): _____
(Hard Copy Only)	

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Medical management

Optum medical management programs provide high-touch care coordination within hospitals, skilled nursing facilities (SNFs) and patients' homes. These programs work in collaboration with the patient, the family/support system, providers and key stakeholders to coordinate discharge, health care services, community resources and referrals to the appropriate next level of care. These services are reviewed and processed by the care coordination team.

Use this guide to help determine if your Optum patient qualifies for one of our medical management programs. If your patient meets at least one criterion for any of the programs listed, please fill out the patient program referral form and email it to umutah@optum.com.

For more information on any of these programs, please contact your respective provider network manager. If you are unable to reach your provider network manager or you are unsure who your provider network manager is, you can email providerservices.ut@optum.com.

Referral fax hotline: 1-844-461-5749

Clinical programs

Device-enabled condition management (DECM)

Focuses on patient(s) with: CHF, COPD, and/or diabetes. This program utilizes digital technology (smartphone app or tablet) that allows for near realtime remote monitoring. Patients are provided monitoring devices (scale, blood pressure cuff, pulse oximeter, etc.) for daily symptom monitoring. With the use of digital technology, alerts are sent for care managers to proactively address any escalations. This program uses personalized care plans, medication reminders, educational videos/tips and videoconferencing.

High-risk care management

Focuses on patient(s) who have multiple comorbidities or are high utilizers with complex conditions. This program helps patient(s) facilitate care coordination, discuss goals of care, and provide education of conditions via telephonic engagement.

Kidney resource specialist

Provides case management for patient(s) via chronic kidney disease or end-stage renal disease programs, including dialysis management.

Medical behavioral integration

Focuses on patient(s) who have multiple comorbidities or are high utilizers with complex conditions and additionally have behavioral health needs. Dedicated in-person or telephonic RN case management support to educate patient(s) on available community behavioral health resources, provide medication review, as well as intervention(s) for behavioral health and substance abuse disorders.

Social work case management

Assess the psychosocial factors that may affect a patient's health, including, but not limited to: community resource coordination, advanced directives/life care goals, emotional adjustments/counseling on life changes, crisis intervention and applications for financial aid or Medicaid.

Short-term case management

Dedicated telephonic RN case manager to provide health goal development, coordinate access to community resources and services, and provide disease education and medication review. This program supports patients that require additional clinical support and education, as well as those transitioning from hospital to home.

Phone number: [1-801-982-3089](tel:1-801-982-3089)

Palliative care

A multidisciplinary approach to specialized medical and nursing care for patient(s) with life-limiting illnesses. The goal is to improve quality of life for the patient(s).

Appropriate referrals might include:

- Patients struggling with symptoms of chronic illness
- Patients needing help coping with disease complications
- Patients face difficult, complex medical decisions from an advanced, life-limiting illness
- Diseases included but not limited to:
 - Cancer with metastases
 - Liver failure
 - Encephalopathy
 - Cirrhosis
 - Kidney failure
 - CKD stage 5
 - ESRD
 - End-stage dementia
 - Chronic oxygen use
 - Chronic and end-stage respiratory diseases

Healthy Mindsets

Patient(s) may not always get the full care they need. This could be due to many factors like limited time or cost. To help, Optum partners with Healthy Mindsets to provide an extra level of care. This self-help program is confidential, easy-to-use and offered at no extra cost.

It can help patient(s) learn:

- Ways to reduce stress
- Skills to improve mental health
- Tips for creating healthy habits

Healthy Mindsets focuses on the following areas of medical care:

- Emotional stress: conditions like depression and anger
- Conditions related to stress: sleep problems, pain and more
- Building resilience: how to recover from a health-related setback
- Wellness and prevention: creating healthy habits like eating well and limiting stress

Patient(s) determine how much they want to participate. The program was created for efficiency, offering them the help they need in as little time as possible.

To get started, patient(s) can ask their Optum representative for a wellness code.

Visit healthy-mindsets.com. Use the wellness code to sign in and start using the tools and trainings today.

Medicare risk adjustment

Optum encourages providers to document patient health information and demographics. CMS uses this demographic information reported for one year, along with risk adjustment diagnosis codes to determine reimbursement rates for the following year. Compensation rates are based on patient risk scores.

CMS hierarchical condition categories (HCC) model

- The model groups diagnose codes into disease groups called HCC that include conditions which are clinically related with similar cost implications
- The model is heavily influenced by costs associated with chronic diseases
- The model is additive, allowing for consideration of multiple conditions
- The model is prospective – diagnoses from base year used to predict payments for the following year

Hypothetical illustration payment under the CMS HCC:

Mr. Smith

- Lives in Marlboro County
- 78 years old

Has:

- CHF (with hospital admission)
- Diabetes
- Renal failure

Medicare monthly payment:

- \$1,599

Mr. Carter

- Lives in Marlboro County
- 78 years old

Has:

- Not seen a doctor in two years

Medicare monthly payment:

- \$289

Keys to success with risk adjustment:

- Good coding and documentation practices indicate that the medical record documentation must support the ICD-10 submitted on the encounter of annual health assessment form
- High reporting levels of encounter data
- Patient retention

Coding and documentation:

- Use the current version of ICD-10 and code to the highest level of specificity
- Do code all conditions when they become certain
- Do not code probable, suspected, rule-out or working diagnoses

Documentation:

- Verify that all diagnosis codes reported can be supported by source medical records
- In addition to the primary reason for the episode of care, document all co-existing, acute and chronic conditions that impact the clinical evaluation and treatment
- CMS will audit medical records to validate codes submitted

Annual wellness visits:

- Face to face visit with all seniors
- PCPs are reimbursed by Optum for each senior patient for whom they conduct an annual wellness visit (AWV) and complete the corresponding attestation form
- The attestation form must be completed in its entirety and submitted to Optum for processing
- The form itself will be used to report the encounters
- AWV can be conducted in the PCP office and in an Optum community center mobile clinic
- The model is heavily influenced by costs associated with chronic diseases
- The model is additive, allowing for consideration of multiple conditions
- The model is prospective – diagnoses from base year used to predict payments for the following year

Optum will offer education about this process to providers and their office staff. For more information, please contact Optum provider services: [1-877-370-2845](tel:1-877-370-2845).

Medicare compliance

Expectations and training

The Centers for Medicare and Medicaid Services (CMS) requires Medicare Advantage (MA) organizations and Part D plan sponsors to annually communicate specific compliance and FWA requirements to their “first tier, downstream and related entities” (FDRs). FDRs include contracted physicians, health care professionals, facilities and ancillary providers, as well as delegates, contractors and related parties.

As a delegate that performs administrative or health care services, 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. As of January 1, 2019, FDRs are no longer required to complete the specific CMS FWA training modules or retain documentation of the training. However, Optum Care Network–Utah’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 subdelegates who are involved in or responsible for the administration or delivery of UnitedHealthcare MA or Part D benefits or services.

We have general compliance training and FWA resources available at [unitedhealthgroup.com](https://www.unitedhealthgroup.com).

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: FDRs must review federal exclusion lists (HHS-OIG and GSA) and state exclusion lists, as applicable, prior to hiring/contracting with employees (including temporary workers and volunteers), the CEO, senior administrators or managers, and subdelegates who are involved in or responsible for the administration or delivery of UnitedHealthcare or other MA plan sponsor and Part D benefits or services to make sure that none are excluded from participating in federal health care programs. FDRs must continue to review the federal and state exclusion lists on a monthly basis thereafter. For more information or access to the publicly accessible excluded party online databases, please see 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

What you need to do for exclusion checks: Review applicable exclusion lists as outlined above and maintain a record of exclusion checks for 10 years. Documentation of the exclusion checks may be requested by Optum, UnitedHealthcare, other MA plan sponsor or CMS to verify that checks were completed.

Reporting misconduct

If you identify compliance issues and/or potential fraud, waste or abuse, please report it to us immediately so 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 at [unitedhealthgroup.com/about/ethics-integrity.html](https://www.unitedhealthgroup.com/about/ethics-integrity.html). Optum expressly prohibits retaliation if a report is made in good faith.

Optum Care Network–Utah 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.

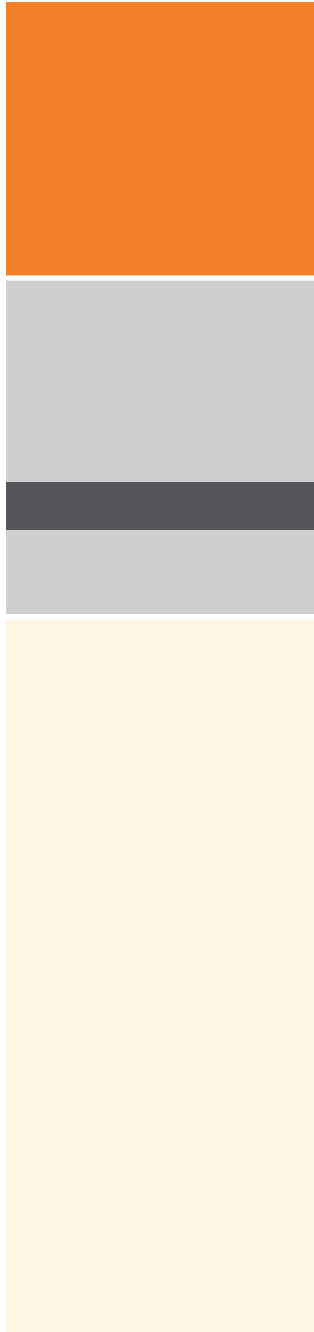
Preclusion list policy

CMS has a preclusion list effective for claims with dates of service on or after January 1, 2020. The preclusion list applies to both MA plans as well as Part D plans. The preclusion list includes a list of prescribers and individuals or entities who:

- Are revoked from Medicare, are under an active re-enrollment 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 Care Network–Utah.

CMS updates the preclusion list monthly and notifies MA and Part D plans of the claim rejection date, which is the date on 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 the Optum Care Network–Utah. Additionally, the precluded care provider must hold Medicare beneficiaries harmless from financial liability for services provided on or after the claim rejection.



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