Optum Care Network – New York

2023 Provider administrative manual

Optum

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Welcome to
Optum Care Network – New York

Provider administrative manual

Dear Provider,

Thank you for becoming a participating provider with Optum Care IPA of New York. As our partner in value- based care, we will work together to provide affordable, high-quality health care to your patients and help them live their best lives. Our goal is to let you focus on the practice of medicine first and foremost and focus on your own wellbeing.

The Optum Care IPA gives your practice the support of a health care industry leader while you remain independent and able to make your own decisions. Our national team of doctors will link your care with the latest evidence-based breakthroughs. And our local support team offers readily available resources to help you deliver exceptional care to your patients.

Attached herein is the provider manual offering valuable information about the Optum Care IPA of New York and how we will partner most effectively. The manual is a user-friendly reference guide and educational resource for both you and your staff.

Visit our home page optumcare.linkplatform.com/home to review our secure provider portal. The provider portal conveniently enables you to verify eligibility, claims status, submit, and review authorizations, and review any medical inquiries.

The staff at Optum Care IPA of New York will work collaboratively with you to create a positive experience for your staff and your patients. For comments, questions, or suggestions on any of the materials, please feel free to the contact the Optum Care IPA staff.

Sincerely, Peter

J. Kelly

President, Optum Care IPA of New York

Chief Value Officer, Optum Tri-State Region

Provider manual overview and delegation defined

Provider manual overview

This provider manual is an extension of your participation agreement. It includes important information for providers, facilities and practice staff regarding policies, procedures, claims submissions and adjudication requirements, and guidelines used to administer plans. The provider manual is updated on a recurring basis and this provider manual replaces and supersedes all previous versions.

As per your participation agreement, all providers and facilities are to comply with CMS and health plan policies and procedures, including, but not limited to those listed herein. Please refer to health plan provider manuals for specific policies and procedures when applicable.

As policies and procedures change, updates will be incorporated into this electronic version of the provider manual.

Any requirements under applicable law, regulation or governmental agency guidance that are not expressly set forth in this provider manual shall be incorporated herein by this reference and shall apply to providers, facilities, Health plans and/or company where applicable. Such laws and regulations, if more stringent, take precedence over this provider manual. Providers and facilities are responsible for complying with all applicable laws and regulations.

Delegation defined

Delegation is the formal process or contract granting an enterprise authority to execute specific functions on behalf of an organization. In the case of Optum Care IPA of New York (OCNY), it refers to health plans. Ultimately, the health plan is the responsible party. As the delegating party, the health plan must remain apprised of the delegate's actions, ensuring adherence to compliance standards.

In full delegation, this translates to providing services on behalf of the mentioned plans to provide care management services, administer utilization management, and adjudicate claims for providers among other services. OCNY has additional plan relationships that serve to delegate specific functions of health plan work.

Please contact your Network Contracting representative or Practice Performance Manager if you have additional questions.

OCNY main number:

General information

- **Hours:** 8 a.m. - 8 p.m. Monday through Friday ET
- **Phone:** 1-866-565-3468 effective Jan. 1, 2022

OCNY resources:

General information

Website: optum.com/business/hcp-resources.html

Website address:

OCNY directory search (provider, facilities)

Website: optum.com

Provider portal:

Website: providers.optumcaremw.com

Customer service:

Eligibility, claims, authorization status, general billing questions

- **Hours:** 8 a.m. - 8 p.m. Monday through Friday ET
- **Phone:** 1-866-565-3468 effective Jan. 1, 2022

Prior authorization intake:

- **Hours:** 7 a.m. - 5 p.m. Monday through Friday ET
- **Phone:** 1-866-565-3468 effective Jan. 1, 2022
- **Fax:** 1-855-248-4063 effective Jan. 1, 2022

Optum Care claims submission address:

- **Mail:** Optum Care Network Claims, P.O. Box 30539, Salt Lake City, UT 84130
- **Electronically:** Payer ID LIFE1 or use your clearinghouse's Optum Care Network payer ID

Claim disputes:

You may submit claim disputes:

- **Phone:** 1-888-685-8491
- **Online:** Download Provider Dispute Resolution Form from Optum Care Website: **optum.com**
- **Mail:** Optum Care Network Claims, P.O. Box 30539, Salt Lake City, UT 84130

Additional resources contact information

Healthcare Coordination:
Pre-authorization, hospital pre-notification, emergent admission, case management
Hours: 7 a.m. - 5 p.m. Monday through Friday ET
Phone: 1-866-565-3468 effective 1/1/2022
Fax: 1-855-248-4063 effective Jan. 1, 2022

Credentialing:
*Refer to your Payer Provider Manual

Provider Data Management:
Jessica Perez (jessperez@caremount.com)

Practice Performance Managers: Email to be provided based on PPM assigned to your practice

Network Contracting
Julie Baker (jubaker@caremount.com)
Josh Dingess (jdingess@caremount. com)

Provider/Payer Relations:
Cheryl Piskutz (cpiskutz@caremount.com)

Practice engagement

Each OCNY provider group is assigned a Practice Performance Manager (PPM). Your Practice Performance Manager, together with their network medical director partner, work to help you succeed in 5-Star quality, patient experience, risk adjustment, care management, affordability, contracting, and growth. The PPM is responsible for provider performance management which is tracked by designated provider metrics, inclusive minimally of 4 STAR gap closure and coding accuracy.

Practice Performance Manager responsibilities

Primary Single Point of Contact with Clinic

- Partners with clinic leadership to strive for optimal performance in quality, accurate risk adjustment, and affordability initiatives to improve long-term clinical outcomes while lowering the total cost of care
- Lead and schedule meetings with practice representative and/or provider
- Care management service coordination
- Updates clinics on new wrap around services
- Communicates incentive program elements and achievements
- Resolves and escalates concerns (Claims issues/processes, etc.)

Analytics & performance management

- Ensures clinic has all data and analytics to ensure success in patient care delivery
- Delivery of monthly QIP performance reporting packets
- Attestation points of care tool delivery and tracking
- Dashboard performance and incentive reporting
- Create strategy and action plans for targeted provider groups to increase healthcare delivery, star ratings, and maximize on gap closures

Training/education

- Assess and coordinate training needs (e.g., Provider Portal Training, Attestation completion, CAHPS/HOS member experience)
- Primary Care Provider (PCP), staff, and clinic administrator education on risk adjustment, quality, and affordability
- Provide ongoing strategic recommendations, training and coaching to provider groups on program implementation and barrier resolution

Member focus

- Member eligibility issues/resolution
- Wraparound services utilization, education, and tracking, sharing best practices to improve CAHPS / HOS member experience

Credentialing

Credentialing refers to the process performed by the health plan to verify and confirm that an applicant meets the established policy standards and qualifications for consideration in the OCNY Network.

Providers joining your practice

Unless the practice has a credentialing sub-delegation arrangement in place with the HealthPlan, all providers joining an existing practice must complete the health plan's credentialing process. Until such time as the provider has successfully completed the credentialing process, claims may not be reimbursed appropriately and/or denied payment. Once provider has been successfully credentialed through the health plan, an updated roster must be sent to OCNY to appropriately process claims. Contact your health plan Credentialing
department and OCNY provider data department at least 60 days prior to your new provider seeing patients to minimize any reduction or denial of payment.

Health plan credentialing

Health plan will retain the credentialing for network providers in 2023. Please refer to the UnitedHealthcare and Humana health plan provider manuals for:

- Types of providers credentialed
- Facilities adding location(s)
- Type of facilities
- Sub-delegation of credentialing
- Recredentialing
- Corrective Action
- Provider/facility rights
- Changes to your practice/facility
- Termination of participation
- Closing your practice

Closing your practice

Closing your practice due to retirement or business considerations is a complex undertaking. OCNY would like to support you in locating resources for your transition and identifying actions needed. The process can be very different for primary care providers and specialists. Please utilize your resources with OCNY by contacting your Practice Advocates to assist in planning the logistics. The table below provides a start in preparing for such a change.

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

Contracting

OCNY's Provider and Facility Participation Agreements allow OCNY to contract with health plans as a risk bearing entity and to take delegation of services. Please refer to your agreement for specifics. Please refer to the Credentialing section to determine eligibility to participate.

OCNY holds the following full delegation payer partnerships in 2023:

Health plan entity name	Market product name	Plan type
Care Improvement Plus South-Central Insurance Co. (UnitedHealthcare)	AARP Medicare Advantage Plans: •Mosaic Choice •Value Care •Premier Choice •Choice	Local PPO
UnitedHealthcare Insurance Company of New York (UnitedHealthcare)	United Healthcare Medicare Advantage Plans: •Patriot •Choice Plan 1 •Choice Plan 3 •Choice Plan 4	Regional PPO
Health plan entity name	**Market product name**	**Plan type**

Oxford Health plans (NY), Inc. (UnitedHealthcare)	AARP Medicare Advantage Plans •Medicare Advantage Plan •Medicare Advantage Plan 1 •Medicare Advantage Plan 2 •Medicare Advantage Prime •Medicare Advantage Patriot	HMO-POS
UnitedHealthcare of New York, Inc. (UnitedHealthcare)	AARP Medicare Advantage Plans: •Medicare Advantage Plan •Medicare Advantage Plan 2 •Medicare Advantage Value Care	HMO-POS
Humana Insurance Company of New York	Humana Choice Partnered (PPO)	Local PPO
CMS Traditional Medicare (Part C)	ACO REACH Model	ACO REACH

This list is subject to change. Please refer to the Claims section, the Credentialing and Contracting Crosswalk in the appendix or contact your Practice Performance Manager for details.

For OCNY attributed members, your OCNY participation agreement will supersede your direct health plan agreement.

Provider Data Maintenance

All OCNY network participants must be identified by individual or entity name, TIN, individual NPI, organizational NPI, and CCN (if applicable). All OCNY network participants must submit a signed W9 form to complete network participation. Failure to submit a signed W9 form may result in claims not reimbursing appropriately and/or denied payment as well as delays in quality incentive payments. Please reach out the OCNY Provider Data Management Team with any questions or concerns related to updating practice information.

Providers are permitted to add/delete individual practitioners throughout the calendar year to ensure OCNY retains the most accurate reflection of participating providers. To satisfy program requirements, the following data points must be provided when adding or for requests to delete providers:

- Provider Full Name
- Provider Title (MD, DO, NP, etc.)
- Provider NPI
- Provider Specialty (Follow Taxonomy List Provided by OCNY)
- Provider TIN
- Group NPI
- Legal Provider Name
- Primary Address (Street, State, Zip)
- Primary Address Phone Number
- Primary Address Fax Number
- Remittance Address (Street, State, Zip)
- Tax Address (Street, State, Zip)

For providers who either join or depart a practice, OCNY requires notification of the provider's addition or deletion within 30 days of the occurrence to maintain compliance with program policies and procedures.

Eligibility and claims processing

Eligibility

The eligibility department receives member information from the health plans on a daily basis. Once this information has been received, it is loaded electronically into the system. This information is reviewed by the eligibility department staff to ensure that the eligibility data matches the information submitted by the health plans. Information is being constantly updated and revised as it is provided to Optum Care by the health plans.

Claims processing

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

Payer plans (H contracts - PBPs)	Submit to	Claims submission information
AARP Medicare Advantage LPPO Plans: •Mosaic Choice (H3418-001) •Value Care (H3418-002) •Premier Choice (H3418-003) •Choice (H3418-004) (H3418-005) (H3418-006) (H3418-007) (H3418-008) **UnitedHealthcare Medicare Advantage RPPO Plans:** •Patriot (R5342-002) •Choice Plan 1 (R5342-001) •Choice Plan 3 (R5342-005) •Choice Plan 4 (R5342-006) **AARP Medicare Advantage HMO Plans** •Medicare Advantage Plan (H3307-025) •Medicare Advantage Plan 1 (H3307-002) (H3307-012) •Medicare Advantage Plan 2 (H3307-023) •Medicare Advantage Prime (H3307-015) •Medicare Advantage Patriot (H3307-018) **AARP Medicare Advantage Plans:** •Medicare Advantage Plan (H3379-039) (H3379-040) (H3379- 041) (H3379-045) (H3379-046) •Medicare Advantage Plan 2 (H3379-001) •Medicare Advantage Value Care (H3379-043)	OCNY	**Electronic Claims:** Payer ID# LIFE1 **Clearing House:** Optum 360 **Paper Claims:** PO Box 30781 Salt Lake City, UT 84130-0781
Payer plans (H contracts - PBPs)	**Submit to**	**Claims submission information**

Humana Insurance Company of New York •Humana Choice Partnered (H5970-025) (H5970-027)	OCNY	**Electronic Claims:** Payer ID# LIFE1 **Clearing House:** Optum 360 **Paper Claims:** PO Box 30781 Salt Lake City, UT 84130-0781
CMS Direct Contract Model (ACO REACH) •Medicare Fee for Service	CMS	* Follow existing CMS claim submission process

Claims processing

For all payers listed above, Claims should be submitted electronically to LIFE1. Paper claims, though not preferred, can be mailed to:

OCNY Paper Claims:

PO Box 30781

Salt Lake City, UT 84130-0781

OCNY Electronic Claims:

Payor ID#: LIFE1

Clearinghouse: Optum 360

Reimbursement

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

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

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

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

Charging members

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

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

Clinical Claims Review (CCR)

Clinical records may be requested for further review by our Clinical Claims Review (CCR) department in order to determine if a service is considered medically necessary. These determinations are based on review of the member's medical information that supports the need for a particular service. These determinations are based on standard medical necessity guidelines.

Electronic Funds Transfer (EFT)

OCNY supports claims payments via electronic remittance advice (ERA) and electronic funds transfer (EFT) via InstaMed. ERA/EFT is a convenient, paperless, and secure way to receive claim payments. Funds are deposited directly into your designated bank account and include the TRN Reassociation Trace Number, in accordance with CAQH CORE Phase III Operating Rules for HIPAA standard transactions.

If you have not already set up your InstaMed account, please go to register.instamed.com/eraeft to register or contact InstaMed Customer Service via telephone or email.

Toll Free Telephone:

1-866-INSTAMED or 1-866-467-8263

Email:

support@instamed.com

Help Portal:

help.instamed.com/providers/s/

Training Tools:

instamed.com/support/providers

Provider dispute resolution process

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

Definition of a provider dispute

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

Sending a provider dispute to Optum Care

Contracted providers must use the provider dispute resolution form which can be downloaded from the Optum Care Website: **optum.com**. The provider dispute resolution form must be completed in full and included with the dispute.

All provider dispute resolution forms can be sent:

- By mail: Optum Care Provider Dispute Resolution P.O. Box 30781 Salt Lake City, UT 84130
- By fax: **1-866-565-3468**
- By email: **ocTSMWDispute@optum.com**

Time period of submission of provider disputes

Contracted providers disputes must be received by Optum Care within 365 calendar days from the action of Optum Care such as the initial date of the remittance explanation of payment. Any inquiries regarding status of provider dispute or about filing a provider dispute, please call the provider dispute resolution unit at **1-866-565-3468**.

Releasing a patient from your practice

Please refer to the UnitedHealthcare and Humana HealthPlan provider manuals for releasing a patient from your practice.

Patient re-assignment

Optum Care Network manages patients assigned to primary care providers (PCPs) for Humana Medicare Advantage HMO, AARP Medicare Advantage HMO through UnitedHealthcare (UHC MA). In some cases, patients may be assigned to your practice in error. When this occurs, the HealthPlan must be notified, and assignment must be corrected in their system(s). Patients who have not been seen by your practice but have been assigned to you should not be re-assigned to another primary care provider unless that patient has initiated the process. See also Population Health.

For Humana patients:

- Patients can call Humana customer service number on the back of their ID card to request a different PCP, or
- Complete a PCP change form and fax to Humana.

For UHC MA patients:

- Patients should call the UHC customer service number on the back of their ID card to request a different PCP.

Compliance

Medicare compliance expectations and training

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

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

We have general compliance training and FWA resources available at **unitedhealthgroup.com**. The required education, training, and screening requirements include the following:

Standards of conduct awareness

What you need to do

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

Fraud, waste, and abuse and general compliance training

What you need to do

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

Exclusion checks

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

What you need to do

Make sure potential employees are not excluded from participating in federal health care programs. For more information or access to the publicly accessible excluded party Online databases, use the following links:

- Health and Human Services - Office of the Inspector General OIG List of Excluded Individuals and Entities (LEIE) at oig.hhs.gov/.
- General Services Administration (GSA) System for Award Management at sam.gov/sam.

Review the exclusion lists every month and disclose to Optum Care IPA of NY any exclusion or any other event that makes an individual ineligible to perform work directly or indirectly on federal health care programs. Maintain a record of exclusion checks for 10 years. We, our plan sponsors, or CMS, may request documentation of the exclusion checks to verify they were completed.

Preclusion list policy

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

- Are revoked from Medicare, are under an active re-enrollment bar, and CMS has determined that the underlying conduct that led to the revocation is detrimental to the best interests of the Medicare program; or
- Have engaged in behavior for which CMS could have revoked the prescriber, individual or entity to the extent possible if they had been enrolled in Medicare and that the underlying conduct that would have led to the revocation is detrimental to the best interests of the Medicare program.
- Have been convicted of a felony under federal or state law within the previous 10 years and that CMS deems detrimental to the best interests of the Medicare program.
- Care providers receive a letter from CMS notifying them of their placement on the preclusion list. They can appeal with CMS before the preclusion is effective. There is no opportunity to appeal with Optum Network–Colorado or the plan sponsor. CMS updates the preclusion list monthly and notifies MA and Part D plans of the claim rejection date, the date upon which we rejector deny a care provider's claims due to precluded status. Once the claim-rejection date is effective, a precluded care provider's claims will no longer be paid, pharmacy claims will be rejected, and the care provider will be terminated from the Optum Network–Colorado. Additionally, the precluded care provider must hold Medicare beneficiaries harmless from financial liability for services provided on or after the claim rejection.

Reporting misconduct

If you identify compliance issues and/or potential fraud, waste, or abuse, please report it to 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:

For UHC Medicare Advantage members at:
unitedhealthgroup.com/people-and-businesses/standards/ethics-and-compliance.html.

Methods for Reporting Suspected or Detected Noncompliance to Humana Examples of methods

offered by Humana:

- By telephone: Ethics Help Line, 1-877-5-THE-KEY (1-877-584-3539)
- Online: Ethics Help Line Web reporting site www.ethicshelpline.com
- By email: ethics@humana.com (Ethics Office)

Suspected or detected FWA violations may also be reported directly to Humana's Special Investigations Referral department by calling 1-800-614-4126, emailing siureferrals@humana.com, or faxing 1-920-339-3613.

Privacy

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

Non-discrimination

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

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

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

Marketing Compliance

For the purposes of this provider manual, “marketing” includes any information, whether oral or written, that is intended to promote or educate current or prospective Medicare beneficiaries about any Medicare plans, products, or services.

All contracted practices and facilities are required to comply with all current CMS regulations regarding marketing. As of January 2019, CMS has clarified that providers may interact with their patients regarding plan options when relevant to the course of treatment or at the patient’s request. A summary of the rules are as follows, however please refer to cms.gov/Regulations-and-Guidance/Regulations-and-Guidance.html for the most current and in-force information.

Guide updates

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

Population health

OCNY has developed programs and resources in concert with health plans to support your practice around population health management. These programs and resources include, but are not limited to, complex care management, quality, risk adjustment programs, clinical education, patient engagement, affordability, and social determinants of health.

There are the following four guiding principles of the OCNY population health program:

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

Quality & risk adjustment

OCNY is committed to supporting our partners in delivering the highest quality of care. To that end, providers may be given the tools and resources to identify quality care gaps, understand best practices, outreach/engage of patients to close quality care gaps, and provide tactical support for meeting requirements in accordance with Medicare's quality standards.

All contracted providers are required to allow OCNY access to patient charts, for OCNY-attributed patients, as part of supporting quality initiatives and clinical documentation accuracy. As an essential part of ensuring all data is captured and reported to health plans, OCNY performs chart reviews through remote EMR access, fax, and onsite access to your practice. Data for only your OCNY attributed patients is reviewed and processed. The chart abstraction and review process can capture documentation to close care gaps and potential coding opportunities, which contribute to our ability to have a complete and accurate clinical picture of each member.

What does this mean for your practice?

- OCNY will deploy chart abstraction staff to facilitate the capture of clinical documentation to close quality care gaps; or
- OCNY will work with your practice to collect records either directly via fax or EMR, or through a third party to facilitate accurate capture of quality care gaps and conditions.
- Practice Performance Managers will work with practices to provide education, consultation, and materials to help our providers improve their systems and processes to impact highest quality of care.

Clinical quality program

The Clinical Quality Program Team is committed to promoting healthy lifestyles and assuring that the highest standards of medical care are provided to all patients through education, information, and preventive care. Our objectives are aimed at driving processes that support continuous quality improvements such as measurement, trending, analysis, intervention, and re-measurement. Our goal is to ensure that our patients have access to health care that is safe, timely, effective, and patient-centered.

The Clinical Quality Program Team consists of licensed clinicians, such as nurses and social workers, who reach out to patients using a telephonic approach. In the event we are unable to reach a patient, we send letters that provide education, support and information about how to contact us. We also access multiple medical record databases to gather information used to close HEDIS Quality care gaps. All quality care gaps closed by the Clinical Quality Department are submitted as supplemental data.

Quality Supplemental Data Submission/Primary Source Verification (SDS/ PSV)

From HEDIS® reporting to medical record review support, audit management, and performance assessment, the Quality SDS/PSV Operations Team is committed to helping our providers maximize data and processes to increase HEDIS scores and bottom-line performance. This same team also conducts HEDIS® "hybrid" medical record requests and reviews each spring. Hybrid measures allow additional information from a medical chart to be used to complement claims data in order to provide a full picture of the care/services provided.

What does this mean to your practice?

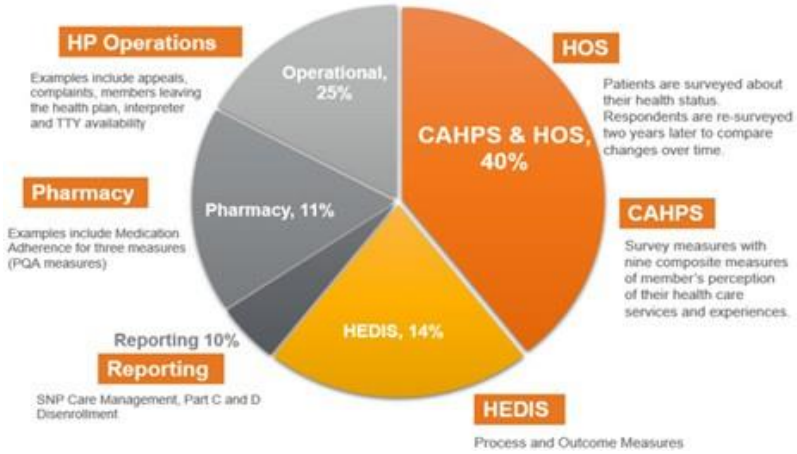
- Respond to records requests in a timely manner.
- Remember to document all the care you provide in your patients' medical records.
- Be sure to accurately code all claims.

Quality performance

Medicare Advantage Health plans are required to collect and report Star measure performance for their Medicare Advantage (MA), Prescription Drug Plan (PDP) and MA Special Need Plans (SNP) patients. Plan ratings are reported publicly by HealthPlan and contract and can be found at medicare.gov/plan-compare.

The Star Ratings Program is consistent with CMS' Quality Strategy of optimizing health outcomes by improving quality and transforming the health care system. CMS' Quality goals are based on the six priorities set out in the National Quality Strategy. These priorities include safety, patient/caregiver-centered experience and outcomes, care coordination, clinical care, population/community health, efficiency, and cost reduction.

OCNY is committed to achieving 5 Stars to improve patient health. Star Rating metrics are reported by health plans to CMS and those Medicare Advantage Plans with an overall rating of 4 or more Stars are eligible for quality bonus payments. These funds are used to provide patient care and enhance participating physician reimbursement.



CMS shall use the following sources for quality reporting:
1. Medicare claims (medical and pharmacy claims) submitted for items and services rendered to patients.
2. Any other relevant data from the patients' medical record (EMR).
3. For Performance Year 2022 and subsequent Performance Years, results from the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) or other patient experience surveys.

Risk Adjustment Factor

Risk Adjustment Factor (RAF) is a numeric measurement based on health conditions a patient has (specifically those that fall within a CMS-assigned Hierarchical Condition Category or HCC), as well as demographic factors such as Medicaid status, gender, age/disabled status and whether the patient lives in an institution (for 90 days or longer) or not.

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

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

Provider attestations

To support providers in submitting accurate documentation and coding, OCNY provides Attestations. Attestations list the gaps in care by member which includes historical chronic conditions, suspected conditions, screenings, and quality measures. Attestations are used by providers at the point of care to promote early detection and ongoing assessment of chronic conditions for our members. The goal of Attestations is to help providers perform a complete and comprehensive annual assessment for their patients. PPMs are available to support all aspects of the attestation process.

Attestations are developed using the following sources of data:

- Diagnoses, procedures, and results reported in prior years.
- Diagnoses and results found by nurses or coders (or, in some cases, M.D.) performing a chart review.
- Data inferred from labs tests, medication fills, and CMS Return files.
- Attestations will be shared with providers in one of two forms:
    1. Healthcare Quality Patient Assessment Form (HQPAF)
        - The form is printed and delivered by the PPM for completion by the clinician.
        - The information on the HQPAF form should be used to assist you in addressing care opportunities during the patient encounter.
        - The PPM will support your practice in completing chart reviews and identifying open care gaps. The HQPAF process would be incorporated in your practice's daily workflow.
    2. Healthcare Quality Patient Assessment Form (HQPAF)
        - DataCORE is a cloud-based, point-of-care application that will display member risk and quality information, dashboards, and reports within an EMR or via a user portal.
        - DataCORE will have the following features:

- DataCORE will have the following features:
  - Display previously coded and suspected HCCs with the ability to accept, disagree or defer the conditions presented
  - Display of and ability to act on member quality gaps
  - Embedded interactions to utilize EMR workflows
  - Ability to upload supporting documentation
  - Access to gap dashboard and reports
  - Access to referrals and clinical education

Coding and documentation ongoing education

As more of our work and payment structures are measured by data, it is increasingly important that we educate and prepare ourselves and our systems to capture the complexity of the care that we provide. To support clinical documentation and an accurate picture of each patient's health and RAF, OCNY provides ongoing education for clinicians and staff as well as regular feedback through reporting and analytics.

OCNY has a team to help each clinic stay up to date, so that they can provide the most accurate coding and documentation of each patient's clinical status. Our educators will help providers with diagnostic coding issues, medical record review, documentation standards, and education opportunities that support this ever-changing work in healthcare. Additionally, OCNY will provide ongoing education and information with industry coding changes as they relate to risk adjustment. OCNY's goal is to help promote the highest quality of care to our patients.

What does this mean to your practice?

- OCNY will provide clinical documentation education and resources to providers and clinic staff to support on- going development of Risk Adjustment coding and Quality metric recognition coding (CPT Category II).
- Our educators can evaluate documentation and coding behavior and identify recommendations for improvement.
- We will provide consultation and education to help our network partners improve their systems and processes to ensure complete, accurate, and compliant Risk Adjustment and Quality reporting.

Opportunities and services

- We will perform reviews of medical documentation to ensure that all offices capture chronic HCC (hierarchical condition categories) that would affect the risk adjustment reimbursement, and any subsequent shared savings.
- OCNY also analyzes data from inpatient hospitalizations, diagnostic testing, outpatient procedures and services, home health care services, durable medical equipment, rehabilitative therapies, and pharmacy reviews for the possibility of chronic codes that have not been addressed in the calendar year.
- OCNY will prepare feedback and training materials to educate providers and their staff on any audit outcomes and will help with accurate documentation procedures.
- OCNY will communicate with providers and staff coding and documentation trends and help implement correct diagnosis reporting.
- OCNY will perform routine audits of documentation and coding in accordance with compliance policies and procedures and communicate the results to the offices.
- We will follow up with written and verbal education regarding coding and compliance to physicians, clinical staff, and non-clinical staff. You will also be able to request OCNY educators to come to your clinics and help with any coding or documenting issues.

- OCNY educators will remain apprised of the latest guidelines and relay that information to the clinics and staff. We will provide any updates of new codes or coding issues. OCNY will send emails with webinars, coding materials, and any other education needed.

Utilization management

OCNY Utilization Management (UM) team works in concert with PCPs, specialists, and ancillary providers of care around the appropriate and efficient use of healthcare resources. The UM team works collaboratively with discharge planners in hospitals and post-acute facilities (SNFs, AIRs, LTACHS) to ensure positive patient outcomes.

However, OCNY is not delegated for Utilization Management for all plans. Please refer to the table below.

HealthPlan	UM managed by:	Contact information
AARP Medicare Advantage LPPO Plans: •Mosaic Choice (H3418-001) •Value Care (H3418-002) •Premier Choice (H3418-003) •Choice (H3418-004) (H3418-005) (H3418-006) (H3418-007) (H3418-008) **UnitedHealthcare Medicare Advantage RPPO Plans:** •Patriot (R5342-002) •Choice Plan 1 (R5342-001) •Choice Plan 3 (R5342-005) •Choice Plan 4 (R5342-006) **AARP Medicare Advantage HMO Plans** •Medicare Advantage Plan (H3307-025) •Medicare Advantage Plan 1 (H3307-002) (H3307-012) •Medicare Advantage Plan 2 (H3307-023) •Medicare Advantage Prime (H3307-015) •Medicare Advantage Patriot (H3307-018) **AARP Medicare Advantage Plans:** •Medicare Advantage Plan (H3379-039) (H3379-040) (H3379-041) (H3379-045) (H3379-046) •Medicare Advantage Plan 2 (H3379-001) •Medicare Advantage Value Care (H3379-043)	OCNY	**Phone:** 1-866-565-3468, eff Jan. 1, 2022 **Fax:** 1-855-248-4063 eff Jan. 1, 2022
HealthPlan	**UM managed by:**	**Contact information**

Humana Insurance Company of New York •Humana Choice Partnered (H5970-025) (H5970-027)	OCNY	**Phone:** 1-866-565-3468 eff Jan. 1, 2022 **Fax:** 1-855-248-4063 eff Jan. 1, 2022
CMS Direct Contract Model (ACO REACH) •Medicare Fee for Service	CMS	

Referrals/pre-authorizations

As a managed care network, patients assigned to us are required to use providers/facilities from within our network for care. Keeping services in-network works to minimize some administrative burden and keep costs contained. We have a diverse group of specialists and facilities within our network but are continuously working to grow and expand our reach in the community.

If your patient requires a specialist or facility that is not within the OCNY Network, then we recommend that the specialist/facility is contracted with the patient's HealthPlan. If the specialist/facility is not contacted with the plan, prior authorization is required. The OCNY and HealthPlan prior authorization lists are subject to change. Updates to the lists will be provided to the network as needed. The most current prior authorization list can also be found on the OCNY provider portal at: optum.com/sign-in/optum-care-professionals.html.

In-Network (Office Visits) (Tier 1):

- OCNY PCP to OCNY specialist referrals do not require precertification
- OCNY specialist to OCNY specialist do not require precertification

Out of Network Referral (Tier 2):

- Requires prior authorization from OCNY

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

Care management

OCNY's Care Management team consists of registered nurses, licensed practical nurses, social workers, and other care coordinators. Primary care offices can refer patients with complex care needs by referral, (see Provider Referral Form for Patient Programs in Appendix), but we also capture members in need of services from utilization management, pre-authorization trends, transitions of care (i.e., Hospital to Skilled Nursing), and members can also self-refer.

Care Management has oversight of the following programs:

- Transition Management
- Complex and High-Risk Care Management (medical/behavioral health)
- Disease Management/Condition Support (Diabetes, COPD, CHF)
- Emergency Department Reduction Program
- High Utilizers (Inpatient and Emergency Department) Program
- Kidney Disease Program (administrated by Kidney Resources Solutions (KRS)

For additional information, please contact Medical Management and Care Coordination department at PopHealthMM@caremount.com

Identifying OCNY members/patients

Health plans assign patients based on PCP selection. In most cases, an identifier can be found on the patient's HealthPlan identification card listing OCNY as the "Provider Group" or by Payer ID (LIFE1). Please refer to the HealthPlan identification card samples in the appendix. Additionally, providers and facilities should verify eligibility using the health plan's portal.

Portal access

Summary

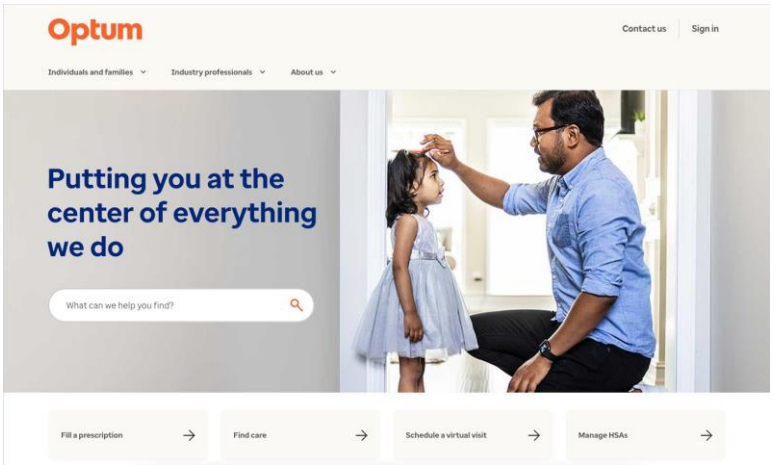
Optum Care Provider Portal will be a secure, internet-based, customized experience for providers to care for their patients and our members. A one-stop shop that has claims and member insights, prior authorizations, quality, risk adjustment and affordability performance data. Providers will have enhanced decision-making tools to improve care and lower costs.

Optum Care Provider Portal will provide access to the following:

- Attestation Review and Submission
- Eligibility Status
- Claims Status
- Prior Authorization Status
- Prior Authorization Submission
- Secure Messaging with Optum Care Network Teams

How to get access

To gain access to the provider portal, visit **optum.com**. If your office does not have provider portal access, you can self-register through the provider portal. The two-step process will require you to register first on the provider portal using your tax identification number and your One Health ID. The second step will confirm your account through an activation email which will be sent within 48 hours of completing the self-registration on the provider portal.



ACO REACH Model

"ACO REACH" shall refer to OCNY's participation in CMS's ACO REACH Model for Global and Professional Options. This model is the most innovative payment system offered by CMS and supports OCNY's pursuit of the quadruple aim. ACO REACH is a fully capitated payment program for Traditional Medicare, with an emphasis on reducing health disparities among underserved communities.

Claims processing

Providers are to submit claims to Medicare following standard processes. Medicare adjudicates the claim. The Explanation of Payment (EOP) from CMS will indicate whether the claim is fully or partially payable by an ACO entity Certain claims are excluded from the ACO REACH program, like those relating to substance abuse treatment, and will be paid under normal processes by CMS. Claims payable in full or in part by OCNY are adjudicated according to the OCNY contracted rate and paid by OCNY. The EOP from OCNY will include the contracted rate paid. The OCNY team receives weekly claims details file and can assist with general payment inquiries not covered by Medicare service authorization and/or the EOP.

Participating provider payment

Participating provider claims, deemed payable by Medicare, are paid in full by OCNY. Payments are issued through InstaMed and configurable as electronic funds transfer (EFT) or paper checks.

SNF case rate/process

SNFs participating in the case rate program should submit claims to Medicare standard processes. Payable claims accrue to the case rate capitation payment. EOPs from CMS will indicate the claim is payable by the ACO. EOPs from Optum will provide information regarding each case compensated under a given case rate payment.

Beneficiary alignment, beneficiary engagement

Alignment

CMS uses claims-based alignment to align beneficiaries to the program for each performance year. Alignment is based off historical utilization patterns for each patient. Not all Medicare patients qualify for this program. Assigned patient list for contracted TINs available through OCNY at any point of the performance year. All assigned Medicare beneficiaries are provided a written notice of their participation in the program. OCNY shall not commit any act or omission, nor adapt any policy, that inhibits beneficiaries from exercising their freedom to obtain healthcare services.

Reports

All ACO REACH beneficiaries will be reported to OCNY by CMS. This data will include a complete list of beneficiaries and their respected data sharing preferences.

Claims data, risk adjustment data, payment reports, benchmark reports, and quality performance score reports will be available for assigned beneficiaries.

Quality performance

CMS shall use the following sources for quality reporting:

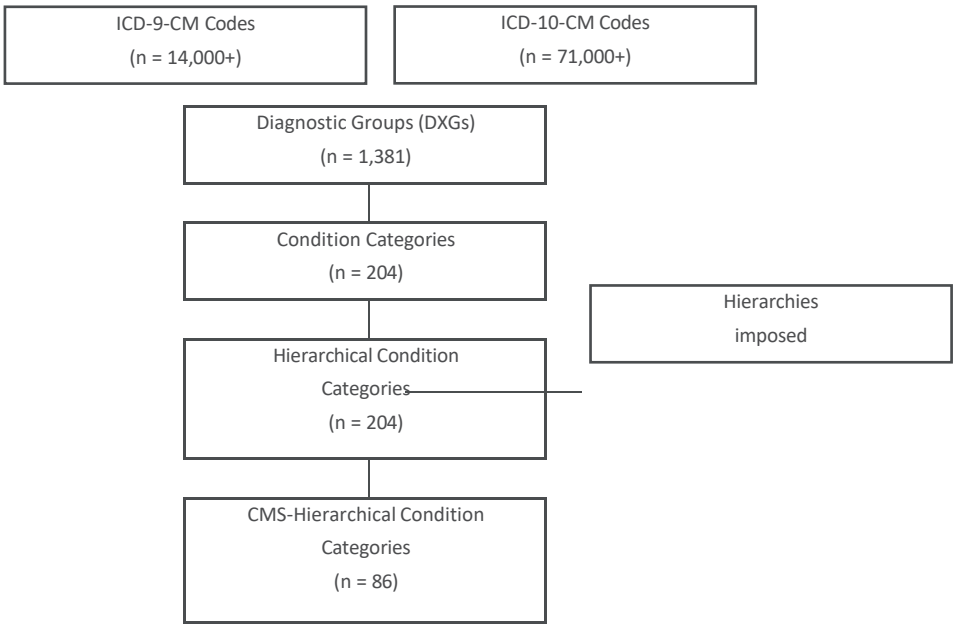
1. Medicare claims submitted for items and services furnished to ACO REACH Beneficiaries.
2. Any other relevant data from the patients' medical record (EMR).
3. For Performance Year 2023 and subsequent Performance Years, results from the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) or other patient experience surveys.

Risk adjustment

CMS will apply the CMS-Hierarchical Condition Categories (HCC) prospective risk adjustment model used in Medicare Advantage (MA) and the HCC concurrent risk adjustment model.

A retrospective Coding Intensity Factor (CIF) will be applied to the aligned beneficiary risk scores to limit risk score growth relative to the baseline period. In addition, a cap will also be applied to the growth in risk scores starting in PY2021, to further diminish the incentive for coding intensity that does not reflect true health status burden.

Figure 1. CMS-HCC Prospective Risk Adjustment model used in MA Version 24, HCC definition and clinical hierarchies



The CMS-HCC risk adjustment model used in MA, the Medicare Shared Savings Program, and the different Innovation Center models is a prospective model design, in which the payment or PY expenditures are predicted using the prior year's diagnoses. The current year's risk scores are calculated based on diagnoses recorded during the previous calendar year.

In Medicare, the CMS-HCC prospective risk adjustment model is generally applied to payments where organizations are serving relatively large panels of enrollees or aligned beneficiaries. With larger panels of enrollees and aligned beneficiaries, challenges associated with risk scores and random variation in high-need, high-expenditure beneficiaries diminish; acute events that are hard to predict tend to get averaged out across the population. In smaller panels, however, an unusually high (or low) frequency of acute events can have large financial impacts. In this context, a concurrent model is well suited to improve fairness by compensating for unforeseen spikes in
acute events.

Table 3. Examples of Risk Score Calculations:

Beneficiary A		Beneficiary B	
Characteristic	**Relative Factor**	**Characteristic**	**Relative Factor**
65-69 year old female	0.323	85-89 year old male	0.686
HCC35	0.308	HCC18	0.302
HCC137	0.289	HCC27	0.882
HCC138	0.000	HCC40	0.421
		HCC52	0.346
		HCC88	0.042
		HCC count=5	0.0042
TOTAL = risk score	0.920	TOTAL = risk score	2.814

For presentation purposes only, the relative factors and risk scores are rounded to 3 decimal places.

Roster management

All providers must be identified by individual or entity name, TIN, individual NPI, organizational NPI, and CCN (if applicable).

OCNY will furnish written notification to each individual or entity included in the program. Notice will include:

1. Stated the individual or entity and the TIN through which it bills Medicare will be submitted to CMS.
2. Stated that participation in the Model may preclude the individual or entity from participating in the Medicare Shared Savings Program, another Medicare ACO REACH, the Next Generation ACO Model, the Comprehensive ESRD Care Model, the Vermont All-Payer ACO Model, the Kidney Care Choices Model, any other Medicare initiative that involves shared savings, the Primary Care First Model, the Maryland Total Cost of Care Model, and the Independence at Home Demonstration, if extended.
3. If the ACO REACH entity selected to participate in TCC Payment for the first Performance Year, the individual's, or entity's agreement to participate in TCC Payment and receive the TCC Fee Reduction, must apply for the full Performance Year and must be renewed annually prior to the start of each Performance Year for the individual or entity to participate as a ACO REACH Participant Provider for that Performance Year.

Updating provider roster during performance year:

Participating Providers are permitted to remove individual practitioners to the ACO REACH starting February 1st, 2023. OCNY must be notified of new or terminated providers 35 days before the proposed effective date. ACO REACH participation effective dates must fall on the 1st of the month. New providers must bill for services under a Medicare billing number assigned to the TIN under an entity contracted with OCNY to participate with ACO REACH and are subject to approval by OCNY.

CMS may reject to add an individual or entity if the individual or entity fails to satisfy the following program requirements:

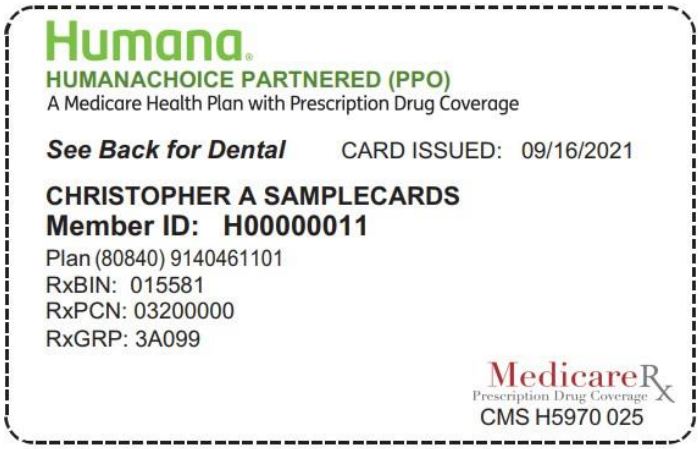
1. Is a Medicare-enrolled provider
2. Bills for items and services it furnishes to Beneficiaries under a Medicare billing number assigned to a TIN in accordance with applicable Medicare regulations
3. Is not a Prohibited Participant
4. Has agreed to participate in the Model pursuant to a written arrangement with OCNY

Appendix A

ID card samples

Participating plans and samples of their ID cards

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



Appendix B

Provider Referral Form for Patient Programs

Please refer to the following pages for the Provider Referral Form for Patient Programs

Optum Provider Referral Form for Patient Programs

Email: PopHealthMM@caremount.com
Fax: 845-592-7733

For emergencies, call 911 or your local police for a welfare check

Date of request: _____

Person submitting request: _____

Organization/program/practice name: _____

Phone: _____ Email: _____

PCP name: _____ PCP phone: _____

☐ Urgent contact needed (within one business day)

Patient information ☐**Patient aware of request**

Patient name: _____

DOB: _____ Member/Medicare ID: _____

Phone 1: Phone 2: _____

Patient address: _____ Zipcode: _ _

☐ Patient's home ☐ Family's home D Group home/ALF/LTC: _____

***If patient is currently in acute setting, planned date of discharge: _____

POA/authorized rep/alternative contact: _____

Phone: _____ Relationship to patient_· _____

Currently, who is patient's decision-maker? _____

Programs available (choose one or more):

☐ Complex Case Management/ CCM*

☐ High-risk Care Management/ HRCM*

*Similar programs with CCM having higher outreach cadence due to patients' higher utilization and clinical coordination needs

☐ Disease management Program

D DM D CHF

DCOPD

☐ Social Work/Social Needs

☐ Kidney Disease Program
(Check which box applies below)

☐ Chronic Kidney Disease

☐ End Stage Renal Disease

Primary reason for request: _____

Patient name: ..... **DOB:** _____

Additional information regarding patient needs/concerns:

_____

_____

_____

_____

_____

Pertinent medical information (hospitalizations, PMH, diagnoses, etc.):

_____

_____

_____

_____

_____

_____

_____

_____

_____

Provider referral form for patient programs

Email: PopHealthMM@caremount.com

Fax: 845-592-7733

Reminder: send in secured format as document contains confidential PHI

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opium.com

Appendix C

Glossary of 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, co-insurance or table of allowance included in the program.

ASC

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

ASC

Ambulatory Surgery Center, used for payments to a surgery center.

Billed charges

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

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-member-per-month (PMPM) payment to a provider/provider organization that covers contracted services and is paid in advance of delivery of any services. The rate can be fixed or adjusted by age/sex of enrollees; percent of premium based on severity ratings.

Case rate

A fixed dollar amount established as payment for a service.

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 member classification scheme that categorizes members 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 members. Primarily used for Medicare members.

DRG rate

A fixed dollar amount based on the average of all members in that DRG in the base year, adjusted for inflation economic factors and bad debts.

Electronic data interchange (EDI)

The process of electronically submitting data to payers, including but not limited to claims, electronic eligibility and pre-authorization requests.

Electronic health records (EHR)/Electronic medical records (EMR)

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

Maximum out-of-pocket (MOOP)

Out-of-pocket expenses are co-pays, deductibles, and co- insurance. The HealthPlan caps the out-of-pocket expenses, meaning when the member reaches the maximum out-of-pocket costs, the HealthPlan takes over and provides coverage for rest of year.

Medical necessity

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

Misdirected claim

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

Non-covered service

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

Out-of-pocket (OOP)

Refers to any portion of payment for medical services that are the member’s responsibility.

Per diem

A flat amount paid for each day the member 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 HealthPlan and/or medical group.

Un-bundling

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

Unclean claim

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

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