OPTUM®

2022 provider manual

A guide to provider responsibilities and procedures.

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Business overview

Who is Optum Care Network–Connecticut (OCNCT)?

Optum Care Network–Connecticut (OCNCT) is a comprehensive multi-payer network of medical providers and hospitals across the state of Connecticut working together to provide high quality coordinated care to our communities. Commonly characterized as an independent provider association (IPA), we offer a full range of services to assist providers in their value-based care and business operations. Optum is an innovative leader with a track record for quality, financial stability, technology and extraordinary services. We are well-positioned to continually invest in new programs and systems for the benefit of our contracted providers and patients and to accommodate the dynamic health care environment.

Mission

We support providers in delivering efficient and compassionate care to each and every patient through the continuum of care.

Vision

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

Values

Integrity. Compassion. Relationships. Innovation. Performance.

OCNCT website

optumcare.com/locations/connecticut.html

OCNCT service area

Litchfield, Hartford, Tolland, Windham, Essex, New London, Middlesex and Fairfield Counties.

Optum contact information

Optum assigns a network liaison to each practice to provide our contracted providers and their staff with personalized service. The liaison serves as an information resource for providers and will become familiar with your operations to assess how we may mutually share best practices.

As an example, Optum providers may reach out to a network liaison for the following:

1. Requests for in-service training
2. Requests to add or term a provider/practitioner
3. Credentialing
4. Provider network inquiry
5. Provider portal inquiry

Below is a full listing of the network team available to serve your practice needs:

Chief Operating Officer and Senior Vice President

Rich Almada
Office: 1-860-284-5310
Email: ralmada@prohealthmd.com

VP, of Payer Strategy and Contracting Operations

Karl Korn
Office: 1-651-495-5381
Email: karl.korn@optum.com

Director Network Management and Managed Care Operations

Nicole Ernsky
Office: 1-860-255-4096
Email: nicole.ernsky@optum.com

Network Operation Manager

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Office: 1-763-361-7087
Email: talina.richardson@optum.com

Senior Network Specialist

Yancy Vazquez
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Chief Medical Officer

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Vice President, Medical Management

Tara Green
Office: 1-860-409-4904
Email: tara.green@optum.com

Manager, Clinical Operations

Margaret Barry, MSN, RN
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Supervisor of Medical Coordinators

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Office: 1-860-409-4904
Email: amanda.kasparian@optum.com

Alicia Luba
Office: 1-860-409-4904
Email: alicia.luba@optum.com

Director, CDQI and Quality

Cristy Baurer, MSN, CPHQ
Office: 1-860-409-4904
Email: cristy_bauer@optum.com

Provider Relations Network Liaisons

Kyle Skene – Operations
Office:1-860-983-4576
Email: kyle.skene@optum.com

Caterina Cipriano – Operations
Office: 1-203-518-2475
Email: caterina.cipriano@optum.com

David Lewandowski – Operations
Office: 1-860-670-7544
Mobile: 1-860-670-7544
Email: david.lewandowski@optum.com

Contact information

Provider Help Desk: 1-888-556-7048
Monday–Saturday, 8 a.m.–4 p.m., ET
(Prior authorization, 8 a.m.–4 p.m.)

- **Press "1"** for UnitedHealthcare® members
- **Press "2"** for Anthem® BlueCross BlueShield members
- **Press "3"** for ConnectiCare members

Fax: 1-855-268-2904

Glossary of claims terminology

The purpose of this glossary is to offer definitions of claims-related terms for use by the provider or other health care professional in a way that might be readily understood by those who may not be familiar with claims terminology.

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

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

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 provider or hospital is paid a fixed amount for each person served regardless of the actual number or nature of services provided each person. This is a per-patient-per-month (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 or adjusted by age/sex of enrollees, percent of premium based on severity ratings.

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

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 preauthorization 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 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. It includes the initial visit and any follow-up visits. This is 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 limits 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; it is required to be forwarded to the appropriate 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 is 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 lower global rate.

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

Urgent: Requiring immediate medical attention or intervention.

Prior authorization and referrals for OCNCT patients

While we are delegated to manage the referrals and prior authorization processes, OCNCT follows the same requirements as directed by the payer. These requirements* should be completed prior to scheduling the appointment.

- An active, approved prior authorization is valid in a 90-day period.

The following services should have prior authorization:*

- Specialists
- Rx injectable only
  - Prescription authorizations will be managed by UnitedHealthcare® and Anthem®.
- Outpatient services
  - Skilled nursing facility
  - Home health
  - Dialysis
  - Infusion
- Inpatient services
- Durable medical equipment
- Physical health
  - Physical therapy
  - Speech therapy
  - Occupational therapy
  - Chiropractic services

We recommend that everyone go through the referral and prior authorization process because some plan eligibility may require network participation and some do not.

If you do not follow this process you may not get reimbursement for services.

Referrals are not required, but highly recommended for OCNCT.

Referrals will be returned to providers via the method they were submitted. For example, if faxed, a fax will be sent back for referral authorization.

Refer to optumcare.com/state/ct.html for a directory of PCPs and specialists.

All prior authorizations/referrals must have the necessary clinical information. All inquiries including but not limited to: new prior authorization, existing prior authorizations and a new hospital admission can use the numbers/applications below:

Online: NAMMNet Express (NE) available through the Optum provider gateway at optumcare-mso.com

Phone: 1-888-556-7048 for clinically urgent (life-threatening) referrals only.

- **Press "1"** for UnitedHealthcare® members
- **Press "2"** for Anthem® BlueCross BlueShield member
- **Press "3"** for ConnectiCare members

Fax: 1-855-268-2904

Hours of operation:
Monday through Saturday, 8 a.m.–4 p.m. ET
For after-hours including Sunday daytime hours: voicemail

Prescribers may file a prior authorization request online. Please visit optumcare-mso.com and click on the "Claims, Eligibility, Prior Authorizations and Referrals" tile.

Prescribers may submit prior authorization requests to the prior authorization department by completing the applicable form and faxing it to **1-855-268-2904.** Prior authorization fax forms are available on the provider portal: professionals.optumcare.com/resources-clinicians/connecticut-authorization.html.

*This information is subject to change. For most up-to-date information, refer to payer website.

Frequently asked questions

Does the referral order need to be linked to a problem?

Yes, the order must be linked to a specific problem, not health maintenance.

How long does an authorization take to approve?

Routine: A routine referral in the gated plan can take up to 14 days to approve.

Urgent: Use only if the order is a life-threatening/ medically necessary STAT referral.
Please call **1-888-556-7048.**

How long are authorizations active?

An active authorization is good for the approved procedure(s) within a 90 day period.

Ideally, specialists should order/prior authorize subsequent procedures, if clinically necessary.

If you are a PCP, make sure that you put in an office visit/consult code and not procedure codes for specialist referrals.

What do I do if NAMMnet experiences an outage?

If NAMMnet isn't working, please fax routine requests to **1-855-268-2904.** The referral authorization request form can be found at **professionals.optumcare.com/resources-clinicians/connecticutclinician-resources.html.** Click on "Resources" in the top left of the black navigation bar. You can then filter resources by Connecticut on the left side of the webpage.

Please call **1-888-556-7048** for clinically urgent (life-threatening) referrals only.

I am a specialist, can I prior authorize tests or procedures that I may need to perform during a patient visit, ahead of the patient's appointment?

Yes, you may request tests or procedures prior to the patient's appointment and submit the necessary clinical documentation, which will be reviewed by our utilization management team.

May I back-date a referral or prior authorization?

No, an authorization needs to be obtained and approved prior to the patient being seen by the specialist/facility. Claims will be denied if an authorization is not obtained.

Referral authorization request form

OPTUM®

Date Received by OCNCT

Referral Authorization Request Form

Optum Care Network–Connecticut

☐ **PATIENT REQUEST** ☐ **Routine (14 Calendar Days)** ☐ **Medically Urgent (72 Hours)** ☐ **Time Sensitive (72 Hours with Notification to UM)**

Please type or print clearly in blue or black ink. **Submitted by:** _____ **# of Pages** _____

A. Member Information ***All Fields Required***

Patient Name	Member ID	Health Plan	DOB

Patient Address	Phone #

B. Primary Care Physician Information ***All Fields Required***

PCP	Phone #

C. Requesting Provider Information ***All Fields Required***

Requesting Physician	Phone #

D. Requested Provider Information ***All Fields Required***

Referred To	Specialty	Phone #

Place of Service	Fax #

E. Diagnosis and Service Requested Information ***All Fields Required***

ICD-10 Code(s)	Diagnosis Description

CPT Code(s)	Service Description

Date of Service or Admission	☐ Second Opinion ☐ Accident-related injury? Date of injury: _____ *If work-related injury, refer to worker's comp provider. Do not submit to NAMM California.*	# of Visits or Tx

F. Clinical Information

Reason for Referral/Clinical Notes *(Please attach chart notes to document medical necessity.)*
Please list.

G. Physician Signature ***Form will be returned without signature.***

Requesting Physician's Signature *(Referral incomplete without MD or DO signature.)*	Date

Please note: ***This form is not a guarantee of payment.*** Charges for noncovered services or services rendered to ineligible patients are the responsibility of the patient.

For questions, call UM at 888-556-7048. **Fax referral requests to 855-268-2904.**

H. Status (For internal use only.)

Criteria Used: ☐ MCG ☐ Health Plan ☐ CMS ☐ Internally Developed

☐ **Pend** ☐ **Approved** ☐ **Denied** ☐ **Duplicate**

Not Processed; Returned
☐ **Member not effective**
☐ **Member could not be identified**
☐ **Carve-Out/HP Responsible**

Date _____ **Initials** _____ **Ref #** _____

Prov Notified: ☐ **Phone** **Date/Time:** **Initials:** ☐ **System Fax** ☐ **Manual Fax** ☐ **Courier** ☐ **Overnight Fax**

(Urgent/Exp) Mbr Notified: ☐ **Phone** **Date/Time:** **Initials:** ☐ **Letter** **Date/Time:** **Initials:**

Updated: 02/23/2018
Created: 09/07/2016

Patient eligibility

Eligibility
When a patient visits his/her provider, the provider should verify the patient's eligibility at each visit before rendering covered services in order to ensure timely and appropriate claims payment for patients who are eligible with health care coverage. **The provider should verify eligibility with the patient's health plan no more than 48 hours prior to providing covered services, and again on the date of service.**

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

Health plan contact information
To verify member eligibility:

NAMMNet Express (NE): through the Optum provider gateway **optumcare-mso.com**

You can also verify directly through the health plan.

Submitting a claim

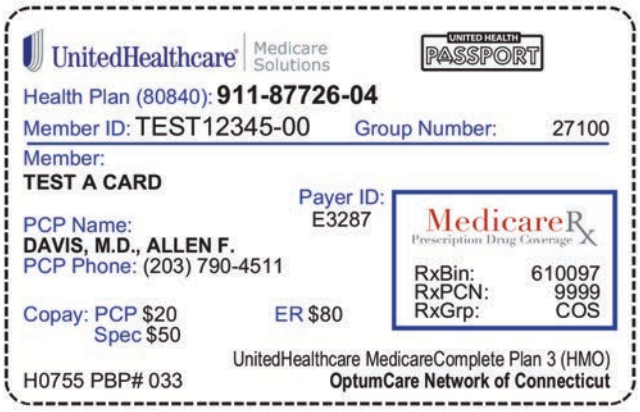
Follow these guidelines when submitting a claim through Optum.

Electronic submissions:
Use payer ID: E3287

Paper submissions:
OCNCT Claims
P.O. Box 2500
Rancho Cucamonga, CA 91729-2500

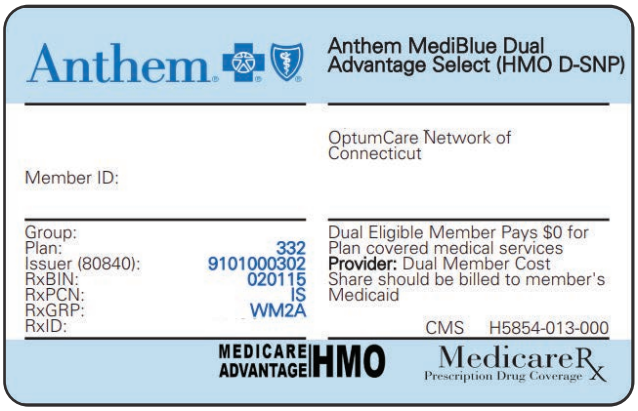
To check status of claims:
NAMMNet Express: through Optum provider gateway: **optumcare-mso.com**

Front of card



Back of card

Front of card



Back of card

UnitedHealthCare® plans

Members that have an OCNCT PCP will have one of the below plan names, PBP#, Group# and Optum logo on their member ID Card.

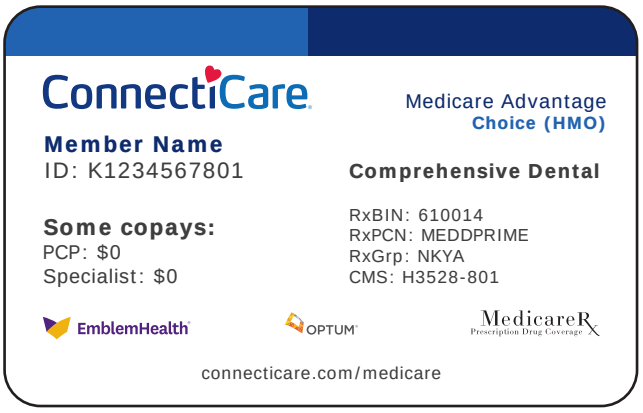
Plan name	PBP#	Group#
UnitedHealthcare® Medicare Complete Plan 1 (HMO)	H0755-030	27151 or 27062
UnitedHealthcare Medicare Complete Plan 2 (HMO)	H0755-031	27153 or 27064
UnitedHealthcare Medicare Complete Plan 3 (HMO)	H0755-033	27100 or 27150
UnitedHealthcare Medicare Complete Essential (HMO)	H0755-032	27155 or 27156
AARP® Medicare Advantage Walgreens (PPO)	H3442-001-000	90125
UnitedHealthcare Dual Complete (PPO DSNP)	H0271-014	09116
AARP Medicare Advantage Choice (Regional PPO)	R7444-001	90150 or 90151

Anthem® plans

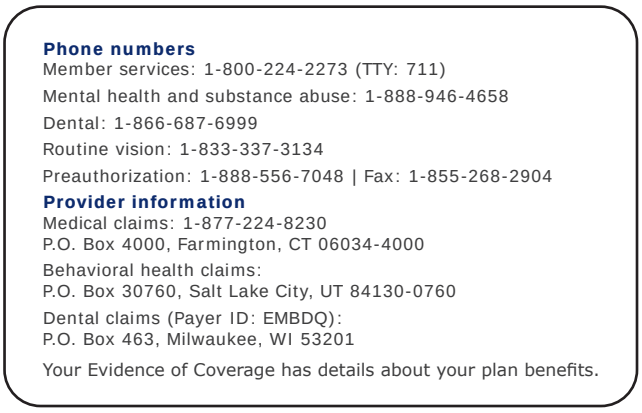
Members that have an OCNCT PCP will have one of the plan name, Group# and Optum name to the left of the member ID# on their plan ID card.

Plan name	PBP#
Anthem® MediBlue Plus (HMO)	H5854-007-000
Anthem MediBlue Dual Advantage (HMO-SNP)	H5854-008-000
Anthem MediBlue Plus (HMO)	H5854-009-000
Anthem MediBlue Select (HMO)	H5854-010-000
Anthem Extra (HMO)	H584-011-000
Anthem MediBlue Dual Advantage Select (HMO-DSNP)	H584-013-000
Anthem MediBlue Prime (HMO)	58540-015-000

Front of card



Back of card



ConnectiCare plans

Members who have an OCNCT PCP will have one of the below plan names, PBP#, Group# and the Optum logo on the front of their member ID card.

Plan name	PBP#
H3528 003 HMO ConnectiCare Choice Plan 2 (HMO)	H3528-003
H3528 006 HMO-POS ConnectiCare Flex Plan 1 (HMO-POS)	H3528-006
H3528 010 HMO ConnectiCare Passage Plan 1 (HMO)	H3528-010
H3528 011 HMO-POS ConnectiCare Flex Plan 3 (HMO-POS)	H3528-011
H3528 014 HMO ConnectiCare Choice Plan 3 (HMO)	H3528-014
H3528 015 HMO-POS ConnectiCare Flex Plan 2 (HMO-POS)	H3528-015
H3528 016 HMO ConnectiCare Choice Plan 1 (HMO)	H3528-016
H3528 017 HMO ConnectiCare Choice Part B Saver (HMO)	H3528-017
H3528 801 HMO ConnectiCare Employer Group Plan (HMO)	H3528-801
H3528 806 HMO-POS ConnectiCare Employer Group Plan (HMO-POS)	H3528-806

How to submit a provider dispute resolution (PDR) form
Get PDR form at professionals.optumcare.com/resources-clinicians.html

Complete form and mail to:
Provider Dispute Resolution - OCNCT
P.O. Box 2500
Rancho Cucamonga, CA 91729-2500
If you need assistance, please contact the service center at **1-877-370-2845.**

Important contact information

Below are numbers and websites you can use to contact Optum or find information on related services.

Optum website provider gateway
Use our Optum provider gateway, a tool giving you access to eligibility, prior authorization and claims information in real time.

To request access to the provider gateway, contact the OCNCT network coordinator at yancy_vazquez@optum.com or contact your network liaison.

Optum website
Visit professionals.optumcare.com/resources-clinicians.html. You can filter documents by choosing "Connecticut" on the left side. This is where you can download the following documents:

1. Electronic transfer fund (ETF)
2. Electronic remittance advice (ERA)
3. Provider dispute resolution (PDR) form
4. Provider referral form
5. Prior authorization form
6. Provider manual
7. Quick reference guide
8. Forum for evidence based medicine communications – COVID-19 resources
9. Cozeva resource guide
10. HEIDIS reference flyer
11. SNF & LTACH prior authorization
12. Affirmative statement
13. Non-discrimination notice

Help desk:
1-888-556-7048, Mon.–Sat., 8 a.m.–4 p.m., ET

- **Press "1"** for UnitedHealthcare members
- **Press "2"** for Anthem BlueCross BlueShield member
- **Press "3"** for ConnectiCare members

Behavioral health: Please refer to member's ID card for their behavior health provider phone number.

Medical record documentation 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. Each contracted provider is responsible for maintaining medical records in compliance with Optum, NCQA, state and regulatory guidelines.

Patient identification
Each page in the record will contain the patient name and patient DOB or patient ID number.

Personal/biographical data
Each record will have the patient's address, employer, home and work phone numbers, and marital status, date of birth, emergency contact and phone number.

Patient language
Each patient's health record shall include the patient's primary language, as well as any linguistic services needed for non- or limited-English proficient or hearing-impaired persons. Documentation of request, use and/or refusal of language interpreter services is required in the patient's medical record.

Practitioner identification
Each entry in a patient's medical record must be dated and signed (first and last name, and title), but electronic identifier or initials are acceptable. Further, all physician assistant (PA) and/or nurse practitioner (NP) signatures not practicing independently in accordance with Connecticut General Statutes Section 20-87a must be cosigned by the supervising/collaborating physician.

Entry date
All entries will be dated.

Legible
The record must 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 illness 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 provider office, if requested.

Advance directives
Presence of an advance directive or evidence of education about advance directives of patients over the age of 18 should be noted. Patients will be provided information as to making their own health care decisions. Advanced directives will be addressed and documented. Patients that have advanced directives will be asked to supply the practitioner with the information for inclusion in their 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, or the use of an electronic medical record system.

Past medical history
Past medical history documentation is required. This documentation includes 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
For patients age 14 and older, there is appropriate notation concerning depression, violence, and the use of cigarettes, alcohol and substances (for patients seen three or more times, there is evidence of substance abuse query).

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 provider.

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 findings in the chart will have the primary care provider'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, providers should follow the guidelines from the Centers for Disease Control and Prevention. 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 screening and services are offered. A suggested checklist may be provided to each office for use and inclusion in the medical record.

Addendum to patient record
Every patient has the right to request the provider amend the patient's medical record. Such addendum request will be reviewed by the provider in order to make a decision whether to grant or deny such addendum request.

If the provider grants the addendum request, he/she will proceed as follows:

A. Identify the affected records and append or provide a link to the amendment;

B. Inform the patient of its acceptance of the amendment within sixty (60) days; and

C. Make reasonable efforts to inform and provide the amendment within a reasonable time to:

1. Persons identified by the patient as having received PHI about the patient and needing the amendment; and
2. Persons, including business associates, that provider knows have PHI that is the subject of the amendment and that may have relied or could foreseeably rely on such information to the detriment of the patient.

D. Receipt of amendment from another covered entity: If provider is informed by another covered entity of an amendment to a patient's record, it must reasonably amend the PHI it maintains in that patient's record.

If the addendum request is denied, in whole or in part, the provider will provide the patient a written denial within sixty (60) days that contains:

A. The basis for the denial;

B. The patient's right to submit a written statement disagreeing with the denial and how to submit such a statement;

1. If the patient submits a statement of disagreement, the provider may prepare a rebuttal statement. The provider will provide a copy of the rebuttal statement to the patient and append or link such statement to the record.
2. If the patient does not submit a statement of disagreement, the patient has a right to request that the amendment request and denial be included in any future disclosures of the PHI record.

C. A description of the complaint process.

Documentation errors

When documentation errors occur on paper medical records, the person that makes the error must correct the error in the following manner:

A. A single line is drawn through the error with "error" written above or near the lined-through incorrect entry;

B. The corrected information is written as a separate entry and includes: a) date of entry; b) signature (or initials); and title.

There are to be no unexplained cross-outs, erased entries or use of correct fluid/tape (white out). Both original entry and corrected entry are to be clearly preserved. One method of correcting documentation errors is the S.L.I.D.E rule: single line, initial, date, and error.

Credentialing and recredentialing

The Optum credentialing department handles all provider credentialing and recredentialing processes for providers and other health care professionals who provide care to Optum patients.

Initial credentialing
Optum utilizes CAQH ProView as our application for credentialing. The timeframe for the initial credentialing process takes approximately 60–90 days, from receipt of the credentialing application to committee decision. The credentialing timeframe is directly dependent upon receipt of requests from the primary source verification sources in a timely manner. If receipt of those verifications is delayed in any way, it will lengthen the process. If the credentialing packet received from the provider is not complete (for example, 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.

Recredentialing
Recredentialing occurs every three years. Prior to the three-year anniversary of the provider's previous credentialing approval date the provider will receive notification that it is time for the recredentialing process. The provider will receive a request from the Credentialing Department to log into CAQH, 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 **caqh.org/cred**. If the provider needs his/her CAQH provider ID number, please contact an Optum representative for further assistance.

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

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

To ensure accurate records and provider directories, please report all demographic changes directly to your assigned network liaison. Please see page 4 for contact information.

Site visits medical office chart review
A site visit will occur within one year of the agreement effective date and annually thereafter.

Site visits will be performed by the network liaison to assure that medical office and medical record keeping standards are being met and that any deficiencies are corrected and brought to compliance.

Standard site tools will be used for the audit. Please contact your network liaison for a copy of these forms and the policy and procedure about this review and process.

Appointment access standards

Scope
All employees of Optum and its affiliated entities, globally referred to as "the company" shall follow the procedures set forth in this policy.

Purpose
To establish a process for timely access to care standards and monitoring activities; and where applicable, compliance with the DOI (Department of Insurance) access standards, and NCQA (National Committee for Quality Assurance) accreditation requirements, to assist in improved availability and accessibility to practitioners, providers, and health care services, meeting regulatory, accreditation and licensing requirements.

Policy
This policy establishes minimum compliance standards for member accessibility to primary, specialist, behavioral health and ancillary care providers. It also defines the process to monitor, where applicable, network compliance with the DOI access standards and NCQA accreditation requirements.

Procedure

A. Assessment against access standards: The company collects and performs an annual analysis of data to measure its performance against standards for access to:

1. Regular and routine care appointments
2. Preventive care
3. Specialty consultations
4. Urgent care appointments
5. Wait time in the office
6. After-hours care
7. Member services, by telephone

B. Behavioral health care access standards: The company collects and annually analyzes data to measure performance against standards for behavioral health care access to:

1. Care for a non-life-threatening emergency within six hours
2. Urgent care within 48 hours
3. An appointment for a routine visit within 10 business days

C. Behavioral health care telephone access standards: The company collects and analyzes data to measure its performance against the following behavioral health care telephone access standards, when delegated:

1. The quarterly average for screening and triage calls shows that the telephones are answered by a live voice within 30 seconds.
2. The quarterly average for screening and triage calls reflects a telephone abandonment rate within 5%.

Access monitoring

1. At least annually, the quality improvement (QI) staff will perform telephonic access audits on all PCPs with >250 members, so that at the end of the year 100% of the PCPs with >250 members will have been audited.
2. For those that meet compliance at 100%, monitoring for complaints will be ongoing.
3. For those that do not meet compliance at 100%, the following will occur:
    i. Access standards will be distributed by QI
    ii. Telephonic site evaluation will be performed by QI, see attachment "B"
    iii. A mystery shopper audit will be performed by QI within 30 days
    iv. QI will conduct an onsite visit if provider fails the mystery shopper audit, attachment "C"
    v. Results will be distributed to the chief operating officer (COO), executive committee (EC), and quality improvement committee (QIC)

Complaint-based monitoring

1. Quarterly, a report will be run by QI identifying all providers with greater than two access issues and/or complaints.
2. For those with two or more access issues per quarter, the following will occur:
    a. Access standards will be mailed to the provider by QI
    b. QI will perform a telephonic site evaluation
    c. Mystery shopper audit will be performed by QI within 30 days
    d. QI will distribute results of above to the COO, EC, and QIC if the provider fails the mystery shopper or has two or more access issues within the next two quarters, the physicians executive committee will develop corrective actions, when indicated, and forward to QI
3. The QIC will continue to monitor, track and trend.

Survey-based issues

1. When surveys are done with an access to care component, such as after hour's access and availability or physician specific member satisfaction survey, results and standards will be distributed to the physicians by the QI department.
2. For those with scores less than the network average, or less than 100% for after-hours access and availability, the following will occur:
    a. QI will provide telephonic and/or written education
    b. Results will be distributed to the COO and Physician's Executive Committee for development of a corrective action plan (CAP)
    c. QI will monitor the CAP
    d. If improvement is not identified, the issue will be forwarded back to the Physician's Executive Committee for additional actions.

PCP and SCP access standards

Appointment type	Time-elapsed standard
Non-urgent care appointments for primary care (PCP): regular and routine care	Within 15 business days of the member request
Non-urgent care appointments with specialist care physicians (SCP)	Within 15 business days of member request
Urgent care appointments that do not require prior authorization (PCP or SCP)	Must offer appointment within 48 hours of request
Urgent care appointments that require prior authorization (specialist and other)	Within 96 hours of request
Access to preventive health services	Within 20 business days of initial request
Non-urgent care appointments for ancillary services (for diagnosis or treatment of injury, illness, or other health condition)	Within 15 business days of member request
In-office wait time for scheduled appointments (PCP and SCP)	Not to exceed 30 minutes, but must explain to member within 15 minutes if the provider is running late
Access to after-hours care (with a PCP)	Within 30 minutes for urgent issues. Appropriate after-hours emergency instructions
Urgent/emergent services requiring immediate attention (ER services)	ER availability is 24/7

Behavioral health emergent and non-emergent appointment access standards

Appointment type	Time-elapsed standard
Non-urgent appointments with a physician behavioral health care provider	Must offer the appointment within 10 business days of request
Non-urgent care appointments with a non-physician mental health care provider	Within 15 business days of member request
Urgent care appointments	Within 48 hours
Access to care for non-life threatening emergency	Within six hours
Access to life-threatening emergency care	Immediately
Access to follow-up care after hospitalization for mental illness	**Must provide both:** One encounter with a behavioral health provider within seven business days after discharge (initial visit) **Plus** One follow-up encounter with a behavioral health provider within 30 business days after discharge (second visit)

Exceptions

Preventive care services and periodic follow-up care

Preventive care services and periodic follow-up care including but not limited to, standing referrals to specialists for chronic conditions, periodic office visits to monitor and treat pregnancy, cardiac or mental health conditions, and laboratory and radiological monitoring for recurrence of disease, may be scheduled in advance consistent with professionally recognized standards of practice as determined by the treating licensed health care provider acting within the scope of his or her practice.

Advance access

A primary care provider may demonstrate compliance with the primary care time-elapsed access standards established herein through implementation of standards, processes and systems providing advance access to primary care appointments as defined herein.

Appointment rescheduling

When it is necessary for a provider or member to reschedule an appointment, the appointment shall be promptly rescheduled in a manner that is appropriate for the member's health care needs, and ensures continuity of care consistent with good professional practice and consistent with the objectives of this policy.

Extending appointment waiting time

The applicable waiting time for a particular appointment may be extended if the referring or treating licensed health care provider, or the health professional providing triage or screening services, as applicable, acting within the scope of his or her practice and consistent with professionally recognized standards of practice, 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.

Clinical documentation and quality improvement

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

These tools will:

- Provide guidance for specific tests and procedures based on a patient's health history and previous diagnoses.
- Enable providers to close both risk and quality-based gaps in care, at the point of care while improving diagnosis capture and reporting.
- Support submission of quality performance measures such as HEDIS-Star

Medicare risk adjustment

Optum encourages providers to document patient health information and demographics for appropriate Medicare reimbursement. 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 diagnoses 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 are used to predict payments for the following year.

Why physician data reporting is critical

- The model is highly data-reliant and only works when complete and accurate diagnosis data is used.
- Eighty percent of the diagnoses are extracted from physician data.
- If diagnoses are not documented per the CMS standards, then they do not count.
- Every January 1 the beneficiary "becomes well." If a condition is not documented each year it does not count toward the next year's payment amount.

What has risk adjustment done?

- Leveled the playing field for enrolling Medicare beneficiaries; no incentive to enroll only "healthy seniors."
- Good medical management is rewarded.
- Physicians are no longer penalized for whom they service.
- Moves the system of care to one that is more supportive of the needs of chronically ill patients.

Risk adjustment is here to stay

- It's the law, and would take an act of Congress to change.
- It's more equitable.
- It works.
- Medicare will refine the model.
- Embrace it, and it can be good for you.

Keys to success with risk adjustment

- Good coding and documentation practices; the medical record documentation must support the material submitted on the encounter of annual health assessment form
- High reporting levels of encounter data
- Member retention

Coding and documentation

- Use the current version of ICD-10CM 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.

Compliance with IPA executive committee decisions

IPA executive committees adopt initiatives during the year to advance Medicare risk adjustment efforts. Physicians are required to participate and comply with these initiatives as may be appropriate.

Home Health Agency (HHA) section

HHA care providers

HHA billing/claims information

Claims must include revenue code 0023, the appropriate HIPPS code, the zero line item charge amount for all inpatient admissions, along with the revenue code in the contract to be reimbursed for services rendered. Any claim received without the above revenue code, HIPPS code and zero line item charge will be rejected or denied accordingly.

Billing intermittent care

Visits shall be defined as up to two hours in length. Thereafter, visits shall be billed in one hour increments. The visit rate below shall be all inclusive of ancillary medical supplies.

Description	Revenue code
Skilled nursing visit	551
Physical therapy	421
Occupational therapy	431
Speech therapy	441
Medical social worker	561
Nursing services – Licensed practical nurse (LPN/LVN)	581
Home health aide	571

Monitoring

Notice of Medicare Non-Coverage (NOMNC) monitoring

1. Quarterly, the utilization management (UM) medical management team will review the percentage of correct versus incorrect NOMNC, and will review the home health agency scores.
2. A score of less than 95% will result in a monthly monitoring and a request for a corrective action plan by the home health agency.
3. Persistent performance score below 95% will result in further disciplinary action which could include removal from the network.

Complaint-based monitoring

1. Quarterly, a report will be run by quality improvement (QI) identifying all home health agencies with greater than two timeliness issues in opening cases or issues and/or complaints.
2. For those with two or more timeliness issues in opening cases or complaint issues per quarter, the following will occur:
    a. HHA will develop a corrective action plan and share the plan with the OCNCT UM medical management team.
    b. QI will distribute results of above to the chief operating officer (COO), executive committee (EC), and quality improvement committee (QIC) if the HHA has two or more timelessness of opening cases or complaint issues within the next two quarters the physician's executive committee will develop corrective actions, when indicated, and forward to QI.
3. The QIC will continue to monitor, track and trend.

Rehospitalization rates

On a quarterly basis, rehospitalization rates will be reviewed. The target is an 8%, 30-day all-cause readmission rate or less for the members assigned to OCNCT. Rehospitalization rates will be discussed during the quarterly joint operating committee (JOC) meeting.

Definitions

1. Custodial care:
Non-health-related services, such as assistance in activities of daily living (examples include feeding, dressing, bathing, transferring, ambulating and companion services).

Health-related services that are provided for the primary purpose of meeting the personal needs of the patient or maintaining a level of function (even if the specific services are considered to be skilled services), as opposed to improving that function to an extent that might allow for a more independent existence.

Services that do not require continued administration by trained medical personnel in order to be delivered safely and effectively. (2011 COC)

2. Intermittent care – Skilled nursing care that is provided or needed, either:
Fewer than seven days each week or fewer than eight hours each day for periods of 21 days or less.
Exceptions may be made in exceptional circumstances when the need for additional care is finite and predictable. Home health services, provided by a home health agency, will be provided on a part-time, intermittent schedule and when skill care is required.

3. Skilled care:

- Skilled nursing
- Skilled teaching
- Skilled rehabilitation

To be skilled, the service must meet all of the following requirements:

- It must be delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome, and provide for the safety of the patient
- It is ordered by a physician
- It is not delivered for the purpose of assisting with activities of daily living (dressing, feeding, bathing or transferring from bed to chair)
- It requires clinical training in order to be delivered safely and effectively
- It is not custodial care (2011 COC)

4. Ancillary medical supplies:
Routine supplies used in conjunction with the professional services are included in the "per unit" or "per visit" payment methods. Routine supplies include, but are not limited to, the following: gauze pads, tape, Band-Aids®, gloves, face masks, alcohol, alcohol pad/wipes, cotton balls/swabs, lubricant jelly, thermometers, lab draw supplies, needles, syringes, gowns and aprons.

5. Institutional claim:
Any U B-04 or electronic version or successor form.

6. Per unit:
The flat rate payment method designated "per unit" is applicable to covered services rendered to an Optum member for each unit of service performed within a home health services category for which a per unit payment method is indicated in the home health services category table. Unless otherwise specified, payment under the per unit payment method, less any applicable Optum member copayment, is payment in full for all covered services rendered to the Optum member including, but not limited to, all ancillary medical supplies, professional and non-professional services billed by provider on an institutional claim, educational materials, Optum member education, clinical management (i.e. monitoring, on-call, record keeping, etc.), and mileage associated with the care rendered. The units reported for covered services for which the contract rate is a per unit must always equal the number of times a procedure or service is performed.

Definitions

7. Per visit:
The flat rate payment method designated “per visit” is applicable to covered services rendered to an Optum member during one continuous encounter for each home health services category for which a per visit payment method is indicated in the home health services category table. Unless otherwise specified in the agreement under exhibit C - compensation, payment under the per visit payment method, less any applicable Optum member copayment, is payment in full for all covered services rendered to the Optum member including, but not limited to, all ancillary medical supplies, professional and non-professional services billed by provider on an institutional claim, educational materials. Optum member education, clinical management (i.e. monitoring, on-call, record keeping, etc.) and mileage associated with the care rendered.

Patient communication with health care team

Mutual agreement

- Collaborate across the health care system to improve member care
- Lower the burden of illness of members who receive home health services
- Improve member and caregiver knowledge of member's health conditions
- Incorporate the member's life plan goals into their life at home
- Identify and address safety issues for members who receive home health services
- Identify and address socioeconomic issues that lead to poor health outcomes
- Identify and address end of life issues, as appropriate
- Offer member/family choices in care management, care planning and care plan implementation
- Endorse the use of the home health care team if chosen by patient
- Use home health services in accordance to national recognized guidelines (CMS and MCG)

Expectations

Optum Care Network–Connecticut (OCNCT) UM medical management team and home health clinical team to meet weekly to review high-risk patients' care plans.

Optum Care Network–Connecticut

- Depending on member eligibility or member capacity, explains, clarifies, and secures mutual agreement with member and/or member-responsible care givers on recommended care plan
- Assists member in identifying the necessary treatment goals
- Depending on member age, describe medical home concept
- Identifies who the member wishes to be included in the care team
- Provides preferred networks for SNF, hospice and specialists

Home Health Agency

- Automate Patient Ping within 16 weeks of signing contract
- Obtains authorization from OCNCT UM medical management team prior to initial evaluation/ start of care (SOC)
- Ensure patients are entered into Patient Ping within 24 hours of case opening
- Ensure patients are discharged within 24 hours of transitioning
- Discusses the illness(es), treatment and their involvement recommendations
- Provides educational material to member for ambulatory predominant conditions, teaches and supports member self-monitoring techniques and advises when to report a medical issue to their PCP or the home health care nurse
- Recommends appropriate follow-up with PCP and/or specialist
- Be available to the member to discuss questions or concerns regarding their care
- Participates with member home health care team as appropriate

Access

Mutual agreement

- Real-time availability to assist the home health agency, OCNCT and/or member
- Respond to urgent situations promptly
- Have 24-hour coverage for urgent situations
- Report appropriate summaries of care delivered and significant interventions as appropriate
- If requested, include hours of service delivered, visit dates and changes in member condition or status
- Provide general information as measured on Medicare Home Health Compare:
  - Skilled nursing care, physical therapy, occupational therapy, speech therapy, medical social services, home health aide

Expectations

Optum Care Network–Connecticut

- Communicates with members preferred home health agency
- Identifies OCNCT's preferred home health agencies with all hospital discharge planners
- Follows up with discharge planners to determine where referral was sent
- Identify network home care agencies to SNFs

Home Health Agency

- Notifies OCNCT care manager of initial home appointment from SNF and hospital
- Notifies OCNCT care manager of visit cancellation or other actions that place member at risk
- Ensures the member's first appointment within seven days with requested follow-up physician has been made within the hospital and or SNF discharge plan's recommendation

Collaborative care management

Mutual agreement

- Define responsibilities between primary care provider (PCP), home health agency and member
- Clarify who is responsible for specific elements of the care plan, member education, medication reconciliation, member assessment, care plan implementation, goals established, and outcomes documented
- Maintain competency and skills within scope licensure requirements
- Define actions to be taken when standards of care are not met
- Agreement on member care plan
- Mutually determine need for home telemonitoring

Expectations

Optum Care Network–Connecticut

- Follows member-centered medical home principles
- PCP manages the medical problem of the member, and refers to the specialist if necessary
- Resumes care of members, assumes responsibility and incorporates care plan recommendations into the overall care of the member

Home Health Agency

- Immediately notifies OCNCT care manager upon assignment of an OCNCT member to home health care
- Works with the member and physician to develop the safest/most effective plan of care and notifies OCNCT
- Provides notification of a change in the member's condition to the OCNCT physician MD and CM
- The home health agency maintains contact with the OCNCT care manager to provide updates and to coordinate member's discharge from home health agency when appropriate
- Provide home health telemonitoring as appropriate

Transition of care

Mutual agreement

- Maintain accurate and up-to-date member clinical information
- Jointly standardize demographic and clinical information in a mutually agreed format, which is approved by the OCNCT home health care team
- Ensure safe and timely oversight of care transition for the member

Expectations

Optum Care Network–Connecticut

- Determine insurance eligibility
- Based on the member's diagnosis and condition upon discharge, a determination will be made as to whether the member will receive just one phone call, or will be enrolled in the transitions in care program (TIC), at which time an initial care plan will be developed.
- If member is enrolled in TIC program, the member will remain in the program until all member clinical goals are met.
- OCNCT UM medical management team will take these actions within 24 business hours after member is discharged from the hospital:
  - Screen member for his/her risk of readmission
  - Perform post-discharge medication review
  - Educate member on early warning signs and ensure that they understand post-discharge instructions by teach-back method
  - Assist the member with making an appointment with the appropriate follow-up physician
  - If member was enrolled in the TIC program prior to hospital discharge, the member will continue in the TIC program post-discharge from home health agency.

Home Health Agency

- Re-determines and/or confirms insurance eligibility.
- Identifies a specific clinical nurse to communicate with the OCNCT care manager.
- Works with the member regarding member needs, the home care course of treatment, and mutual goals.
- Upon completion of the initial home care visit, contact the designated OCNCT care manager to review medication review.
- Update the OCNCT UM medical management team with any changes in the member's condition and care plan.
- Upon member's discharge, the home health care agency will fax the official discharge summary to the UM medical management team when service is completed and will be documented in the EHR.

<table>
<tr><th colspan="2">Quality of member care</th></tr>
<tr><th colspan="2">Mutual agreement</th></tr>
<tr><td colspan="2">• Provides quality member care to each member</td></tr>
<tr><th colspan="2">Expectations</th></tr>
<tr><td>Optum Care Network–Connecticut
• Meets all criteria/deliverables for member-centered medical home</td><td>Home Health Agency
• Managing member: physical, functional, social and behavioral activity
• Manages member pain if present
• Begins nursing start of care within 24 hours
• Begins rehab start of care within 48 hours
• Access to social worker five days a week; discuss members under social services during weekly rounding
• Observes member self-medication techniques and oversees medication regimen
• Works towards prevention of hospital readmissions and non-emergent emergency room visits while under the care of the home health agency, and reports frequency to OCNCT care manager</td></tr>
</table>

Optum Care Network–Connecticut
3 Farm Glen Boulevard
Farmington, CT 06032

Home Health Agency (HHA) planned discharge disposition

As of the day of the Notice of Medicare Non-Coverage (NOMNC) is delivered
Please send this form to Optum Care Network–Connecticut on the day that the patient receives the NOMNC. If needed, information in this form is used in the CMS Detailed Explanation of Non-Coverage (DENC) letter which is delivered to the patient. Please avoid using abbreviations.

HHA name:
Patient name:
Date of birth:
Date of admission:
Admission diagnosis:
Prior level of functioning:
Planned discharge date:
Planned discharge disposition:
Current functional or medical needs on day of Notice of Medicare Non-Coverage (NOMNC) letter is delivered.

- Bed mobility:
- Sit to stand:
- Transfers:
- Ambulation:
- Toileting:
- Weight-bearing status:
- Wound care status:
- IV therapy status:
- Other skilled need status:

Skilled services are no longer indicated based on (check one):

_____ Therapy completed
_____ Unable to participate in therapy
_____ No longer has a medical skilled care
_____ No longer homebound

Please fax this form to the Optum Care Network–Connecticut UM medical management team:
Fax: 1-888-999-1604

Optum Care Network–Connecticut
3 Farm Glen Boulevard
Farmington, CT 06032

Date

Dear (Executive Director Name),

Optum Care Network–Connecticut (OCNCT) recently completed an audit of the Notice of Medicare Non-Coverage (NOMNC) documents from your facility. Documents reviewed were for Skilled Nursing Facility (SNF) discharges in Quarter 1, 2018. The finding for your facility are as follows:

Number of NOMNCs reviewed	
Number of NOMNCs compliant	
Number of noncompliant NOMNCs	
Score	

Issues identified:

1. Xyz
2. Xyz

It is our expectations that (insert facility) will implement processes to correct these deficiencies going forward.

OCNCT continues to monitor NOMNCs on an ongoing basis and will provide reports quarterly.

Please send any questions to **ocnct@optum.com.**

Regards,

Medical management team

HHA Notice of Medicare Non-Coverage (NOMNC) and Detailed Explanation of Non-Coverage (DENC) process meeting agenda

1. Introductions
2. Authorization for admission
    a. Must call Optum Care Network–Connecticut Prior Authorization for authorization number within 24 hours of patient arrival
        i. Saturday/Sunday admissions have until 5 p.m. Monday
        ii. **1-888-556-7048**
3. Policies
    a. Appointment of Representative (AOR)/Power of Attorney (POA)
    b. Electronic release of PHI
    c. Weekend coverage for DENCs
4. Review of CMS instructions for completing NOMNC
    a. New instructions as of January 2018
    b. Valid notice delivery
    c. Notice delivery to incompetent enrollees in an institutional setting
5. Review of NOMNC critical elements
    a. Logo
    b. Correct form
        i. Must include the ACA 1557 declaration
    c. Coverage end date
    d. Plan contact information
    e. Additional Information elements
        i. Mailing NOMNC if verbal notice
            1. Must be mailed even if family requests a copy be left in room
    f. Signature
    g. Date
6. Review of DENC form
    a. Additional page for ACA 1557 declaration
    b. Timeliness of delivery
        i. Weekend delivery
    c. DENC must be given to same person to whom the NOMNC was given
7. DENC delivery verification form
    a. Documents NOMNC and DENC given to same person
    b. Signed by staff
    c. Fax back to Optum Care Network–Connecticut at **1-888-999-1604**
        i. Payment may be pended if form not received

HHA NOMNC and DENC training attendance form

Home Health Agency name_____ Date _____
By signing below, I acknowledge I have received education regarding the Optum Care Network–Connecticut NOMNC and DENC process including required time frames and weekend delivery.

Name	Title

Skilled nursing facility (SNF) section

Skilled Nursing Facilities

SNF billing/claims information

All claims must include revenue code 0022, the appropriate HIPPS code, the zero line item charge amount for all inpatient admissions, along with the revenue code in the contract to be reimbursed for services rendered. Any claim received without the above revenue code, HIPPS code and zero line item charge will be rejected or denied accordingly.

Care category	Revenue code(s)	CPT code(s)	HCPCS code(s)	Additional information
Level I – Skilled nursing care	191			
Level II – Skilled nursing care	192			
Level Ill – Skilled nursing care	193			
Level IV – Skilled nursing care	194			
CMA appeal day revenue	190			
High-cost medication	636			• Name of medication and NDC# • HCPC code • Dosage
Annual vaccination – Influenza	0636	90654-90698	Q2034-Q2039	• Separately reimbursable covered service • Per unit via CMS fee schedule
Annual vaccination administration – Influenza	0771		G0008	
Annual vaccination – Pneumococcal	0636	90732/90670		
Annual vaccine administration – Pneumococcal	0771		G0009	
Outpatient services – Physical therapy	0420-0424, 0429			
Outpatient services – Occupational therapy	0430-0434, 0439			
Outpatient services – Speech therapy	0440-0444, 0449			

1. Billing skilled nursing care

Facility shall provide Optum members with covered services subject to authorization by Optum. The level of care may be changed by Optum to reflect an increase and/or decrease in services, consistent with patient medical status. Unless otherwise indicated, all levels of care are to include the following services:

Semi-private rooms (private room if medically necessary)

- Meals and nutritional assessment/evaluation (including special diets)
- Recreational activities
- Pain management
- Nursing care and restorative nursing; supervision of ADLs and assistive devices
- Respiratory and oxygen supplies and services (nursing or respiratory therapist performs treatment)
- Administration of medications
- Routine medications and medical supplies; including ostomy and incontinent supplies
- X-ray radiology services performed in-house
- Laboratory services performed in-house
- Medical/in-house and nursing supplies
- Discharge planning, social services and internal case management
- DME including, but not limited to: wheelchair, trapeze, walker and commode, hospital bed and wheelchairs

Level	Description	Rev code	Rate type
Level I	**Nursing services includes one or more of the following:** • Nursing services up to three hours a day • Simple wound care or dressing changes • Suctioning • Routine SQ/IM injectable medications administration • Catheter changes and irrigation • Oxygen, three liters or less, respiratory and oxygen supplies and service (nursing or respiratory therapist performs treatment) • Restorative nursing care • Bowel and bladder training • Standard/stable tracheostomy care • Diabetic education relating to glucose monitoring and subcutaneous injection (insulin dependent) • Education care and education of new ostomy patient family • Foley catheter (maintenance and irrigation) • IDDM patients incapable of self-injection • Wound care including Stage I decubitus ulcers requiring complex care	**191**	**Per diem**

Level	Description	Rev code	Rate type
Level II	**In addition to services provided in Level I above, one or more items below:** • NG, G-tube, or J-tube feeding, including supplies and services • IV pump/feeding pump • Peripheral line for IV hydration (including IV solutions and supplies) • Pharmacy services, including pharmacist consultation • Routine oxygen services and supplies, including oximetry and small volume nebulizer by licensed nurse • Respiratory therapy services • Rehabilitative treatments, up to two hours daily, up to six days per week (PT, OT or Speech Therapy) up to 720 minutes • All central line care • Whirlpool (cleaning wounds) • Wound care including Stage II decubitus ulcers requiring complex care • IV antibiotic up to two times a day • New colostomy/ileostomy wound care with dressing changes and shift as PNR • Coumadin monitoring	**192**	**Per diem**
Level III	**In addition to services in Levels I or II above, and at one or more item below:** • Rehabilitative treatments, greater than 2.1 hours daily, up to six days per week (PT, OT or Speech Therapy) or greater than 720 minutes • Tracheostomy care and teaching • Pulse oximetry and ABGs PRN • Meter dose inhalers, side arm nebs for bronchodilation • Wound management-complex (dehiscence, debridement, burns and wound suction) Stage lll or IV at least two times daily • TPN administration • IV antibiotics greater than two times day • Continuous oxygen with tracheotomy • Tracheotomy care • Skilled nursing with bariatric care (>400lbs)	**193**	**Per diem**

Level	Description	Rev code	Rate type
Level IV	**In addition to Levels I, II or III above (pages 39-40) and at least one or more of item(s) below:** • All infectious disease diagnoses requiring isolation • IOU Levels of Care, including but not limited to, vent care • Peritoneal dialysis performed skilled center and not billed by a separate entity • Brain injury • Spinal cord injury	**194**	**Per diem**

2. CMA appeal day

Additional inpatient days resulting from an appeal for Medicare reconsideration request by the Center for Medicare Advocacy, Inc. (CMA).

Rev code	Rate type
190	Per diem

3. High-cost medication

High-cost medication (which includes TPN) that exceed $125 per medication per day, or three medications that combined exceed $240 per day and are covered services on a case-by case basis. These thresholds are calculated by dividing the cost of the drug(s) by the number of skilled days authorized.

High-cost medication covered services must be approved in advance of the member's admission to facility. Any high-cost medications that are covered services, that occur after the member's admission to facility, shall require prior approval of Optum before the member is discharged from the facility. High-cost medications shall be paid at the average wholesale price of the drug, minus 20%, less any applicable member copayments.

The following must be included on the claim:

- **Revenue code 636**
- **Name of medication and NDC#**
- **HCPC code**
- **Dosage**

See Appendix 1 for list of medications.

4. Separately reimbursable covered services

OCNCT will separately reimburse facility as indicated in table below for the separately reimbursable covered services that (a) facility renders and has billing responsibility and (b) are listed in table below.

If more than one type of separately reimbursable covered service listed in table below is provided to a member during one calendar day, the applicable contract rate for each separately reimbursable covered service will be considered in calculating the aggregate contract rate.

Service category	Rev code	CPT codes	HCPCS codes	Payment method
Annual vaccination – Influenza	0636	90654-90698	Q2034-Q2039	Per unit via CMS fee schedule
Annual vaccination administration – Influenza	0771		G0008	Per unit via CMS fee schedule
Annual vaccination – Pneumococcal	0636	90732/90670		Per unit via CMS fee schedule
Annual vaccine administration – Pneumococcal	0771		G0009	Per unit via CMS fee schedule

5. Specialty pharmacy claims

Appropriate National Drug Code (NDC) number and the corresponding quantity for each NDC unit dispensed. Claims submitted for payment must also include the appropriate HCPC/CPT code and the corresponding quantity for each HCPC/CPT unit dispensed. Reimbursement may be denied if claim does not list NDC and HCPC/CPT code and quantity detail.

6. Outpatient services

Service category	Rev codes	Payment method
Physical therapy	0420-0424, 0429	Per visit
Occupational therapy	0430-0434, 0439	Per visit
Speech therapy	0440-0444, 0449	Per visit

Definitions

Bariatric skilled nursing services
Skilled nursing services for a bariatric patient. A bariatric patient is a member who has a physician-determined and measured body mass index (BMI) of at least 40 which has been documented by the physician in the facility medical record. Bariatric skilled nursing services can only be provided by skilled nursing facilities with the personnel and specialty equipment, including, but not limited to, bariatric beds, patient lifts, bedside commodes and wheelchairs to provide for the safety of the bariatric patient.

Covered service
A CMA appeal day or health care service or product for which a member is entitled to receive coverage from a payer, pursuant to the terms of the member's benefit plan with that payer.

Custodial care
Domiciliary care, respite care, rest care, private duty nursing or other non-health services such as assistance in activities of daily living.

Institutional claim
Any UB-04 or electronic version or successor form.

Per diem
The payment method designated "per diem" in this appendix and applicable to covered services rendered to a member for each day of an admission of a member. Unless otherwise specified in this appendix, payment under the per diem payment method, less any applicable member expenses, will be considered payment in full for all covered services rendered to the member during each day of the admission including, but not limited to:

- Physician and other professional fees and services rendered by non-physician personnel billed by facility on an institutional claim
- Nursing care
- Respiratory care (services and supplies), diagnostic and therapeutic services (including, but not limited, to laboratory services and diagnostic imaging)
- Ancillary services
- Pain management
- Medications
- Fluids
- IVs including the poles, pumps, diluents (the agent that dilutes the substance or solution to which it is added) and solutions (the agent or vehicle that delivers the active drug ingredient)
- Parenteral nutrition, tube feedings and all associated supplies (including, but not limited to, pump, pole and pump sets)
- Durable medical equipment
- Room and board

Except per diem does not include payment for separately reimbursable covered services or high-cost medications.

Payment per unit via fee schedule
The payment method designated "per unit via fee schedule" in this appendix, based on the CPT/HCPCS specific fee listed in the applicable fee schedule for each unit of service and applicable to covered services rendered to a member for services performed for which a per unit via fee schedule payment method is indicated in this appendix. The number of units for each procedure or service rendered will be billed in accordance with the guidelines in the latest edition of the Current Procedural Terminology (CPT) manual as published by the American Medical Association or the latest edition of the HCPCS manual as published by the Centers for Medicare and Medicaid Services (CMS). Unless otherwise specified in this appendix, payment under the per unit via fee schedule payment method, less any applicable member expenses, will be considered payment in full for all covered services rendered to the member including, but not limited to, physician and other professional fees and services rendered by non-physician personnel (regardless of whether those personnel are employed by facility and regardless of whether those services are characterized as professional services) billed by facility on an institutional claim, nursing care, diagnostic and therapeutic services, durable medical equipment, supplies, medications, and facility and ancillary

services. The units reported for covered services for which the contract rate is a per unit via fee schedule must always equal the number of times a procedure or service is performed.

Per visit

The flat rate payment method designated "per visit" in this appendix and applicable to covered services rendered to a member on one calendar day period (regardless of the number of modalities/units of service or visits per day), for each service category for which a per visit payment method is indicated in this appendix. Unless otherwise specified in this appendix, payment under the per visit payment method, less any applicable member expenses, will be considered payment in full for all covered services rendered to the member including, but not limited to:

- Physician and other professional fees and services rendered by non-physician personnel (regardless of whether those personnel are employed by facility and regardless of whether those services are characterized as professional services) billed by facility on an institutional claim
- Nursing care
- Diagnostic and therapeutic services
- Durable medical equipment
- Supplies
- Medications
- Facility and ancillary services

Facility is required to identify each date of service when submitting claims spanning multiple dates of service.

Monitoring

Notice of Medicare Non-Coverage (NOMNC) monitoring

1. Quarterly, the utilization management (UM) medical management team will review the percentage of correct versus incorrect Notice of Medicare Non-Coverage (NOMNC) and will review the Skilled Nursing Facility (SNF) scores.
2. A score of less than 95% will result in a monthly monitoring and a request for a corrective action plan by the SNF.
3. Persistent performance score below 95% will result in further disciplinary action which could include removal from the network.

Complaint-based monitoring

1. Quarterly, a report will be run by quality improvement (QI) identifying all SNFs with greater than two timeliness issues in opening cases or issues and/or complaints.
2. For those with two or more timeliness issues in opening cases or complaint issues per quarter, the following will occur:
    a. SNF will develop a corrective action plan and share the plan with Optum Care Network–Connecticut UM medical management team.
    b. QI will distribute results of above to the chief operating officer (COO), executive committee (EC), and quality improvement committee (QIC) if the SNF has two or more timeliness issues of opening cases or complaint issues within the next two quarters the physicians executive committee will develop corrective actions, when indicated, and forward to QI.
3. The QIC will continue to monitor, track and trend.

Rehospitalization rates

1. On a quarterly basis, rehospitalization rates will be reviewed. The target is a 15% 30-day all-cause readmission rate or less for the members assigned to Optum Care Network–Connecticut. Rehospitalization rates will be discussed during the quarterly joint operating committee (JOC) meeting.

Communication

Mutual agreement

At time of admission:

- Communication of member information
- Medication reconciled
- Life plan (set care and life goals of care including advanced care planning)
- Palliative care and hospice referral, if appropriate
- Establish goal for length of stay (LOS) (Medicare 20th percentile)

During stay:

- Communicate with Optum Care Network–Connecticut UM team and SNF clinical team
- Provide effective and efficient care that minimizes rehospitalizations
- Goal monitoring and length of stay optimization

Member discharge:

- Member's life plan finalized and approved
- Communication of discharge plan
- Appropriate preferred home care and durable medical equipment (DME) referral
- Medication reconciled

Quarterly joint operating committee (JOC) meetings with SNF and Optum Care Network–Connecticut management

Expectations

Optum Care Network–Connecticut	Skilled Nursing Facility
• Inform facility re: member/family goals • Inform member/family of goals and anticipated LOS for SNF visit using MCG criteria • Collaborate and communicate with hospitals re: preferred networks • Discuss member's life plan with family; when appropriate, discuss hospice with member and member's family • Participate with member care team round	• Interface Patient Ping within 16 weeks of signing compact • Manual use of Member Ping; enter/discharge all members in Member Ping within 24 hours • Educate on-call physicians and ED staff regarding the facilities' capabilities • Standardize report to on-call physician on member status (SBAR) Participate with member care team rounds • Discuss member life plan • Complete end-of-life documentation for all members • Complete capabilities matrix to be distributed to on-call staff and the ED • Utilize real-time or recommended notification tool

Access	
Mutual agreement	
Collaborate to manage the member's length of stay (LOS) set at the Medicare 20th percentile	
Expectations	
Optum Care Network–Connecticut • Medical director/PCPs communicate with UM nurse to determine clinically appropriate length of stay • Indicate continued need for SNF stay reviewed internally at least weekly • Medical director/PCP will work with the facility to make sure the members are discharged from the facility in a timely manner after a clinically appropriate stay	**Skilled Nursing Facility** • Provide members transitioning home with appropriate ADLs and supplies • Work collaboratively with the Optum Care Network–Connecticut utilization nurse manager reviewing Optum Care Network–Connecticut member charts to ensure goals for LOS being met • Provide up-to-date information on member status changes to the Optum Care Network–Connecticut UM nurse • Inform Optum Care Network–Connecticut utilization nurse manager of any ED or hospital visit

Collaborative care management

Mutual agreement

- Confirm goals set at admission for member are being met
- Define actions to be taken when standards of care are not met
- Define responsibilities between PCP, medical director, Optum Care Network–Connecticut medical director, advanced practice registered nurse (APRN) on-call service (if applicable), SNF and members
- Agree on member care plan, and probable discharge date as well as member's life plan
- Work with the member's care team to determine clinically appropriate course of treatment and location of treatment
- Collaborate to keep the member's care team informed of changes in the member's condition
- Build a two-way communication pathway with the member's care team

Expectations

Optum Care Network–Connecticut

- Accept and engage with the SNF on pre-ED transfer calls
- Educate all on-call staff on area SNF capabilities
- Accept and engage hospital ED staff in pre-ED admission call
- Utilization manager to complete medication reconciliation
- Education will be provided on proper use of Patient Ping software
- Optum Care Network–Connecticut UM team to provide acute care discharge summary as well as acute care medical record to SNF clinical team

Skilled Nursing Facility

- Complete member home evaluation within 72 hours of admission to SNF when warranted; determine what level of ADLs/DME might be needed
- 72 hours prior to discharge, perform urinalysis C&SA on Optum Care Network–Connecticut members who are high risk and/or had a recent hospitalization with history of UTI; share results with UM and director of medical management
- Supply Optum Care Network–Connecticut and all affected EDs with a SNF capabilities matrix
- Complete the pre-ED transfer document
- Work with Optum Care Network–Connecticut preferred homecare agencies to invite the homecare agency into the SNF to meet with the member prior to discharge
- Collaborative approach with UM, PCP and home care to determine appropriate plan of care for member while within the facility and determine appropriate functional discharge goals
- Collaborative approach with member's family to provide a safe discharge when appropriate functional status is met
- Provide exceptional medical care
- When transferring member to ED, send SBAR form with member.

Transition of care

Mutual agreement

- Agree on discharge plan and member's life plan
- Maintain accurate and up-to-date member clinical information
- Jointly standardize demographic and clinical information in an acceptable format
- Ensure safe and timely oversight of care transition for the member
- Utilize preferred networks for home care and/or hospice

Expectations

Optum Care Network–Connecticut

- Review with member anticipated SNF LOS and any changes from admission-anticipated LOS
- Have PCP appointments available for the member's discharge follow-up appointment within seven days

Skilled Nursing Facility

- Educate local hospital of ability to re-admit a member back to the SNF within 30 days
- Upon discharge, facility transfer, or death communicate via Patient Ping of change in status to facilitate transitions in care handoff
- Supply the member with enough medication for 48 hours and prescriptions for necessary narcotics
- Utilize preferred home care network with warm/safe handoff

Quality of member care

Mutual agreement

- Provide quality member care to each member
- Measures from CMS and utilization data will be mutually reviewed annually on performance

Expectations

Optum Care Network–Connecticut

- Work with SNF clinical team to assist as needed

Skilled Nursing Facility

- Work toward prevention of hospital readmissions and non-emergent emergency room visits while under the care of the SNF

Optum Care Network–Connecticut
3 Farm Glen Boulevard
Farmington, CT 06032

Skilled Nursing Facility (SNF) planned discharge disposition

As of the day of the Notice of Medicare Non-Coverage (NOMNC) is delivered
Please send this form to Optum Care Network–Connecticut on the day that the patient receives the NOMNC. If needed, information in this form is used in the CMS Detailed Explanation of Non-Coverage (DENC) letter, which is delivered to the patient. Please avoid using abbreviations.

SNF name:
Patient name:
Date of birth:
Date of admission:
Admission diagnosis:
Prior level of functioning:
Planned discharge date:
Planned discharge disposition:
Current functional or medical needs on day of Notice of Medicare Non-Coverage (NOMNC) letter is delivered.

- Bed mobility:
- Sit to stand:
- Transfers:
- Ambulation:
- Toileting:
- Weight-bearing status:
- Wound care status:
- IV therapy status:
- Other skilled need status:
- Is patient able to participate in therapy?

Skilled services are no longer indicated based on (check one):

_____ Therapy completed
_____ Unable to participate in therapy
_____ Therapy may be continued at a lower level of care

Fax: 1-888-999-1604

Optum Care Network–Connecticut
3 Farm Glen Boulevard
Farmington, CT 06032

Date

Dear (Executive Director Name),

Optum Care Network–Connecticut (OCNCT) recently completed an audit of the Notice of Medicare Non-Coverage (NOMNC) documents from your facility. Documents reviewed were for Skilled Nursing Facility (SNF) discharges in Quarter 1, 2018. The finding for your facility are as follows:

Number of NOMNCs reviewed	
Number of NOMNCs compliant	
Number of noncompliant NOMNCs	
Score	

Issues identified:

1. Xyz
2. Xyz

It is our expectations that (insert facility) will implement processes to correct these deficiencies going forward.

OCNCT continues to monitor NOMNCs on an ongoing basis and will provide reports quarterly.

Please send any questions to **ocnct@optum.com.**

Regards,

Medical management team

SNF Notice of Medicare Non-Coverage (NOMNC) and Detailed Explanation of Non-Coverage (DENC) process meeting agenda

1. Introductions
2. Authorization for admission
    a. Must call Optum Care Network–Connecticut Prior Authorization for authorization number within 24 hours of patient arrival
        i. Saturday/Sunday admissions have until 5 p.m. Monday
        ii. Telephone number: **1-888-556-7048**
3. Policies
    a. Appointment of Representative (AOR)/Power of Attorney (POA)
    b. Electronic release of PHI
    c. Weekend coverage for DENCs
4. Review of CMS instructions for completing NOMNC
    a. New instructions as of January 2018
    b. Valid notice delivery
    c. Notice delivery to incompetent enrollees in an institutional setting
5. Review of NOMNC critical elements
    a. Logo
    b. Correct form
        i. Must include the ACA 1557 declaration
    c. Coverage end date
    d. Plan contact information
    e. Additional Information elements
        i. Mailing NOMNC if verbal notice
            1. Must be mailed even if family requests a copy be left in room
    f. Signature
    g. Date
6. Review of DENC form
    a. Additional page for ACA 1557 declaration
    b. Timeliness of delivery
        i. Weekend delivery
    c. DENC must be given to same person to whom the NOMNC was given
7. DENC delivery verification form
    a. Documents NOMNC and DENC given to same person
    b. Signed by staff
    c. Fax back to Optum Care Network–Connecticut at **1-888-999-1604**
        i. Payment may be pended if form not received

SNF NOMNC and DENC requirements training attendance form

Skilled Nursing Facility name_____ Date _____

By signing below, I acknowledge I have received education regarding the Optum Care Network–Connecticut NOMNC and DENC process including required time frames and weekend delivery.

Name	Title

Appendix 1

Examples of high-cost medications

- Advent
- Afinitor
- Aldurazyme
- Apokyn
- Avastin
- Bexarotene
- Bosulif
- Chemotherapy
- Cinryze
- Cubicin
- Cuprimine
- Daklinza
- Daraprim
- Dificid
- Elaprase
- Erivedge
- Exjade
- Eylea
- Ferriprox
- Firazyr
- Gammagard liquid
- Gamunex-C
- Gattex
- Gleevec
- HIV medications
- HP Acthar
- Harvoni
- Hetlioz
- Humira pen – Crohn's disease
- Ibrance
- Iclusig
- Ilaris
- Imbruvica
- Increlex
- Inlyta
- Jadenu
- Jakafi
- Juxtapid
- Kalydeco
- Kuvan
- Lazanda
- Lenvima daily dose
- Lynparza
- Mekinist
- Myalept
- Naglazyme
- Neulasta
- Nexavar
- Olysio
- Opdivo
- Orenitram
- Orkambi
- Pomalyst
- Privigen
- Procysbi
- Prolastin-C
- Promacta
- Ravicti
- Revlimid
- Rituxan
- Sabril
- Samsca
- Serostim
- Soliris
- Sovaldi
- Sprycel
- Stivarga
- Subsys
- Supprelin LA
- Sutent
- Syprine
- Targretin
- Tasinga
- Tetrabenazine
- Thalomid
- Thiola
- TPN medications
- Tyvaso refill
- Viekira Pak
- Vpriv
- Xalkori
- Xenazine
- Xtandi
- Xyrem
- Zolinza
- Zykadia
- Zyvox

Medicare compliance expectations and CMS fraud, waste and abuse training: FDRs

As part of an effective Compliance Program, CMS requires Medicare Advantage (MA) organizations and Part D plan sponsors, including Optum Care Network–Connecticut, to annually communicate specific compliance and fraud, waste and abuse (FWA) requirements to their "first tier, downstream, and related entities" (FDRs), which include contracted physicians, health care professionals, facilities and ancillary providers, as well as delegates, contractors, and related parties.

The required education, training, and screening requirements to which we — and you — are subject include the following:

Standards of conduct awareness: FDRs working on Medicare Advantage and Part D programs — including contracted providers — must provide a copy of their own or the UnitedHealth Group (UHG) code of conduct (**unitedhealthgroup.com/~/media/UHG/PDF/About/UNH-Code-of-Conduct.ashx?la=en**) to their employees (including temporary workers and volunteers), the CEO, senior administrators or managers, governing body and subdelegates who have involvement in or responsibility for the administration or delivery of UnitedHealthcare MA, other MA plan sponsor or Part D benefits or services within 90 days of hire and annually thereafter (by the end of the year).

What you need to do for standards of conduct awareness: Provide your own or the UHG's code of conduct as outlined above, and maintain records of distribution standards (i.e. in an email, website portal or contract, etc.) for 10 years. Documentation may be requested by Optum, UnitedHealthcare, or other Medicare Advantage plan sponsor or CMS to verify compliance with this requirement.

Fraud, waste, and abuse and general compliance training: FDRs working on Medicare Advantage and Part D programs — including contracted providers — must provide CMS Fraud, Waste, and Abuse (FWA) and General Compliance training within 90 days of employment and annually thereafter (by the end of the year) to their employees (including temporary workers and volunteers), CEO, senior administrators or managers, and subdelegates who have involvement in or responsibility for the administration or delivery of UnitedHealthcare, or other Medicare Advantage plan sponsor MA or Part D benefits or services.

Effective January 1, 2016, CMS has amended the regulations to mandate only the use of CMS published training materials by FDRs of a contracted Medicare plan sponsor. FDRs cannot alter the published CMS training material content; however, CMS will allow FDRs to download CMS training material and add content and topics specifics to your organization.

FDRs meeting the fraud, waste and abuse (FWA) certification requirements through enrollment in the fee-for-service Medicare program or accreditation as durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) provider, are deemed by CMS rules to have met the training and education requirements.

It is the health plan's responsibility to make sure that your organization has access to appropriate training. To facilitate that, we are providing you information on the CMS Parts C and D FWA and General Compliance training module. This module is available on the CMS Medicare Learning Network® at **cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Fraud-Waste_Abuse-Training_12_13_11.pdf**.

What you need to do for FWA and compliance training: Administer FWA and general compliance training as outlined above and maintain a record of completion (i.e., method, training materials, dated employee sign-in sheet(s), attestations or electronic certifications that include the date of the training) for 10 years. Documentation may be requested by Optum, UnitedHealthcare, other Medicare Advantage plan sponsors, or CMS to verify compliance with this requirement.

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/~/media/UHG/PDF/About/UNH-Code-of-Conduct.ashx?la=en**. Optum expressly prohibits retaliation if a report is made in good faith.

Optum Care Network–Connecticut 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–Connecticut.

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 Optum Care Network–Connecticut. 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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