OPTUM®

Skilled nursing facility (SNF) manual

A guide to responsibilities and resources.

Contents

Letter from our staff

On behalf of everyone at Optum Care Network–Arizona, I thank you for partnering with us. It is truly a team effort to deliver the highest quality care and safety for our members.

Health care is a complex business with many regulatory, compliance and contract-related components. We want to collaborate with you to make sure that both your facility and Optum Care Network–Arizona are in compliance with all requirements at all times.

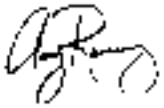
This SNF manual is a guide to help your providers, nurses and staff understand and follow all requirements. As always, our team is available and willing to meet with you to review these policies, procedures, regulatory and compliance requirements at your facility.

Optum Care Network–Arizona reserves the right to pend claims if any regulatory, compliance or contractual requirements described in our contract are not met. Of course, this would only be a last resort. We would prefer to be proactive and collaborate with you to avoid or resolve any issues before having to take such measures.

Please take time to review the contract language on the next page, as well as the policies and procedures in this SNF manual. The same terms will apply whether your contract is with a health plan or directly with Optum Care Network–Arizona. Following the policies and procedures outlined in this manual will avert the need to pend any claims.

We look forward to enjoying a long and successful partnership with your facility. Together, we will continue to achieve the highest standards of care in Arizona.

Thank you and best regards,



Amy Ramirez, MSN, RN, CMCN, CCM
Vice President, Medical Management
Optum Care Network–Arizona

Contract language

"Policies and procedures" means the written or electronic versions of provider manual, policies, procedures and other requirements, including but not limited to the quality management program and utilization management program, developed and amended by Optum Care and plan from time to time.
Facility shall comply with all policies and procedures. Facility understands that failure to comply with or failure to take corrective action to comply with the agreement, including the policies and procedures, may result in non-payment under this agreement or termination of this agreement. In addition to the policies and procedures, facility warrants that it and its participating providers shall also participate in the implementation of continuous quality improvement and clinical pathways, support systems in the daily operations of the practice to support such efforts, commit time to receive education or training on quality improvement and clinical pathways, and to monitor and control the utilization and cost of covered services rendered to Optum Care members. Plans may change policies and procedures in accordance with the plan agreement, Optum Care may implement changes in the policies and procedures without facility's consent if such change is applicable to all or substantially all of the other providers. To the extent there is any conflict between the policies and procedures and this agreement, the terms of this agreement shall control.

Records and access. Facility shall maintain such books, medical and other records and information, including, but not limited to, those relating to: (a) the provision of facility services; (b) the cost of facility services; (c) the payments received from Optum Care members (or from others on their behalf); and (d) facility's financial condition, as may be necessary or required by Optum Care for compliance by Optum Care with applicable laws. All such books, records and information shall be made available to Optum Care and CMS at all reasonable times, upon demand, for inspection, examination and copying at facility's principal place of business during normal business hours. Such books, records and information as they pertain to Optum Care members of commercial plans shall be retained for at least six (6) years and for MA members shall be retained for at least ten (10) years, from the date of creation or, in the event facility has been notified of any federal or state audit or investigation of Optum Care, until the date such audit or investigation is resolved, whichever is later, or as otherwise required by law.

Timing: Fee-for-service. Facility shall submit fee-for-service claims within ninety (90) calendar days of the date of service, or Optum Care may deny payment. Optum Care shall pay or deny facility's commercial fee-for-service claims within forty-five (45) working days of receipt of a complete, clean and accurate claim, or such shorter time period if required by applicable Law. Optum Care shall pay fee-for-service claims for MA members in accordance with the time frames set forth under federal law. Facility shall not bill Optum Care members for covered services for which Optum Care has denied payment for untimely claim submission. Acceptable evidence of timely filing is found in the policies and procedures.

Hours of operation

Optum Care Network–Arizona Center for Service Coordination and our utilization review team operates seven days a week from 8 a.m. to 5 p.m. Arizona local time, including weekends and holidays. Contact us via:

- **Phone:** 1-623-293-9775
- **Fax:** 1-888-405-2734
- **Email:** servicecoordination@optum.com

Optum observed holidays and office closures

(excludes the center for service coordination)

- New Year's Day
- Martin Luther King, Jr. Day
- Memorial Day
- Independence Day
- Labor Day
- Thanksgiving (Thursday and Friday)
- Christmas Day

Prior authorization

Prior authorization operates via telephone Monday–Friday, 8 a.m.–5 p.m. (MST) at **1-877-370-2845.** Supporting documentation may be faxed seven days per week to **1-888-992-2809.** *Please note that prior authorization is not available via phone on weekends or holidays, but is available to review faxed admission requests.*

Optum Care Network–Arizona primary contacts

Optum Care Network–Arizona Corporate Office 20414 N. 27th Avenue, Suite 500, Phoenix, AZ 85027		
Center for Service Coordination	Phone: 1-623-293-9775 Fax: 1-888-405-2734	Email: servicecoordination@optum.com
Optum service center (benefits, eligibility, etc.)	Phone: 1-877-370-2845	
Prior authorization	Phone: 1-877-370-2845 Fax: 1-888-992-2809	Web portal: providers.optumcaremw.com
OptumRx prior authorization	Phone: 1-800-711-4555 Alternate phone: 1-877-889-5802 Fax: 1-800-527-0537	
Optum Care Network–Arizona quality department	Fax: 1-866-727-2918	Email: quality_ocaz@optum.com
Optum Care Network–Arizona pharmacy department	Phone: 1-623-707-2939 Fax: 1-855-869-8979	Email: pharmD@optum.com
Issue resolution (claim disputes)		Email: claimdispute@optum.com
Optum provider resources		Web portal: professionals.optumcare.com

Optum website

Our website, optumcare.com, provides contracted network providers and patients with access to timely information, updates and resources.

Patient website
On the patient portion of the website, existing and potential patients can explore the various services Optum offers. Features include:

- A community center page
- Information about fitness classes
- Health-related presentations
- Social events
- An up-to-date community center calendar
- FAQs to address the most common questions from existing and potential patients
- A provider lookup tool that allows patients to find primary care physicians, specialists and facilities in Optum
- A page where potential patients can request more information by mail or email
- Information about prior authorizations, urgent care locations, skilled nursing facilities and more
- Health-related news and articles on topics such as diabetes, cancer screenings and cardiovascular disease

Members can also access a secured patient portal to access their secure email authorization and claims information online.

Provider website
On the provider portion of the website, non-contracted physicians and other health care professionals can learn more about what it means to be part of Optum and the philosophies that guide our approach to care. There are also valuable work resources for the network contracted providers including:

- Prior authorization forms and electronic processing
- Home health and care coordination order forms
- Referral reference guides for various specialties, including locations for cardiac services, nephrology, and skilled nursing facilities
- User guide for creating an account for the Optum provider portal
- Coding tips and tools

Register for your account access at optumcare.com/provider-login.

Optum customer service

By phone

The phone number for providers to contact customer service is 1-877-370-2845. Service advocates are available to answer questions Monday through Saturday, 8 a.m. - 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 optumcare.com/provider-login. 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 secured 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.

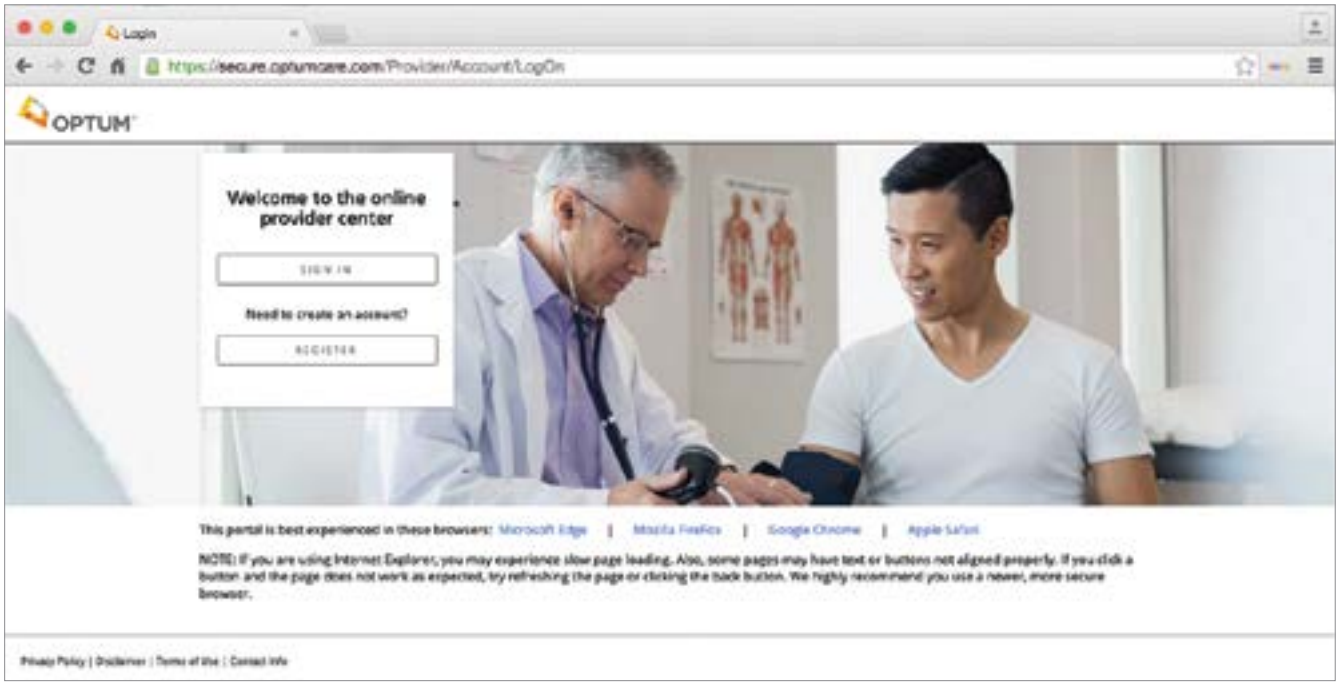
Using the provider portal, provider staff can:

- Submit referrals
- Verify patient eligibility
- Search prior authorizations and claims
- Send secure emails to our service center, utilization management, eligibility and claims staff
- 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 their account profile and reset their 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 optumcare.com/provider-login. If your office does not currently have portal access, you will need to designate an account administrator and have them create a new account. The account administrator will be responsible for creating and editing user profiles for your providers, as well as resetting passwords and editing accounts. 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.



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. The TTY 711 and language lines are open 24 hours a day, seven days a week. The service center is available Monday through Saturday 8 a.m. to 8 p.m.

Eligibility

The eligibility department receives patient information from the health plans on a daily basis. 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.

Referral policy — Maricopa/Pinal

Optum Care Network–Arizona members need a referral from their primary care provider (PCP) to see a specialist, except for those specialties listed below

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?
Referrals help ensure that PCPs are aware of their patients' ongoing needs as part of managing their routine health and wellness. Referral requirements may be subject to change.

- No referral is necessary for these specialties:
  - Behavioral health (Optum Behavioral Health)
  - Chiropractic, PT, OT, ST (Optum Physical Health)
  - Obstetrics and gynecology (OB/GYN)
  - Ophthalmology and Optometry do not require a referral, however referrals to retinal groups may require a referral in the future. Please check with your network manager.
  - Specialists who are not contracted require prior authorization

How to complete a referral.
Our online portal makes it quick and easy. To see if a specialist is contracted with Optum Care Network– Arizona, or to complete a referral, please go to optumcare.com/provider-login.

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 good for six months from the date of issue.
- After the six-month period, re-evaluation is required by the patient's PCP.

If you have any questions, please call the Optum service center at: 1-877-370-2845, TTY 711.

For more information, visit: professionals.optumcare.com/resources-clinicians/library/arizona-referral-policy.html

Claims

ATTENTION: Office managers and billing managers

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

Topics addressed:

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

Corrected claims can be submitted electronically by following the guidelines below:

Professional claims

- 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.
- 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

- 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:

- All claims with carve-outs must be submitted via paper to include a copy of the letter of agreement.
- 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

Medical necessity and admission notification requirements

Facilities are responsible for verification of medical necessity and providing notification for all SNF admissions. This is required even if the physician has supplied advance notification and a pre-service coverage approval is on file.

Optum Care Network–Arizona direct contracted SNFs

Medical necessity *must* be obtained from Optum Care Network–Arizona prior to admission. To verify medical necessity, please contact the Center for Service Coordination Sunday through Saturday, 8 a.m. to 5 p.m. at 1-623-293-9775.

- If you leave a message, please include the following information:
  - Member name
  - Member date of birth
  - Name of admitting SNF
  - SNF contact name
  - SNF contact phone number
- Messages will be returned within two hours or the next day if received after 3 p.m.
- Only leave one message as additional messages will cause a delayed response.
- Medical necessity is communicated with an expiration date. If medical necessity expires, a new verbal approval must be obtained prior to transferring the member.

Non-contracted or UnitedHealthcare contracted skilled nursing facilities:

All prior authorization requests that do not hold a direct contract with Optum Care Network–Arizona must receive prior authorization prior to any skilled nursing admission.

- All referrals for a SNF admission must fax all clinical information to Optum Care Network–Arizona
- Prior authorization numbers:
  - Phone: 1-877-370-2845
  - Fax: 1-888-992-2809

Requirement for all admission notifications

Admission notification must be received by the end of the next business day following admission.
Notification can be done via the online web portal, phone or fax.

- **To notify via web portal (preferred method):**
  - Go to secure.Optum.com/provider/account/logon
  - First-time users will need to create an account.
  - Web notification is available 24 hours a day and will provide an immediate case number.
  - Portal questions? Please call 1-877-370-2845, option 1.

- **To notify by phone or fax:**
  - Phone: 1-877-370-2845, option 2.
    - Available from Monday–Friday, 8 a.m.–5 p.m. Arizona local time
  - Fax:1-888-992-2809
    - Processed during regular business hours

Reimbursement reductions for failure to provide timely admission notification.
If a facility does not provide timely admission notification, reimbursement reductions will apply. The facility will be paid from the date of the admission notification. Prior days will be coded as non-payable.

Receipt of an admission notification does not guarantee payment.
Payment depends on:

- Coverage being within an individual customer's benefit plan.
- The facility being eligible for payment.
- All claim processing requirements being met.
- The facility's participation agreement.

Inpatient utilization management: Clinical information

Initial review
Upon admission, post acute case managers are required to complete an initial clinical review within 72 hours of admission.

Concurrent review
Post acute case management will accept concurrent review information provided by the admitting skilled nursing facility during routinely scheduled interdisciplinary team meetings or remotely at a minimum of every seven days. The skilled nursing facility must also provide the discharge plan on or before the discharge date. If a member requires an extended length of stay or more consultations, contact your post acute case manager directly to discuss.

All clinical documentation must be submitted to the Center for Service Coordination via secure email servicecoordination@optum.com or via fax 1-888-405-2734.

We require you to comply with our requests:

- For information, documents or discussions related to concurrent review and discharge planning. This includes primary and secondary diagnosis, clinical information, treatment plan, admission order, member status, discharge planning needs, barriers to discharge and discharge date. When available, provide access to electronic medical records (EMR).
- From the post acute case management team and/or SNF provider. This includes our requests that you help us engage our members directly face-to-face or by phone.
- If you receive the request before 1 p.m. local time please supply all requested information within four hours.
- If you receive our request after 1 p.m. local time please provide the information within the same business day, but no later than 12 p.m. local time the next business day.

The post acute case management team utilizes MCG™ Care Guidelines, which are nationally recognized clinical guidelines, to help clinicians make informed decisions in many health care settings.

Community admissions

SNF admission should be considered to avoid an unnecessary hospital admission and/or when a member has a skilled need that does not otherwise require hospital care.

- Patients can go to any Optum Care Network–Arizona contracted SNF by visiting professionals.Optum.com/resources-clinicians/library/skilled-nursing-arizona.html
- SNF must notify Optum Care Network–Arizona prior to SNF admission with anticipated admission date
- SNF must provide clinical documentation to Optum Care Network–Arizona within 72 hours of admission

Note: If you would like more information or assistance with a community admission please contact the Center for Service Coordination at 1-623-293-9775 or by visiting professionals.Optum.com/resources-clinicians/library/specialist-referral.html

Skilled nursing facility return to acute/length of stay targets

Return to acute (RTA) is defined as a discharge from a SNF with a non-elective acute admission within 30 days of the SNF discharge. This includes non-elective acute admissions within one day of the SNF discharge. This is derived by the use of the following methodology:

- Number of RTAs/total number of SNF discharges
- The calendar year RTA target is 18.00%
- Length of stay (LOS) is the average length of stay for all patients discharged from a SNF within a reporting month. It is only calculated after a member has been discharged and attributed to the month of discharge
- The calendar year LOS target is 13.50 days

Please note the yearly updated metrics may be on the electronic version only after 2020

Carve-outs and letters of agreement

Carve-outs are available to help facilities reduce costs for high-cost medications and supplies that are above the per diem. A letter of agreement (LOA) is issued once a medical director deems the carve-out request to be appropriate.

The carve-out request must come directly from the SNF to Optum.

To make a carve-out request:
1. Complete the Optum carve-out form and submit it by:

- **Email:** servicecoordination@optum.com
- **Fax:** 1-888-405-2734

After all information is received from the admitting facility, the request will be reviewed by an Optum medical director for determination. Once a decision is made, Optum will notify the SNF. An LOA will be issued, if appropriate.

Discharge planning

Discharge planning begins on the day of admission.

Elements to consider include:

- Discharge goal of the member/family
- Available support system (willing and able)
- Holistic view of member needs (physical, medical, social/cultural, mental/emotional, environmental)
- Palliative or hospice care needs
- Care alternatives to address potential barriers
- Need for higher level of care and related resources, such as Arizona Long Term Care System (ALTCS). To maintain a proactive approach, ALTCS applications should be addressed early and often throughout the patient's stay

Discharge planning should be discussed at all weekly interdisciplinary team (IDT) meetings.
Items to address include:

- Advanced directives
- Burden of illness
- Palliative care and/or hospice
- Transition of care
- Discharge plans and potential barriers

Leaving against medical advice (AMA)
Because of the propensity for AMA discharges to return to the acute setting, all or part of the discharge plan should be implemented to the fullest extent. Please notify your Optum post-acute case manager directly.

- Home health
- Durable medical equipment (DME)
- Transition visits at home

Discharge summary
A discharge summary must be provided directly to the PCP within seven days of discharge. A copy may also be given to the member but this does not take the place of sending the discharge summary to the PCP.

Medical management and Center for Service Coordination

Optum medical management programs provide high-touch care coordination within hospitals, skilled nursing facilities (SNFs) and members' homes. These programs work in collaboration with the member, 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 Center for Service Coordination (CSC) team.

Medical management request process
To refer members to Optum medical management programs, submit a completed Optum request form via email to the CSC at servicecoordination@optum.com or fax to 1-888-405-2734.

This form can be found as a writable, savable PDF on the Optum website under provider resources: https://www.optumcare.com/
Requests will initiate a response within two business days unless otherwise indicated as urgent, for which we will respond within one business day.

Program availability is based on member's area of residence.

Medical management services

Post acute case managers

- Support utilization review in collaboration with an interdisciplinary team
- Ensure that patients are receiving the right care at the right time, working directly with the physician and SNF staff
- Identify programs and services to support member needs and goals
- Make post-discharge calls to patients, family members/care giver to ensure the discharge plan is successfully implemented to help reduce unnecessary readmissions

Optum nurse case managers
Our team of nurse case managers provides high-touch care coordination and case management. They work with patients, their support teams and providers to coordinate care, improve patients' self-management skills and help them access covered health services. The ultimate goal is to help patients better manage their health conditions, avoid unnecessary complications and achieve high-quality outcomes in the most appropriate care setting.

The role of our nurse case managers is to:

- Act in partnership with the PCP to support patients with complex needs
- Meet with patients at home, in provider offices, in the acute care setting or at the SNF
- Help patients decide on their health goals, including addressing advance directives and end-of-life care if appropriate
- Work with PCPs to address patients' health care needs and promote quality, cost-effective outcomes
- Assist with complex discharges, ensuring patients follow up with their PCP or specialist
- Complete medication reviews in collaboration with pharmacists and PCPs
- Help patients understand and access community resources and services

Optum social work case managers
The role of our social workers is to help:

- Coordinate community resources to address social service needs, such as financial resources, housing, transportation, placement, and meal assistance
- Provide education and support to complete advanced directives and living wills
- Educate and empower patients in self-care and provider engagement
- Support patients and families through emotional adjustments to life changes

Complex case management
The complex case management (CCM) program is to facilitate appropriate health care services for the Optum Care Network–Arizona member patient population across the continuum of care. The CCM program uses a holistic patient-centered model focused on care coordination, complex chronic condition management and education, medication adherence, lifestyle modification and access to available community and medical resources.

The goals of the program are:

- Support the member to maintain functional status
- Reduce acute events through safe and effective transitions of care
- Slow further disease progression
- Prevent complications of chronic illness

Diabetes disease management
The diabetes disease management program is designed to improve health outcomes for patients with diabetes. We take a proactive, population-based approach to managing diabetes, which includes:

- Interventions are based on having the right provider, right care, right medication and right lifestyle.
- Care is based on evidenced-based guidelines.
- Key components include educational support, self-management techniques, informed decision-making and support of the physician's treatment plan.

Medical behavioral integration (MBI)
The medical behavioral integration program is a specialized component of the nurse care management team that integrates a collaborative process to meet the member's medical and behavioral health needs. Our MBI nurses provide home and SNF-based member visits for the purpose of evaluation and engagement in the MBI program. Our nurses provide ongoing follow up, evaluation, planning, implementation, and monitoring services. Our staff utilizes education, communication and all available resources to promote quality health outcomes.

Kidney resource services (KRS): End-stage renal disease
Kidney resource services (KRS) is part of our complex medical conditions management program. KRS offers specialty case management for members with chronic kidney disease (CKD) and end-stage renal disease (ESRD). This is available for Medicare Advantage members.

- Managing co-morbid conditions
- Dialysis coordination – focusing on reduction of infections, anemia, fluid and electrolyte imbalances.
- In-person case management for complex and high-risk cases.

Transplant case management
Our transplant case management team helps patients through every step of the transplant process. Careful care coordination ensures patients get the right level of care at the right time.

- Pre-transplant and transplant services
- Transplant notification
- Post-transplant services

Behavioral health

Maricopa County:
Crisis Preparation and Recovery, Inc.
1-480-804-0326

- Urgent prescriber resource

Maricopa County and Tucson:
Optum Behavioral Health
1-800-579-5222

- Consultations
- Placement support
- Urgent prescriber program

Palliative care (not available in Pinal County)

- Chronic symptom management
- In-home interdisciplinary care team (provider, RN, social worker and volunteers)
- Disease education
- Collaboration with health care providers
- End of life planning discussions
- 24/7 nurse support

Advanced wound care

- Comprehensive wound care for members with complex wounds
- Treatment is provided in a member's place of residence (home, SNF, ALF)
- Field clinicians provide evidence-based wound care and oversee all aspects of wound management (treatment plans, debridement and education)

Transition to home program
*Available only in Maricopa

- Short-term provider to follow-up post-discharge
- Collaboration with health care providers
- Support safe discharge until member can return to PCP
- Coordination of transitional services and supports

Preferred providers for Maricopa and Pinal counties

Durable medical equipment (DME):

Preferred Homecare
Phone: 1-480-446-9010
Fax: 1-480-446-7695

Home health care:

Assisted Home Health
Phone: 1-480-860-2345
Fax: 1-805-413-7998

Home IV infusion:

Coram Healthcare
Phone: 1-800-871-6605
Fax: 1-480-505-0455

In-home laboratory services:

VeniExpress
Phone: 1-877-670-8364
SNF Requests: https://vxbis.com/v3/api/snf_request.php
Medical Staff Requests: https://vxbis.com/v3/api/lab_request_med.php

1st Choice Phlebotomy
Phone: 1-480-593-9192

Laboratory services:

LabCorp
Phone: 1-602-454-8000
Website: labcorp.com

Nephrology:

Arizona Kidney Disease & Hypertension Center
Phone: 1-602-351-3000
Website: akdhc.com

Desert Kidney
Phone: 1-480-834-9039
Website: desertkidney.com

Southwest Kidney Institute
Phone: 1-480-610-6100
Website: swkidney.com

Nutritional supplies:

Aveanna (formerly known as Epic)
Phone: 1-480-883-1188
Fax: 1-844-754-1345

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

Optum Physical Health
Phone: 1-800-873-4575

Radiology and imaging services:

Southwest Medical Imaging (SMIL)
Phone: 1-602-955-4734
Website: esmil.com

Arizona Diagnostic Radiology Group
Phone: 1-480-455-1850
Website: arizonadiagnosticradiology.com

SimonMed Imaging
Phone: 1-623-972-9669
Website: simonmed.com

Banner Imaging Services
Website: imaging.bannerhealth.com

Sun Radiology
Phone: 1-623-815-8200
Website: https://sunradiology.com/

Desert Valley Imaging (see website)
Website: dvrphx.com

Mobile radiology:

Pacific Mobile
Phone: 1-602-249-4790

Dispatch Health

Mobile urgent care. Learn more about the injuries and illnesses they treat at dispatchhealth.com. Please contact Dispatch Health to confirm service area and request member visit.
Phone: 1-480-877-0765

Tucson metro area preferred providers

Durable medical equipment (DME):

Preferred Homecare
Phone: 1-520-888-4002
Fax: 1-520-888-7340

Home Health Care:

Arista Home Health
Phone: 1-520-333-0333

At Home Healthcare
Phone: 1-520-498-2288

Dependable Home Health
Phone: 1-520-721-3822

Hacienda Home Health
Phone: 1-520-269-6091

Interim Health Care
Phone: 1-520-747-1800

NSI Nursing Service Inc.
Phone: 1-520-731-1117

Northwest Home Care
Phone: 1-520-441-9914

Patient Care Advocates
Phone: 1-520-546-4141

Reliable Nurses, LLC
Phone: 1-520-889-1328

Santa Rita Home Health
Phone: 1-520-230-4532

Home IV infusion:

Coram Healthcare
Phone: 1-800-871-6605
Fax: 1-480-505-0455

Laboratory services:

LabCorp
Phone: 1-602-454-8000
Website: labcorp.com

Sonora Quest Laboratories
Phone: 1-855-367-2778
Website: sonoraquest.com

Nephrology referrals:

Arizona Kidney Disease and Hypertension Centers (AKDHC)
Phone: 1-520-351-5700
Website: akdhc.com/appointments

Southwest Kidney Institute
Phone: 1-480-610-6100
Website: swkidney.com

Nutritional supplies:

Aveanna (formerly known as Epic)
Phone: 1-480-883-1188
Fax: 1-844-754-1345

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

Optum Physical Health
Phone: 1-800-873-4575

Radiology and imaging services:

SimonMed Imaging
Phone: 1-866-614-8555
Website: simonmed.com

Radiology Ltd
Phone: 1-520-901-6777
Website: radltd.com

Mobile radiology:

Pacific Mobile
Phone: 1-602-249-4790

Dispatch Health

Mobile urgent care. Learn more about the injuries and illnesses they treat at dispatchhealth.com. Please contact Dispatch Health to confirm service area and request member visit.
Phone: 1-520-485-2702

Quality initiatives

Optum is committed to making sure quality health care is delivered to our patients. It's important that all providers support our quality programs and initiatives to help improve member safety and quality of care. These include, but are not limited to:

- Providing medical records upon request or access to records free of charge.
- Cooperating with quality-of-care investigations, including responding to queries and/or completion of improvement action plans in a timely manner.
- Participating in quality audits, including site visits and medical record standards reviews.

Star initiatives
Optum will provide protocols for Star initiatives based on CMS requirements. We expect SNFs to assist in providing data and/or scheduling tests. The following are current area(s) of focus. Other initiatives may be added.

Medication review
Optum Care Network—Arizona has a medications review process to help prevent re-admissions to the acute setting.

It is imperative that the member's current medication is reconciled with any medications that the member was taking before being admitted to the facility, as well as any changes made upon discharge.

Upon admission:

Following the physician's initial assessment, please email the medication list to pharmD@optum.com or fax to 1-855-869-8979.

For facilities that have granted EMR access, the clinical pharmacy department will obtain the member's records via facilities health care software (i.e. Point click care, MyUnity).

The facility will receive a medication therapy review report from Optum. This report will identify any drug therapy issues, including a notation if no follow-up needed.

** Please make sure attending physician receives a copy of the report and takes appropriate action

Coding process
Accurate coding is essential to capture patient health status. Physicians should address all relevant conditions during the initial assessment. Findings must be documented in the patient's history and physical report (H&P). Email the completed H&P to servicecoordination@optum.com or fax to 1-888-405-2734.

Compliance

Notice of Medicare Non-Coverage (NOMNC)

The NOMNC must be delivered at least two calendar days prior to the last day covered.
The most current version of the standard CMS NOMNC form (Appendix B) is available online at:
cms.gov/medicare/medicare-general-information/bni/maednotices.html

Information required to complete the NOMNC form

- Facility name and contact information (including address and telephone number) must be at the top of the first page.
- Patient name and medical record number (Medicare ID, HIC or SSN may NOT be used).
- Date that services will end (last covered day, NOT date of discharge).
- Plan contact information section for Medicare Advantage patients.
- Patient's signature (or authorized representative if the patient is incompetent) and date of delivery.
- The representative may be notified by telephone. The facility must document telephone notification of the representative in the "Additional Information" section including:
    - Name and phone number of representative.
    - Date and time contacted.
    - Date patient's liability begins.
    - Appeal rights provided.
    - QIO telephone number provided to representative.
    - Date and time by which an immediate appeal must be requested.
    - The facility staff signature and telephone number.
- Messages left on the representative's voicemail do not constitute valid delivery. The facility must request that the representative call back to ensure full understanding of rights of appeal.
- NOMNC must also be mailed to the representative on the same day that verbal notification is given.

Documentation of unusual circumstances

- If a patient chooses to leave before the right-to-appeal window closes, the facility must state "patient waives 48-hour notice" on the NOMNC.
- If a patient leaves against medical advice (AMA), a NOMNC is required stating that "patient left AMA or refused to sign."
- If a patient is not capable of signing the NOMNC, the representative is not on site and the facility is unable to reach the representative by telephone, please follow the directions in the "CMS Form Instructions for the Notice of Medicare Non-Coverage."
- NOMNC is not required if the patient expires, transfers to another facility, signs onto hospice or returns to acute setting.

NOMNC submissions:
Optum Care Network–Arizona is required to retrieve Notice of Medicare Non-Coverage (NOMNC) letters. The skilled nursing facility must submit all NOMNCs to the Center for Service Coordination at 1-888-405-2734 or secure email to servicecoordination@optum.com.

If NOMNC letters are not received or do not meet compliance standards, the Optum Quality Department has a process for following up with the facility.

Skilled nursing facility appeals:
When a member files an appeal with the quality improvement organization (QIO), Optum Care Network–Arizona is required to provide the member and the QIO with a detailed explanation of non-coverage (DENC) letter.

To complete this letter, Optum Care Network–Arizona requires skilled nursing facilities to submit a copy of the signed NOMNC and current records regarding the member's medical and functional status. The skilled nursing facility must provide records within two hours of being notified of the appeal. This information may be faxed to 1-888-405-2734 or secure emailed to servicecoordination@optum.com.

Once the DENC is completed, it will be sent to the skilled nursing facility for delivery to the member. The member must receive the DENC in accordance with CMS regulations. It is an Optum Care Network–Arizona requirement that skilled nursing facilities complete the DENC Delivery Verification Form and fax to 1-888-405-2734 or secure email to servicecoordination@optum.com.

Authorized representative
In the event the patient (1) lacks capacity and is unable to act as her/his own decision maker; and (2) does not have a power of attorney, guardian or other legally authorized representative, the facility must follow CMS regulations and Arizona state statutes for the appointment of an authorized representative/surrogate decision maker. Designation of an AZ surrogate decision maker (Appendix E) and the relationship to the patient must be submitted with any NOMNC that is not signed by the patient/beneficiary.

For details on specific compliance areas, please see Appendices A-H:

A. CMS instructions
B. UnitedHealthcare® NOMNC
C. Detailed explanation of non-coverage (DENC)
D. Detailed explanation of non-coverage (DENC) delivery verification
E. Arizona Surrogate Decision Maker Statute
F. Medicare Compliance
G. Maricopa County ID sample cards
H. Tucson ID sample cards

Form Instructions for the Notice of Medicare Non-Coverage (NOMNC) CMS-10123

When to Deliver the NOMNC

A Medicare provider or health plan (Medicare Advantage plans and cost plans , collectively referred to as "plans") must deliver a completed copy of the Notice of Medicare Non-Coverage (NOMNC) to beneficiaries/enrollees receiving covered skilled nursing, home health (including psychiatric home health), comprehensive outpatient rehabilitation facility, and hospice services.

The NOMNC must be delivered at least two calendar days before Medicare covered services end or the second to last day of service if care is not being provided daily.

Note: The two day advance requirement is not a 48 hour requirement.

This notice fulfills the requirement at 42 CFR 405.1200(b)(1) and (2) and 42 CFR 422.624(b)(1) and (2). Additional guidance for Original Medicare and Medicare Advantage can be found, respectively, at Chapter 4, Section 260 of the Medicare Claims Processing Manual and Chapter 13, Sections 90.2-90.9 of the Medicare Managed Care Manual.

Plans only:
In situations where the decision to terminate covered services is not delegated to a provider by a health plan, but the provider is delivering the notice, the health plan must provide the service termination date to the provider at least two calendar days before Medicare covered services end.

Provider Delivery of the NOMNC

Providers must deliver the NOMNC to all beneficiaries eligible for the expedited determination process per Chapter 4, Section 260 of the Medicare Claims Processing Manual and Chapter 13, Sections 90.2-90.9 of the Medicare Managed Care Manual. A NOMNC must be delivered even if the beneficiary agrees with the termination of services. Medicare providers are responsible for the delivery of the NOMNC. Providers may formally delegate the delivery of the notices to a designated agent such as a courier service; however, all of the requirements of valid notice delivery apply to designated agents.

The provider must ensure that the beneficiary or representative signs and dates the NOMNC to demonstrate that the beneficiary or representative received the notice and understands that the termination decision can be disputed. Use of assistive devices may be used to obtain a signature.

Electronic issuance of NOMNCs is not prohibited. If a provider elects to issue a NOMNC that is viewed on an electronic screen before signing, the beneficiary must be given the option of requesting paper issuance over electronic if that is what is preferred. Regardless of whether a paper or electronic version is issued and regardless of whether the signature is digitally captured or manually penned, the beneficiary must be given a paper copy of the NOMNC, with the required beneficiary-specific information inserted, at the time of electronic notice delivery.

Notice Delivery to Representatives

CMS requires that notification of changes in coverage for an institutionalized beneficiary/enrollee who is not competent be made to a representative. Notification to the representative may be problematic because that person may not be available in person to acknowledge receipt of the required notification. Providers are required to develop procedures to use when the beneficiary/enrollee is incapable or incompetent, and the provider cannot obtain the signature of the enrollee's representative through direct personal contact. If the provider is personally unable to deliver a NOMNC to a person acting on behalf of an enrollee, then the provider should telephone the representative to advise him or her when the enrollee's services are no longer covered.

The date of the conversation is the date of the receipt of the notice. Confirm the telephone contact by written notice mailed on that same date. When direct phone contact cannot be made, send the notice to the representative by certified mail, return receipt requested. The date that someone at the representative's address signs (or refuses to sign) the receipt is the date of receipt. Place a dated copy of the notice in the enrollee's medical file. When notices are returned by the post office with no indication of a refusal date, then the enrollee's liability starts on the second working day after the provider's mailing date.

Exceptions

The following service terminations, reductions, or changes in care are not eligible for an expedited review. Providers should not deliver a NOMNC in these instances.

- When beneficiaries never received Medicare covered care in one of the covered settings (e.g., an admission to a SNF will not be covered due to the lack of a qualifying hospital stay or a face-to-face visit was not conducted for the initial episode of home health care).
- When services are being reduced (e.g., an HHA providing physical therapy and occupational therapy discontinues the occupational therapy).
- When beneficiaries are moving to a higher level of care (e.g., home health care ends because a beneficiary is admitted to a SNF).

Form Instructions 10123-NOMNC OMB Approval 0938-xxxx

- When beneficiaries exhaust their benefits (e.g., a beneficiary reaches 100 days of coverage in a SNF, thus exhausting their Medicare Part A SNF benefit).

- When beneficiaries end care on their own initiative (e.g., a beneficiary decides to revoke the hospice benefit and return to standard Medicare coverage).

- When a beneficiary transfers to another provider at the same level of care (e.g., a beneficiary transfers from one SNF to another while remaining in a Medicare-covered SNF stay).

- When a provider discontinues care for business reasons (e.g., an HHA refuses to continue care at a home with a dangerous animal or because the beneficiary was receiving physical therapy and the provider's physical therapist leaves the HHA for another job).

Plans Only:

If a member requests coverage in the above situations, the plan must issue the CMS form 10003 - Notice of Denial of Medical Coverage.

Alterations to the NOMNC

The NOMNC must remain two pages. The notice can be two sides of one page or one side of two separate pages, but **must not** be condensed to one page.

Providers may include their business logo and contact information on the top of the NOMNC. Text may not be moved from page 1 to page 2 to accommodate large logos, address headers, etc.

Providers may include information in the optional "Additional Information" section relevant to the beneficiary's situation.

Note: Including information normally included in the Detailed Explanation of Non-Coverage (DENC) in the "Additional Information" section does not satisfy the responsibility to deliver the DENC, if otherwise required.

Heading

Form Instructions 10123-NOMNC OMB Approval 0938-xxxx

Contact information: The name, address and telephone number of the provider that delivers the notice must appear above the title of the form. The provider's registered logo may be used.

Member number: Providers may fill in the beneficiary's/enrollee's unique medical record or other identification number. The beneficiary's/enrollee's HIC number must not be used.

THE EFFECTIVE DATE YOUR {INSERT TYPE} SERVICES WILL END: {Insert Effective Date}: Fill in the type of services ending, **{home health, skilled nursing, comprehensive outpatient rehabilitation services, or hospice}** and the actual date the service will end. Note that the date should be in no less than 12-point type. If handwritten, notice entries must be at least as large as 12- point type and legible.

YOUR RIGHT TO APPEAL THIS DECISION

Bullet # 1 not applicable

Bullet # 2 not applicable

Bullet # 3 not applicable

Bullet # 4 not applicable

Bullet # 5 not applicable

HOW TO ASK FOR AN IMMEDIATE APPEAL

Bullet # 1 not applicable

Bullet # 2 not applicable

Bullet # 3 not applicable

Bullet # 4 Insert the name and telephone numbers (including TTY) of the applicable QIO in no less than12-point type.

Signature page:

Plan contact information (Plans only): The plan's name and contact information must be displayed here for the enrollee's use in case an expedited appeal is requested or in the event the enrollee or QIO seeks the plan's identification.

Optional: Additional information. This section provides space for additional pertinent information that may be useful to the enrollee. It may not be used as a

Detailed Explanation of Non-Coverage, even if facts pertinent to the termination decision are provided.

Signature line: The beneficiary/enrollee or the representative must sign this line.

Date: The beneficiary/enrollee or the representative must fill in the date that he or she signs the document. If the document is delivered, but the enrollee or the representative refuses to sign on the delivery date, then annotate the case file to indicate the date that the form was delivered.

{ENTER LOGO HERE}

Notice of Medicare Non-Coverage

Patient name: **Patient number:**

The Effective Date Coverage of Your Current **SKILLED** Services Will End:

- Your Medicare provider and/or health plan have determined that Medicare probably will not pay for your current {insert type} services after the effective date indicated above.
- You may have to pay for any services you receive after the above date.

Your Right to Appeal This Decision

- You have the right to an immediate, independent medical review (appeal) of the decision to end Medicare coverage of these services. Your services will continue during the appeal.
- If you choose to appeal, the independent reviewer will ask for your opinion. The reviewer also will look at your medical records and/or other relevant information. You do not have to prepare anything in writing, but you have the right to do so if you wish.
- If you choose to appeal, you and the independent reviewer will each receive a copy of the detailed explanation about why your coverage for services should not continue. You will receive this detailed notice only after you request an appeal.
- If you choose to appeal, and the independent reviewer agrees services should no longer be covered after the effective date indicated above;
  - Neither Medicare nor your plan will pay for these services after that date.
- If you stop services no later than the effective date indicated above, you will avoid financial liability.

How to Ask For an Immediate Appeal

- You must make your request to your Quality Improvement Organization (also known as a QIO). A QIO is the independent reviewer authorized by Medicare to review the decision to end these services.
- Your request for an immediate appeal should be made as soon as possible, but no later than noon of the day before the effective date indicated above.
- The QIO will notify you of its decision as soon as possible, generally no later than two days after the effective date of this notice if you are in Original Medicare. If you are in a Medicare health plan, the QIO generally will notify you of its decision by the effective date of this notice.
- Call your QIO at: Livanta at 1-877-588-1123 (TTY: 1-855-887-6668) to appeal, or if you have questions.

See page 2 of this notice for more information.

Form CMS 10123-NOMNC (Approved 12/31/2011) OMB approval 0938-0953

If You Miss The Deadline to Request An Immediate Appeal, You May Have Other Appeal Rights:

- If you have Original Medicare: Call the QIO listed on page 1.
- If you belong to a Medicare health plan: Call your plan at the number given below.

Plan contact information

UnitedHealthcare
Attn: Appeals & Grievances Department
Mail Stop CA 124-0157
P.O. Box 6106
Cypress, CA 90630
Telephone: 1-877-262-9203
TDD/TTY: 711

Additional Information (Optional):
To be completed by SNF if verbal notice provided to member representative:
Member Representative Name and Phone Number: _____
Date and Time contacted: _____
Date Member's liability begins: _____
Appeal Rights provided: Y or N
QIO Telephone # provided (enter#): _____
Date/Time Fast Track Appeal must be requested by: _____
Facility Staff Signature and Contact Number: _____
DATE NOMNC LETTER MAILED: _____
☐ RESIDENT LEFT AGAINST MEDICAL ADVICE ON:_____
☐ Waives 2 day notice to discharge on: _____

Please sign below to indicate you received and understood this notice.

I have been notified that coverage of my services will end on the effective date indicated on this notice and that I may appeal this decision by contacting my QIO.

_____ _____

Signature of Patient or Representative Date

Form CMS 10123-NOMNC (Approved 12/31/2011) OMB approval 0938-0953

The company does not treat members differently because of sex, age, race, color, disability or national origin.

If you think you were treated unfairly because of your sex, age, race, color, disability or national origin, you can send a complaint to the Civil Rights Coordinator.

- **Online**: UHC_Civil_Rights@uhc.com
- **Mail**: Civil Rights Coordinator. UnitedHealthcare Civil Rights Grievance. P.O. Box 30608, Salt Lake City, UT 84130

You must send the complaint within 60 days of when you found out about it. A decision will be sent to you within 30 days. If you disagree with the decision, you have 15 days to ask us to look at it again. If you need help with your complaint, please call the member toll-free phone number listed on your ID card.

You can also file a complaint with the U.S. Dept. of Health and Human Services.

- **Online**: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

- **Phone**: Toll-free 1-800-368-1019, 1-800-537-7697 (TDD)
- **Mail**: U.S. Dept. of Health and Human Services. 200 Independence Avenue. SW Room 509F, HHH Building, Washington, D.C. 20201

We provide free services to help you communicate with us. Such as, letters in other languages or large print. Or, you can ask for an interpreter. To ask for help, please call the member toll-free phone number listed on your ID card.

ATENCIÓN: Si habla español (Spanish), hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al número de teléfono gratuito que aparece en su tarjeta de identificación.

請注意：如果您說中文 (Chinese)， 我們免費您您提供語言協助服務。請撥打會員卡所列的免付費會員電話號碼。

XIN LƯU Ý: Nếu quý vị nói tiếng Việt (Vietnamese), quý vị sẽ được cung cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Vui lòng gọi số điện thoại miễn phí ở mặt sau thẻ hội viên của quý vị.

알림: 한국어(Korean)를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다. 귀하의 신분증 카드에 기재된 무료 회원 전화번호로 문의하십시오.

PAALALA: Kung nagsasalita ka ng Tagalog (Tagalog), may makukuha kang mga libreng serbisyo ng tulong sa wika. Pakitawagan ang toll-free na numero ng telepono na nasa iyong identification card.

ВНИМАНИЕ: бесплатные услуги перевода доступны для людей, чей родной язык является русском (Russian). Позвоните по бесплатному номеру телефона, указанному на вашей идентификационной карте.

تنبيه: إذا كنت تتحدث **العربية (Arabic)**، فإن خدمات المساعدة اللغوية المجانية متاحة لك. الرجاء الاتصال على رقم الهاتف المجاني الموجود على معرّف العضوية.

ATANSYON: Si w pale Kreyòl ayisyen (Haitian Creole), ou kapab benefisye sèvis ki gratis pou ede w nan lang pa w. Tanpri rele nimewo gratis ki sou kat idantifikasyon w.

ATTENTION : Si vous parlez français (French), des services d'aide linguistique vous sont proposés gratuitement. Veuillez appeler le numéro de téléphone gratuit figurant sur votre carte d'identification.

UWAGA: Jeżeli mówisz po polsku (Polish), udostępniliśmy darmowe usługi tłumacza. Prosimy zadzwonić pod bezpłatny numer telefonu podany na karcie identyfikacyjnej.

ATENÇÃO: Se você fala português (Portuguese), contate o serviço de assistência de idiomas gratuito. Ligue gratuitamente para o número encontrado no seu cartão de identificação.

ATTENZIONE: in caso la lingua parlata sia l'italiano (Italian), sono disponibili servizi di assistenza linguistica gratuiti. Per favore chiamate il numero di telefono verde indicato sulla vostra tessera identificativa.

ACHTUNG: Falls Sie Deutsch (German) sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Bitte rufen Sie die gebührenfreie Rufnummer auf der Rückseite Ihres Mitgliedsausweises an.

注意事項：日本語 (Japanese) を話される場合、無料の言語支援サービスをご利用いただけます。健康保険証に記載されているフリーダイヤルにお電話ください。

توجه: اگر زبان شما فارسی **(Farsi)** است، خدمات امداد زبانی به طور رایگان در اختیار شما می باشد. لطفا با شماره تلفن رایگانی که روی کارت شناسایی شما قید شده تماس بگیرید.

ध्यान दें: यदि आप हिंदी (Hindi) बोलते है, आपको भाषा सहायता सेबाएं, नि:शुल्क उपलब्ध हैं। कृपया अपने पहचान पत्र पर सूचीबद्ध टोल-फ्री फोन नंबर पर कॉल करें।

CEEB TOOM: Yog koj hais Lus Hmoob (Hmong), muaj kev pab txhais lus pub dawb rau koj. Thov hu rau tus xov tooj hu deb dawb uas teev muaj nyob rau ntawm koj daim yuaj cim qhia tus kheej.

ចំណាប់អារម្មណ៍: បើសិនអ្នកនិយាយភាសាខ្មែរ (Khmer) សូវាជំនួយភាសាដោយឥតគិតថ្លៃ គឺមានសំរាប់អ្នក។ សូមទូរស័ព្ទទៅលេខឥតគិតថ្លៃ ដែលមាននៅលើអត្តសញ្ញាណប័ណ្ណរបស់ អ្នក។

PAKDAAR: Nu saritaem ti Ilocano (Ilocano), ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Maidawat nga awagan iti toll-free a numero ti telepono nga nakalista ayan iti identification card mo.

DÍÍ BAA'ÁKONÍNÍZIN: Diné (Navajo) bizaad bee yáníłti'go, saad bee áka'anída'awo'ígíí, t'áá jíík'eh, bee ná'ahóót'i'. T'áá shǫǫdí ninaaltsoos nitł'izí bee nééhozinígíí bine'dęę' t'áá jíík'ehgo béésh bee hane'í biká'ígíí bee hodíilnih.

OGOW: Haddii aad ku hadasho Soomaali (Somali), adeegyada taageerada luqadda, oo bilaash ah, ayaad heli kartaa. Fadlan wac lambarka telefonka khadka bilaashka ee ku yaalla kaarkaaga aqoonsiga.

Insert contact information here

Detailed Explanation of Non-coverage

Date:

Patient name: Patient number:

This notice gives a detailed explanation of why your Medicare provider and/or health plan has determined Medicare coverage for your current services should end. ***This notice is not the decision on your appeal.*** The decision on your appeal will come from your Quality Improvement Organization (QIO).

We have reviewed your case and decided that Medicare coverage of your current {insert type} services should end.

• The facts used to make this decision:

• Detailed explanation of why your current services are no longer covered, and the specific Medicare coverage rules and policy used to make this decision:

• Plan policy, provision, or rationale used in making the decision (health plans only):

If you would like a copy of the policy or coverage guidelines used to make this decision, or a copy of the documents sent to the QIO, please call us at: {insert provider/plan toll-free telephone number}

Form CMS-10124-DENC (Approved 12/31/2011) OMB Approval No. 0938–0953

The company does not treat members differently because of sex, age, race, color, disability or national origin.

If you think you were treated unfairly because of your sex, age, race, color, disability or national origin, you can send a complaint to the Civil Rights Coordinator.

- **Online**: UHC_Civil_Rights@uhc.com
- **Mail**: Civil Rights Coordinator. UnitedHealthcare Civil Rights Grievance. P.O. Box 30608, Salt Lake City, UT 84130

You must send the complaint within 60 days of when you found out about it. A decision will be sent to you within 30 days. If you disagree with the decision, you have 15 days to ask us to look at it again. If you need help with your complaint, please call the member toll-free phone number listed on your ID card.

You can also file a complaint with the U.S. Dept. of Health and Human Services.

- **Online**: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

- **Phone**: Toll-free 1-800-368-1019, 1-800-537-7697 (TDD)
- **Mail**: U.S. Dept. of Health and Human Services. 200 Independence Avenue. SW Room 509F, HHH Building, Washington, D.C. 20201

We provide free services to help you communicate with us. Such as, letters in other languages or large print. Or, you can ask for an interpreter. To ask for help, please call the member toll-free phone number listed on your ID card.

ATENCIÓN: Si habla español (Spanish), hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al número de teléfono gratuito que aparece en su tarjeta de identificación.

請注意：如果您說中文 (Chinese)，我們免費您您提供語言協助服務。請撥打會員卡所列的免付費會員電話號碼。

XIN LƯU Ý: Nếu quý vị nói tiếng Việt (Vietnamese), quý vị sẽ được cung cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Vui lòng gọi số điện thoại miễn phí ở mặt sau thẻ hội viên của quý vị.

알림: 한국어(Korean)를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다. 귀하의 신분증 카드에 기재된 무료 회원 전화번호로 문의하십시오.

PAALALA: Kung nagsasalita ka ng Tagalog (Tagalog), may makukuha kang mga libreng serbisyo ng tulong sa wika. Pakitawagan ang toll-free na numero ng telepono na nasa iyong identification card.

ВНИМАНИЕ: бесплатные услуги перевода доступны для людей, чей родной язык является русском (Russian). Позвоните по бесплатному номеру телефона, указанному на вашей идентификационной карте.

تنبيه: إذا كنت تتحدث **العربية (Arabic)**، فإن خدمات المساعدة اللغوية المجانية متاحة لك. الرجاء الاتصال على رقم الهاتف المجاني الموجود على معرّف العضوية.

ATANSYON: Si w pale Kreyòl ayisyen (Haitian Creole), ou kapab benefisye sèvis ki gratis pou ede w nan lang pa w. Tanpri rele nimewo gratis ki sou kat idantifikasyon w.

ATTENTION : Si vous parlez français (French), des services d'aide linguistique vous sont proposés gratuitement. Veuillez appeler le numéro de téléphone gratuit figurant sur votre carte d'identification.

UWAGA: Jeżeli mówisz po polsku (Polish), udostępniliśmy darmowe usługi tłumacza. Prosimy zadzwonić pod bezpłatny numer telefonu podany na karcie identyfikacyjnej.

ATENÇÃO: Se você fala português (Portuguese), contate o serviço de assistência de idiomas gratuito. Ligue gratuitamente para o número encontrado no seu cartão de identificação.

ATTENZIONE: in caso la lingua parlata sia l'italiano (Italian), sono disponibili servizi di assistenza linguistica gratuiti. Per favore chiamate il numero di telefono verde indicato sulla vostra tessera identificativa.

ACHTUNG: Falls Sie Deutsch (German) sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Bitte rufen Sie die gebührenfreie Rufnummer auf der Rückseite Ihres Mitgliedsausweises an.

注意事項：日本語 (Japanese) を話される場合、無料の言語支援サービスをご利用いただけます。健康保険証に記載されているフリーダイヤルにお電話ください。

توجه: اگر زبان شما **فارسی (Farsi)** است، خدمات امداد زبانی به طور رایگان در اختیار شما می باشد. لطفا با شماره تلفن رایگانی که روی کارت شناسایی شما قید شده تماس بگیرید.

ध्यान दें: यदि आप हिंदी (Hindi) बोलते है, आपको भाषा सहायता सेबाएं, नि:शुल्क उपलब्ध हैं। कृपया अपने पहचान पत्र पर सूचीबद्ध टोल-फ्री फोन नंबर पर कॉल करें।

CEEB TOOM: Yog koj hais Lus Hmoob (Hmong), muaj kev pab txhais lus pub dawb rau koj. Thov hu rau tus xov tooj hu deb dawb uas teev muaj nyob rau ntawm koj daim yuaj cim qhia tus kheej.

ចំណាប់អារម្មណ៍: បើសិនអ្នកនិយាយភាសាខ្មែរ (Khmer) សូវាជំនួយភាសាដោយឥតគិតថ្លៃ គឺមានសំរាប់អ្នក។ សូមទូរស័ព្ទទៅលេខឥតគិតថ្លៃ ដែលមាននៅលើអត្តសញ្ញាណប័ណ្ណរបស់ អ្នក។

PAKDAAR: Nu saritaem ti Ilocano (Ilocano), ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Maidawat nga awagan iti toll-free a numero ti telepono nga nakalista ayan iti identification card mo.

DÍÍ BAA'ÁKONÍNÍZIN: Diné (Navajo) bizaad bee yáníłti'go, saad bee áka'anída'awo'ígíí, t'áá jíík'eh, bee ná'ahóót'i'. T'áá shǫǫdí ninaaltsoos nitł'izí bee nééhozinígíí bine'dęę' t'áá jíík'ehgo béésh bee hane'í biká'ígíí bee hodíilnih.

OGOW: Haddii aad ku hadasho Soomaali (Somali), adeegyada taageerada luqadda, oo bilaash ah, ayaad heli kartaa. Fadlan wac lambarka telefonka khadka bilaashka ee ku yaalla kaarkaaga aqoonsiga.

OPTUM

Detailed explanation of non-coverage (DENC) delivery verification

AZ fax back to 1-888-405-2734

Patient information:

Patient name: _____ Patient's DOB: _____

Date NOMNC given: _____ Date appeal filed: _____
(The DENC must be given to the same person the NOMNC was given to.)

DENC delivery verification:

DENC given to: _____

Date given: _____ Time given: _____
Was this the person the NOMNC was issued to? Yes: _____ No: _____

If not, please deliver to the person the NOMNC was issued to and verify the delivery time and date to the person. If by telephone, please email or mail same day as notification.

Notes: _____

Name of person completing the form: _____

Signature of person completing this form: _____

Date: _____ Time: _____

36-3231. Surrogate decision makers; priorities; limitations

A. If an adult patient is unable to make or communicate health care treatment decisions, a health care provider shall make a reasonable effort to locate and shall follow a health care directive. A health care provider shall also make a reasonable effort to consult with a surrogate. If the patient has a health care power of attorney that meets the requirements of section 36-3221, the patient's designated agent shall act as the patient's surrogate. However, if the court appoints a guardian for the express purpose of making health care treatment decisions, that guardian shall act as the patient's surrogate. If neither of these situations applies, the health care provider shall make reasonable efforts to contact the following individual or individuals in the indicated order of priority, who are available and willing to serve as the surrogate, who then have the authority to make health care decisions for the patient and who shall follow the patient's wishes if they are known:

1. The patient's spouse, unless the patient and spouse are legally separated.

2. An adult child of the patient. If the patient has more than one adult child, the health care provider shall seek the consent of a majority of the adult children who are reasonably available for consultation.

3. A parent of the patient.

4. If the patient is unmarried, the patient's domestic partner.

5. A brother or sister of the patient.

6. A close friend of the patient. For the purposes of this paragraph, "close friend" means an adult who has exhibited special care and concern for the patient, who is familiar with the patient's health care views and desires and who is willing and able to become involved in the patient's health care and to act in the patient's best interest.

B. If the health care provider cannot locate any of the people listed in subsection A of this section, the patient's attending physician may make health care treatment decisions for the patient after the physician consults with and obtains the recommendations of an institutional ethics committee. If this is not possible, the physician may make these decisions after consulting with a second physician who concurs with the physician's decision. For the purposes of this subsection, "institutional ethics committee" means a standing committee of a licensed health care institution appointed or elected to render advice concerning ethical issues involving medical treatment.

C. A person who makes a good faith medical decision pursuant to this section is immune from liability to the same extent and under the same conditions as prescribed in section 36-3205.

D. A surrogate may make decisions about mental health care treatment on behalf of a patient if the patient is found incapable. However, a surrogate who is not the patient's agent or guardian shall not make decisions to admit the patient to an inpatient psychiatric facility

http://www.azleg.gov/ars/36/03231.htm

licensed by the department of health services, except as provided in subsection E of this section or section 14-5312.01, 14-5312.02 or 36-3281.

E. If the admitting officer for a mental health care provider has reasonable cause to believe after examination that the patient is incapable as defined in section 36-3281 and is likely to suffer serious physical harm or serious illness or to inflict serious physical harm on another person without immediate hospitalization, the patient may be admitted for inpatient treatment in an inpatient psychiatric facility based on informed consent given by any surrogate identified in subsection A of this section. The patient shall be discharged if a petition for court ordered evaluation or for temporary guardianship requesting authority for the guardian to consent to admission to an inpatient psychiatric facility has not been filed within forty-eight hours of admission or on the following court day if the forty-eight hours expires on a weekend or holiday. The discharge requirement prescribed in this section does not apply if the patient has given informed consent to voluntary treatment or if a mental health care provider is prohibited from discharging the patient under federal law.

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 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 Jan. 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–Arizona'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.

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 have involvement in or responsibility 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 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 at unitedhealthgroup.com/about/ethics-integrity.html. Optum expressly prohibits retaliation if a report is made in good faith.

Optum Care Network–Arizona 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 Service (CMS) regulations and relevant federal and state laws. This guide will be amended as needed.

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 January 1, 2020. 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 have the opportunity to appeal with CMS before the preclusion is effective. There is no opportunity to appeal with Optum Care Network–Arizona.

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 the Optum Care Network–Arizona. Additionally, the precluded care provider must hold Medicare beneficiaries harmless from financial liability for services provided on or after the claim rejection.

Contracted health plans

Maricopa/Pinal counties:
H0609-026 AARP Medicare Advantage Plan 1 HMO (Maricopa & Pinal)
H0609-027 AARP Medicare Advantage Plan 2 HMO (Maricopa & Pinal)
H2228-074 AARP Medicare Advantage Walgreens Plan 1 PPO (Maricopa Only)
H2228-097 AARP Medicare Advantage Walgreens Plan 2 PPO (Maricopa Only)
H2228-077 AARP Medicare Advantage Walgreens Plan 2 Rebate (Maricopa Only)

Tucson Metro Area (Pima County):
H0609-025 AARP Medicare Advantage HMO
H5253-035 AARP Medicare Advantage HMO POS
H2228-075 AARP Medicare Advantage Walgreens PPO
H2228-096 AARP Medicare Advantage Walgreens Plan 2 PPO
H2228-095 AARP Medicare Advantage Patriot PPO

Sample ID cards for Optum Care Network–Arizona

1. Participating health plan logo
2. Payer ID
3. Network Name
4. Plan Name
5. Provider services toll free number
6. Medical claims address
7. CMS code