Optum

Provider administrative manual 2023

Optum Care Network of Indiana

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Overview

Purpose and use of this manual

The manual contains important information about Optum Care Network of Indiana (OCN-IN), policies and procedures, claims submission and adjudication requirement. General recommendations are provided to support and enable participating providers and their staff to deliver effective care for members of Optum Care though contracts with AARP® Medicare Advantage H plans and plan benefit packages (PBP) listed below insured through UnitedHealthcare® in Indiana.

Plan name and type	CMS contract	Group numbers
AARP® Medicare Advantage Profile (HMO-POS)	H2802-007	00746
AARP® Medicare Advantage Plan 1 (HMO-POS)	H2802-008, 010, 012, 016, 018, 020	00744, 00745, 00748, 00749, 00750, 00751, 00755, 00756, 00758, 00761, 00762
AARP® Medicare Advantage Choice Plan 1 (PPO)	H2228-019, 021, 022, 064	67026, 67030, 67034, 90101, 90102
AARP® Medicare Advantage Focus (PPO)	H2228-020	74000
AARP® Medicare Advantage Choice (PPO)	H2228-065, 066	90103, 90105, 90106
AARP® Medicare Advantage Choice Plan 2 (PPO)	H2228-080, 081, 110, 111	90126, 90127, 90128, 92018, 92019, 92020, 92021
AARP® Medicare Advantage Patriot (PPO)	H2228-091	90041

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

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

The purpose of this manual is to provide key information to our contracted network providers and support you in delivering effective care for mutual patients in accordance with Optum Care Network and industry standards.

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

Business Overview

Optum Care Network (OCN)

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

OCN-IN service area

Optum Care Network of Indiana serves the entire state of Indiana.

Administrative tasks to change for dates of services started Jan. 1, 2022

Optum Care Network, an affiliate of UnitedHealthcare, manages administrative services for UnitedHealthcare Medicare Advantage members with a primary care provider (PCP). Optum administers these administrative services:

- Claim processing and reconsiderations
- Hospital admission notifications
- Prior authorization requests
- Utilization management requests

Online resources and contact information

How to contact OCN

You may contact OCN-IN through the following methods:

- Your provider account manager - Each practice in our network is supported by a dedicated account manager who is your go-to resource. To connect with your provider account manager, login through optumproportal.com/home.
- Optum Care Pro Portal - The provider portal is a secure web tool providing you access to view eligibility and claims information in real time, create and submit prior authorizations, and review and electronically submit attestations. You'll also have access to important forms and many other resources. Login through optumproportal.com/home.
- Optum Care Service Center - Our service advocates are available to answer questions on topics such as provider search, claims, eligibility, and more.

Telephone

Optum Care Service Center - Our service advocates are available to answer questions on topics such as provider search, claims, eligibility, and more.

Hours of operation

Monday through Friday: 8a.m.to 9p.m. ET

Phone: 1-866-565-3361

Secure email

You can contact the Optum Care Service Center through secure email on the Optum Care Pro Portal. On optumproportal.com/home scroll down and click Contact us.

Provider relations

Each practice in OCN is supported by a dedicated provider account manager who is your go-to resource. To connect with your provider account manager, login through optumproportal.com/home.

OCN processes

This manual, reference guides, forms and other resources can be found at optum.com/business/hcp-resources.html?selectedFilters=Indiana

Commonly used forms

Commonly used forms and other resources can be found at optum.com/business/hcp-resources.html?selectedFilters=Indiana.

Language and hearing-impaired assistance

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

Language assistance

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

Hearing impaired assistance

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

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

- For more information, call Optum Care at 1-866-565-3361. The Optum Care service center is open Monday through Friday: 8a.m. to 9p.m. ET
- The TTY 711 and language lines are open 24 hours a day, seven days a week.
- For technical difficulties and additional assistance, please contact Optum Care service center: 1-866-565-3361.

Provider responsibilities

Primary care physician responsibilities

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

Non-discrimination

Do not discriminate against any patient on quality of service or accessibility of services. You must keep policies and procedures to show your compliance. This includes discrimination based on:

- Type of health insurance
- Race
- Ethnicity
- National origin
- Religion
- Sex
- Age
- Disability
- Sexual orientation
- Claims experience
- Medical history
- Genetic information
- Type of payment

Cooperation with quality improvement and patient safety activities

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

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

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. OCN’s expectation remains that FDRs, and their employees, are sufficiently trained to identify, prevent, and report incidents of non-compliance and FWA. This includes temporary workers and volunteers, the CEO, senior administrators or managers, and sub delegates who are involved in or responsible for the administration or delivery of MA or Part D benefits or services.

We have general compliance training and FWA resources available at unitedhealthgroup.com. The required education, training, and screening requirements 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/content/dam/UHG/PDF/About/UNH-Code-of-Conduct.pdf. 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 – what you need to do

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 OCN. 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 exclusions.oig.hhs.gov.
- General Services Administration (GSA) System for Award Management at sam.gov/content/exclusions/federal.
- Review the exclusion lists every month and disclose to OCN 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. 43 For internal use only. Proprietary and confidential. Not for external distribution.

Preclusion list policy

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

- Are revoked from Medicare, are under an active reenrollment bar, and CMS has determined that the underlying conduct that led to the revocation is detrimental to the best interests of the Medicare program; or
- Have engaged in behavior for which CMS could have revoked the prescriber, individual or entity to the extent possible if they had been enrolled in Medicare and that the underlying conduct that would have led to the revocation is detrimental to the best interests of the Medicare program.
- Have been convicted of a felony under federal or state law within the previous 10 years and that CMS deems detrimental to the best interests of the Medicare program.
- Care providers receive a letter from CMS notifying them of their placement on the preclusion list. They have the opportunity to appeal with CMS before the preclusion is effective. There is no opportunity to appeal with OCN 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 Care Network. Additionally, the precluded care provider must hold Medicare beneficiaries harmless from financial liability for services provided on or after the claim rejection.

Reporting misconduct

If you identify compliance issues and/or potential fraud, waste, or abuse, please report it to 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/content/dam/UHG/PDF/About/UNH-Code-of-Conduct.pdf.

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.

Guide updates

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

Provider demographic changes notice requirements

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

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

Notification of changes must be proactive

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

providers credentialed by the delegate, may be subject to penalties. Penalties may include a delay of processing claims or the denial of claims payment, until the records are reviewed and attested to or updated.

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

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

If a health care provider leaves your practice, notify us immediately. This gives us time to notify impacted members. When you submit demographic updates, list only those addresses where a member may make an appointment and see the care provider. On-call and substitute care providers who are not regularly available to provide covered services at an office or practice location should not be listed at that address. Please submit all changes on an OCN roster, which can be provided or for any questions email ocn-midwest-providerdata@optum.com.

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

To submit the change, please email the physician and provider updates to ocn-midwest-providerdata@optum.com.

Patient eligibility

Verification of 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 retroactivity 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.

For members with coverage in a UHC Medicare Advantage Health plan and where the member has

selected a provider within OCN-IN you can access UHC's member eligibility tool to verify member eligibility and benefits and to view the member's ID card.

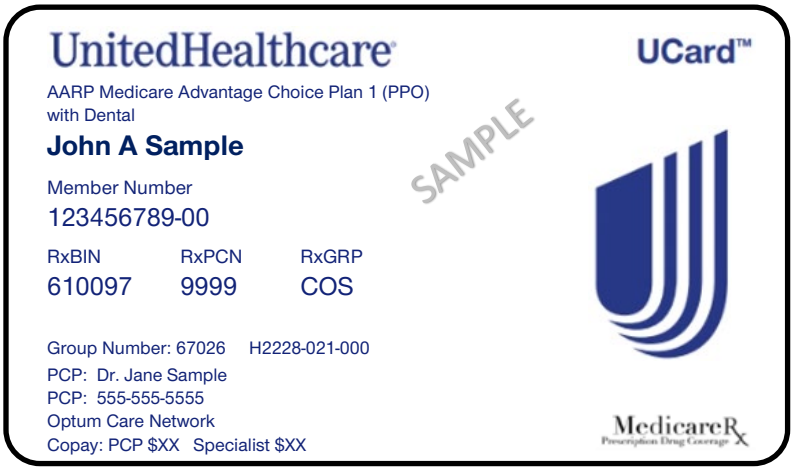
Online: uhcprovider.com/eligibility

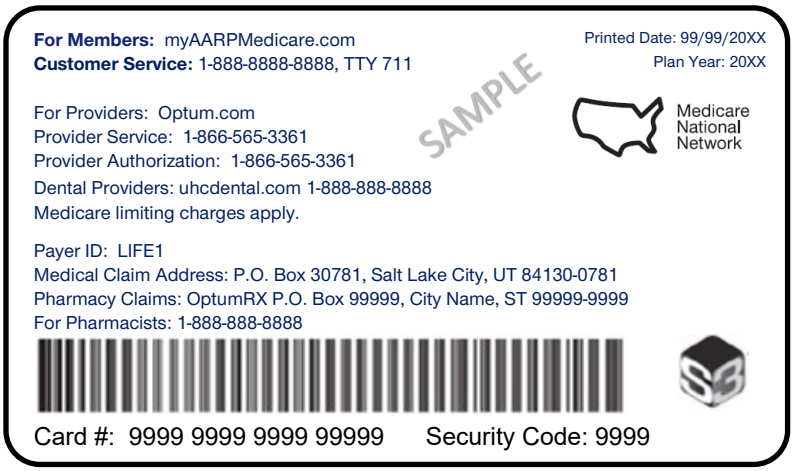
Example ID cards

The Medicare Advantage ID card will include the payer ID LIFE1, the Optum Care Network claims address, and provider services phone number.

Participating plans and sample of their member ID cards

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





UnitedHealthcare Medicare Advantage delegation to Optum Care Network of Indiana

Optum Care Network of Indiana has a contract with AARP® Medicare Advantage insured through UnitedHealthcare® in Indiana.

Claims

OCN-IN 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:

Plan name and type	CMS contract	Group numbers
AARP® Medicare Advantage Profile (HMO-POS)	H2802-007	00746
AARP® Medicare Advantage Plan 1 (HMO-POS)	H2802-008, 010, 012, 016, 018, 020	00744, 00745, 00748, 00749, 00750, 00751, 00755, 00756, 00758, 00761, 00762
AARP® Medicare Advantage Choice Plan 1 (PPO)	H2228-019, 021, 022, 064	67026, 67030, 67034, 90101, 90102
AARP® Medicare Advantage Focus (PPO)	H2228-020	74000
AARP® Medicare Advantage Choice (PPO)	H2228-065, 066	90103, 90105, 90106
AARP® Medicare Advantage Choice Plan 2 (PPO)	H2228-080, 081, 110, 111	90126, 90127, 90128, 92018, 92019, 92020, 92021
AARP® Medicare Advantage Patriot (PPO)	H2228-091	90041

Claims submission

Claims should be submitted electronically to **LIFE1.** Paper claims, though not preferred, can be mailed to:

OCN Paper Claims

Optum Care Network Claims
PO Box 30781
Salt Lake City, UT 84130-0781

OCN Electronic Claims

Payor ID#: LIFE1
Clearinghouse: Optum360

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

Reimbursement

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

- Patient's eligibility at the time of the service
- Whether services provided are covered benefits under the patient's health plan
- Whether services are medically necessary as required by the patient's health plan

- Whether services were without prior approval/authorization if authorization is required
- Patient copayments, coinsurance, deductibles, and other cost-share amounts due from the patient and coordination of benefits with third-party payors as applicable
- Adjustments of payments based on coding edits described above

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

Nothing contained in the agreement or 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.

Electronic funds transfer (EFT)

Optum Pay is our free payer payments method for providers. To get your Optum payments electronically, please sign up for free EFT through Optum Pay.

Enrollment
Phone: 1-877-620-6194 (Mon.–Fri., 7 a.m.–6 p.m. CT)
1-888-477-0256 (Mon.–Fri., 7 a.m.–7 p.m. CT)

Online: optum.com/enroll

Payment support
Phone: 1-888-477-0256 (Mon.–Fri., 7 a.m.–7 p.m. CT)
Optum Pay provider portal: optum.com/optumpay

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 OCN-IN 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 OCN or health plan before any such services are rendered. Please refer to your participation agreement for complete language.

Clinical claims review

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.

Claims status

The fastest and most-efficient way to check a claim's status for contracted providers is to utilize the provider portal - optumproportal.com/home. Providers can view detailed claims information associated with their tax ID number by clicking on the Patient Information option and clicking Claim Search. Most claim inquiries can be researched on the provider portal.

You can also call 1-866-565-3361 to check a claim status.

Timely filing requirements

Timely filing requirements are determined by the provider-contracted timely filing provisions. We may deny claims not filed within the timely filing limits. If you dispute a claim that was denied due to timely filing, you must submit proof that you filed the claim within the timely filing limits. Timely filing limits vary based on provider contract.

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

You are required to submit clean claims for reimbursement no later than 90 days from the date of service. If you do not submit clean claims within these time frames, we reserve the right to deny payment for the claim(s). Claim(s) that are denied for untimely filing may not be billed to a member.

We have claims processing procedures to help ensure timely claims payment to care providers. We are committed to paying claims for which we are financially responsible within the time frames required by state and federal law.

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.

For how to submit a provider dispute please follow the dispute language on explanation of payment (EOP). Each provider dispute must contain, at a minimum, the following information:

- Provider’s name
- Provider’s TIN
- Provider’s contact information
- Clear identification of the disputed item such as the claims number and the date of service
- Clear explanation of the issue
- Provider’s explanation why the action taken is incorrect

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

When Optum Care is not the primary payer

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

Benefits will be coordinated with other carriers when Optum Care is notified that the patient has other insurance.

Workers’ compensation

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

Medical management

Prior authorizations

Prior authorization requirements can be found by logging in through optumproportal.com/home or calling OCN at 1-866-566-3361. Additionally, Medicare Advantage prior authorization requirements can be found on the Provider Portal at UHCprovider.com.

Requesting prior authorization

To submit a prior authorization notification, sign in to optumproportal.com/home. If online is not available, call **1-866-565-3361** or fax your notification to:

- New Auth (General): 1-855-248-4063
- Part B New Auth: 1-855-244-8503
- Clinicals Submission for Auth: 1-877-940-3604

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

Login through Optum Care Pro Portal at optumproportal.com/home and navigate to the prior authorizations area. Then click to start a new request, fill out the form and click Submit.

For urgent requests call: 1-866-565-3361

Prior authorization provider notification process

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

When an adverse determination is made, OCN will notify both the provider and enrollee with a formal written notification that includes member appeal rights and next steps. The provider may also use the OCN provider portal, found at optumproportal.com/home to see the status of a prior authorization request.

Prior authorization time frames

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

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

Prior authorization status

Prior authorization can be viewed by logging in through provider portal at optumproportal.com/home or by calling 1-866-565-3361.

Referrals

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

Specialty care

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

Hospital admission notification requirements for admission notifications

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

- All planned/elective admissions for acute care
- All unplanned admissions for acute care
- All post-acute care admissions:
    - Skilled Nursing Facility (SNF)
    - Long Tern Acute Care (LTAC)
    - Acute Inpatient Rehab (AIR)
- All admissions following outpatient surgery
- All admissions following observation stay
- All admissions for observation

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

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

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

Admission notifications must contain the following details regarding the admission:

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

For emergency admissions when a patient is unstable and not capable of providing coverage

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

Reimbursement reductions for failure to timely provide admission notification

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

How to submit admission notifications

To notify OCN of hospital admissions no later than 24 hours after admission and 24 hours post discharge, sign in at optumproportal.com/home.

If online is not available, notifications can be submitted:

- **Phone**: 1-866-565-3361
- **Fax**: 1-844-700-5131

Clinical Information for hospital admissions can be submitted:

- **Online:** optumproportal.com/home
- **Fax**: 1-844-700-5131

Referral vs. prior authorization vs. advanced notification

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

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

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

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

Prior authorization & hospital admission peer-to-peer process

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

Please call 1-866-565-3361 for a peer-to-peer discussion during the hours of 8 a.m. to 8 p.m. ET, Monday through Friday.

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

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

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

Health improvement

Optum Care affirmative statement:

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

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

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

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

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

Credentialing and recredentialing

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

Providers requesting participation with Optum Care Network should contact their local network manager. Please ensure that your provider CAQH account is up to date to prevent delays in credentialing.

CAQH Provider Support
Website: proview.caqh.org/PR

Initial credentialing

The initial credentialing process is from receipt of completed credentialing application to committee approval. The credentialing time frame is directly dependent upon receiving verifications from the primary source verification sources in a timely manner. If receipt of those verifications is delayed in any way, it will hold up completion of the process. If the packet is not complete (e.g., required documents are not attached, fields on application not filled in, etc.), this will also delay the processing of the application.

Recredentialing

Recredentialing occurs every three years. Prior to the three-year credentialing anniversary, the provider will receive a request to login through CAQH, a universal provider data source, and complete the online application or if provider has already done so, then verify that the attestation is current and up to date. CAQH requires that the re-attestation process be completed every 120 days.

Providers are required to immediately notify their local Optum Care 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 Care patients. It is fraudulent practice to bill under one provider when services are 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.

Quality

Quality improvement committee mission

The QI/UM committee supports the QI, UM, and credentialing programs to promote measurable quality improvement reviews. The members of the QI/UM committee have the responsibility to create a quality improvement culture throughout the organization. The QI/UM committee systematically oversees the continuous improvement in the quality of care and services delivered to Optum Care patients. The committee also monitors and oversees the utilization of services to enrolled patients to ensure that patients are in the right setting at the right time. The committee is accountable for the implementation of the UM program plan and medical management plan. The committee meets quarterly to discuss and adopt policies and procedures and to initiate and review quality initiatives that impact care and service delivery.

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

Committee objectives

The committee shall oversee the following functions:

- Review and adoption of QI Program and related policies and procedures
- Review and adoption of UM Program, UM Work Plan and related policies and procedures
- Review and adoption of Complex Care Management (CCM) Program and related policies

and procedures

- Review and approve practice protocols and guidelines related to the use of non-physician practitioners such as nurse practitioners
- Review and adoption of UM Criteria and Clinical Guidelines
- Oversight of clinical care and services to include but not be limited to:
    - Complex Case Management
    - Patient Safety reviews (such as Medication Reconciliation)
    - Utilization Management
    - Delegated and subdelegated functions
- Conduct an annual evaluation of the UM and QI programs to assess accomplishments and barriers and to establish goals for the next year's program
- Quality of clinical care and service monitoring and evaluation activities include but may not be limited to the following activities and outcomes:
- Prior authorization
    - Concurrent review
    - Patient safety
    - UM timeliness of decisions
    - Oversight of delegated functions

Committee goals

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

The CDQI (clinical documentation and quality improvement) department oversees risk adjustment and quality-based activities. This 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-Stars.

CMS quality measure overview

Several industry quality programs, including the Centers for Medicare & Medicaid Services (CMS) star ratings, provide external validation of Medicare Advantage and Part D plan performance and quality progress. Quality scores are provided on a 1- to 5-star scale, with 1 star representing the lowest quality and 5 stars representing the highest quality. Star ratings scores are derived from 4 sources:

- Consumer Assessment of Healthcare Providers and Systems (CAHPS) or patient satisfaction

data

- Health Care Effectiveness Data and Information Set (HEDIS) or medical record and claims data
- Health Outcomes Survey (HOS) or patient health outcomes data
- CMS administrative data on plan quality and customer satisfaction

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

Glossary

Definitions and terminology

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

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

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

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

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

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

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

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

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

Coordination of benefits (COB): Allows benefit plans that provide health and/or prescription coverage

for a person with Medicare to determine their respective payment responsibilities (i.e., determine which insurance benefit plan has the primary payment responsibility and the extent to which the other benefit plans will contribute when an individual is covered by more than one benefit plan).

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

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

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

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

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

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

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

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

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

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

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

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

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

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.

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

Global period: A time 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.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Service area: A geographic area serviced by an Optum Care contracted provider, as stated in the health care provider's agreement with us

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

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

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

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