Optum

2023 Provider Guide

Optum Care Network–Kansas & Missouri

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

Benefit plan sponsors are coping with cost pressures and demanding more for less.

Patients are seeking education, value, simplicity, and a better experience.

Care providers are expected to deliver greater value, assume more risk, and take on more responsibility.

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

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

Programs, systems, platforms, and tools are subject to change at any time. We will provide as much notice as possible in advance of any changes.

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Purpose

The purpose of this guide 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–Kansas & Missouri 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 provide you with the support you need to improve the health and well-being of your patients.

Business overview

Who is Optum?
Optum Care Network–Kansas & Missouri is an independent physician's association. We offer a full range of services to assist physicians and other providers in their managed care and business operations. The network is a health care innovator, with a track record for quality, financial stability, and extraordinary services. We are well positioned to continually invest in new infrastructure and systems for the benefit of our contracted physicians and to accommodate the impending changes of health care reform.

Optum is a fully delegated entity, assuming both institutional and professional financial risk which allows us to enhance the coordinated care model. The network currently accepts global capitation agreements with health plans for the provision of medical services for most of its Medicare Advantage patients.

Mission

We connect and support providers to deliver the most effective and compassionate care to each and every patient.

Vision

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

Values

Integrity. Compassion. Relationships. Innovation. Performance.

Optum contact information

Network contact information

Optum service center

Call 1-855-822-4325 or visit us online: https://providers.optumcaremw.com
Service advocates are available to answer questions Monday through Friday, 8 a.m. to 8 p.m.

Network management team

Optum assigns Network Performance Managers to each practice to give you personal service. They will get to know your business needs, make sure your practice understands the network's best practices and assist with your questions and requests. Provider network managers include:

Prior authorization (urgent and routine)

Phone: 1-855-822-4325
Fax: 1-888-992-2809
Online: https://optumcare.com/provider-login

Please see page 9 for user instructions or contact your network manager for assistance with the online tool.

Prescriptions (Rx) prior authorization for UnitedHealthcare patients

Phone: 1-800-711-4555
Fax: 1-800-527-0531
Online: https://optumcare.com/provider-login

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

Transplant prior authorization

Phone: 1-888-936-7246

Referral policy – Kansas & Missouri

Optum Care Network–Kansas & Missouri patients need a referral from their primary care provider (PCP) to see a specialist, except for those specialties listed below.

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

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

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

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

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

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

How long are patient referrals valid?
Evaluation and treatment referrals are good for **six months** from the date of issue. After the six-month period, re-evaluation is required by the patient's PCP.
If you have any questions, please call the Optum service center at: **1-855-822-4325**

Patient enrollment and assignment

Health plan contact information

Optum proudly accepts the following health plans:

AARP® Medicare Advantage®
insured through UnitedHealthcare®

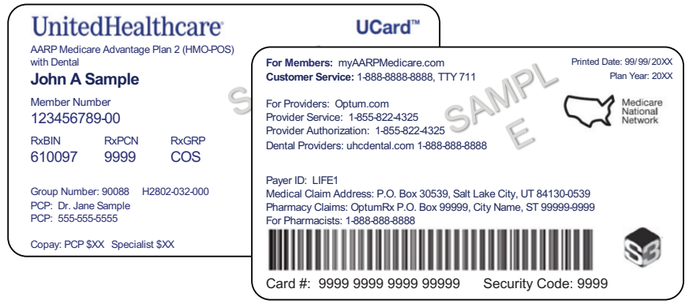
UnitedHealthcare® Group
Medicare Advantage

Affected UnitedHealthcare Medicare Advantage plans

Plan name	CMS contract number	Group number
AARP Medicare Advantage Choice Plan 1 - preferred provider organization (PPO)	H2228-071	90193
AARP Medicare Advantage Choice Plan 1 (PPO)	H2228-071	90194
AARP Medicare Advantage Plan 2 health maintenance organization (HMO-POS)	H2802-032	90088
AARP Medicare Advantage Plan 2 (HMO-POS)	H2802-032	90152
AARP Medicare Advantage Plan 1 (HMO-POS)	H2802-033	90167
AARP Medicare Advantage Plan 1 (HMO-POS)	H2802-033	90168
AARP Medicare Advantage Choice Plan 2 (PPO)	H8768-023	90053
AARP Medicare Advantage Choice Plan 2 (PPO)	H8768-023	90326
AARP Medicare Advantage Patriot (PPO)	H8768-025	90328
AARP Medicare Advantage Patriot (PPO)	H8768-025	90329
UnitedHealthcare Medicare Advantage Choice Plan 3 (Regional PPO)	R3444-023	90054
UnitedHealthcare Medicare Advantage Choice Plan 3 (Regional PPO)	R3444-023	90327
UnitedHealthcare Medicare Advantage Choice Plan 2 (Regional PPO)	R3444-012	99932
UnitedHealthcare Medicare Advantage Choice Plan 2 (Regional PPO)	R3444-012	99936

Example ID card

1. Participating health plan logo
2. Payer ID
3. Network name
4. Plan name
5. CMS Contract/ PBP
6. Medical claims address
7. Provider services toll-free number



Optum website

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

Patient website

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

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

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

Provider resource page

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

- Prior authorization forms and electronic processing
- User guide for creating an account for the Optum provider portal
- Coding tips and tools

Provider search tool

For access to the provider resource page please visit: **https://providers.optumcaremw.com**

Optum customer service

By phone

The phone number for providers to contact customer service is **1-855-822-4325**. Service advocates are available to answer questions Monday through Friday, 8 a.m. to 8 p.m.

Online

For faster service regarding claims or authorization inquiries, access the secure provider portal at **https://providers.optumcaremw.com**

Experience the benefits of online access:

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

Secure email

Service advocates can also be reached by secure email through the provider portal at **https://providers.optumcaremw.com**. Our secure email allows contracted providers to submit questions on important topics such as correcting claims payments, submitting or inquiring about prior authorizations, and more. Any provider who has access to the secured portal can use this feature.

When you submit a question via the web portal, you will receive a response within 24 hours. Emails received on weekends will be responded to the following business day. All questions and replies sent through this system are encrypted to ensure safe transfer of personal health information.

Optum provider portal

About the provider portal

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

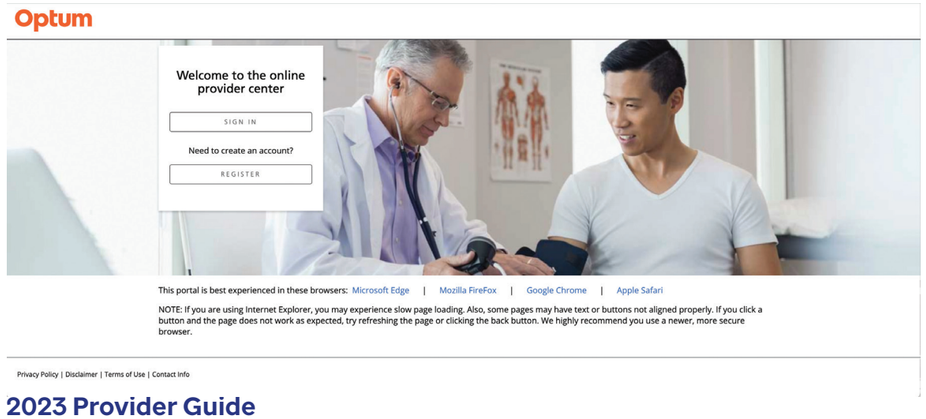
Using the provider portal, provider staff can:

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

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

How to get access

To gain access to the provider portal, visit **https://providers.optumcaremw.com**. If your office does not have portal access, you will need to register for an account before using the system. To create an account you will select “Register,” and complete the form found under the register link. You will receive an initial email confirming your request and no action is required on your part. An admin will then approve your request, and you will receive a secondary email in about two business days that will require you to select the “click here” link to complete your registration. Your office will then create an Optum ID. You will receive an email notification requiring you to verify your email address used to create the ID and you will click “activate my Optum ID” and select continue. Your office will sign into the portal using your Optum ID username and password.



Language and hearing impaired assistance

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

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

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

For more information, call Optum at **1-855-822-4325**. The **TTY 711** and language lines are open 24 hours a day, seven days a week. The service center is available Monday through Saturday, 8 a.m. to 8 p.m.

Eligibility

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

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

Physicians, facilities, and health professionals should contact their current clearinghouse vendor to discuss their ability to support the 270/271 005010X279A1 Health Care Eligibility and Benefit Inquiry and Response transaction, as well as associated time frames, costs, etc. This includes protocols for testing the exchange of transactions with Optum through your house clearing.

Claims

ATTENTION: Office managers and billing managers
The following sections include key information for claim submission and re-submission to initiate claims payment.

Topics addressed:
- Claim submission and field requirements
- EDI (electronic data interchange) claim payment policy and processing standard billing
- Reading a provider remittance advice (PRA)
- Helpful hints on defining time frames

Corrected claims can be submitted electronically by following the guidelines:

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

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

This will indicate the claim is a corrected claim.

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

Health care providers must comply with version 5010 of the HIPAA EDI standards.
Use format 837, ANSI x12.
- 837i–Institutional claims
- 837p–Professional claims

Additional transactions performed by Optum:
- 997–Functional acknowledgment (claim receipt acknowledgment via clearinghouse)

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

Paper submission:
- Professional vendors must submit on a CMS 1500
- Ambulatory surgery centers’ preferred method of billing is a CMS 1450 with appropriate modifiers SG or TC
- Hospital and facility vendors must submit on a CMS 1450

Claim submission address:
Optum Claims
P.O. Box 30539
Salt Lake City, UT 84130-0539

Billing

Complete (clean) claims are those claims and attachments or other documentation that include all reasonably relevant information necessary to determine payer liability. To be considered a complete claim, the claim should be prepared in accordance with the National Uniform Billing Committee standards and should include, but not be limited to, the following information.

A complete claim form contains:

- A description of the service rendered using valid CPT, ICD-10, HCPCS and/or revenue codes, the number of days or units for each service line, the place of service code/bill type, and the type of service code
- Patient demographic information
- Provider of service name, address, National Provider Identifier (NPI) number, and tax identification number
- Date(s) of service
- Amount billed
- Signature of person submitting the claim
- Other documentation necessary to adjudicate the claim may include medical reports, claims itemization or detailed invoice, medical necessity documentation, other insurance payment information, referring provider information, attending provider information, and associated NPI, as applicable

Incomplete claims or claims requiring medical records to determine payer liability will be contested back to the provider via EOB with a descriptive reason code informing the provider what additional information is needed. Medicare claims will be developed in accordance with CMS regulations. Any claims submitted with invalid codes or claims missing required billing elements will be mailed back to the provider with reason codes attached requesting a corrected claim.

All payments and copayments are subject to the benefit information as defined by the patient's specific health plan benefit plan. Claims payment depends on patient eligibility status on the date of service as determined by the health plan.

Submission time frames

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

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

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

Claims submissions

For proper payment and application of copayment, deductible and co-insurance, it is important to accurately code all diagnoses and services in accordance with national coding guidelines. It is particularly important to accurately code because a patient's level of coverage under his or her benefit plan may vary for different services. You must submit a claim for your services, regardless of whether you have collected the copayment, deductible, or co-insurance from the patient at the time of service. All claims are validated using clinical editing software to check for coding accuracy.

Anesthesia

Anesthesia is processed following the American Society of Anesthesiologists (ASA) guidelines.

- One (1) unit = 15 minutes of anesthesia time
- All anesthesia time is prorated and rounded to the nearest tenth
- 5010 EDI transactions must be reported in minutes; should the procedure code have minutes in the description, then units are still acceptable

Immunizations and injectable medications

- Must include the appropriate National Drug Code (NDC) number and the corresponding quantity for each NDC unit dispensed
- Must include the appropriate HCPCS/CPT code and corresponding quantity for each HCPCS/CPT unit dispensed
- Reimbursement is based on CMS payment methodology for Part B drugs

DRG/APC reimbursements

DRG/APC reimbursement is validated using an outside vendor to verify DRG grouping and provide appropriate CMS pricing. DRG claims may be reviewed, post-payment, to determine necessity for DRG validation, which includes a complete review of medical records.

Fee schedules

Reimbursement is based on the current Medicare fee schedule for the appropriate geographical area unless otherwise stated in the provider's contract.

Modifiers

The AMA industry standard modifiers are acceptable for billing. The Correct Coding Initiative (CCI) guidelines for claims payment and use of modifiers are used when adjudicating claims. CPT defines the standard, acceptable modifiers to be used for professional claims. HCPCS also includes acceptable modifiers for services not defined by CPT. Optum accepts modifiers published by CPT and HCPCS.

Multiple procedures

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

Reading the provider remittance advice (PRA)

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

Denied claims are listed on the PRA with a detailed denial reason or reasons. These are helpful to refer to when submitting a provider dispute, correcting a claim, or contacting the service center with questions regarding a claim.

Electronic remittance advice (ERA) and electronic funds transfer (EFT)

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

Benefits include:

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

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

Electronic data interchange (EDI)

Optum encourages and supports EDI, particularly claims and encounters. Electronic claims submission lets you eliminate the hassle and expense of printing, stuffing, and mailing your claims to the network. It substantially reduces the delivery, processing, and payment time of claims. There is no charge for submitting claims electronically to the network. Providers can use any major clearinghouse.

Payer ID: LIFE1

Benefits of EDI:

Reduces costs

- No more handling, sorting, distributing, or searching paper documents
- Keeps health care affordable to the end customer

Reduces errors

- Improves accuracy of information exchanged between health care participants
- Improves quality of health care delivery and its processes

Reduces cycle time

- Enhanced information is available quicker
- Ensures fast, reliable, accurate, secure, and detailed information

EDI format

EDI has a standardized format, which ensures that data can be sent quickly and is interpreted on both sides. EDI transactions adhere to HIPAA regulations and American National Standards Institution (ANSI) standards.

Helpful billing and claims hints

Things to remember when billing and submitting claims:

- EDI submission is the way Optum prefers to receive claims. It's fast, easy, and cost effective; always verify the patient's eligibility at the time of service
- Submit the most current information; this will increase the chance of accurate payment
- Provide accurate data and complete all required fields on the claim
- If the provider has time limits for claims submission in the contract, be sure to know what they are and submit claims accordingly
- Know the contract(s)–be sure all billing staff is familiar with current billing and contract information
- To verify and view claim status, go to **https://providers.optumcaremw.com** or contact the service center at **1-855-822-4325** Monday–Friday, from 8 a.m.–8 p.m; please have a current tax ID available

Glossary of claims terminology

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

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

Ambulatory surgery center (ASC): Used for payments to a surgery center

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

Capitation: Method of payment for health services in which a physician or hospital is paid a fixed amount for each person served regardless of the actual number or nature of services provided each person. This is a per-patient-per-month (pppm) payment to a provider/provider organization that covers contracted services and is paid in advance of delivery of any services. The rate can be fixed, adjusted by age/gender of enrollees, or 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

Diagnosis related group (DRG): A patient classification scheme that categorizes patients who are medically related with respect to diagnoses and treatment, and are statistically similar in their lengths of stay

DRG payment method: An approach to paying for hospital inpatient acute services that bases the unit of payment on the DRG system of classifying patients. (primarily used for Medicare patients)

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

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

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

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

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

Global period: A time period set aside before and after a surgical procedure is done. This includes the initial visit and any follow-up visits. Per CMS claims processing manual, section 40, including but not limited to minor surgery, endoscopies, and global surgical packages

Maximum out-of-pocket (MOOP): Out-of-pocket expenses are copays, deductibles and 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 the rest of the year

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

Misdirected claim: A claim that is submitted to the incorrect payer and must be forwarded to the appropriate financial entity

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

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

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

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

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

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

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

Credentialing and recredentialing

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

Initial credentialing

The initial credentialing process takes approximately 60 to 90 days to complete, from receipt of completed credentialing application to committee approval. Once received, the credentialing process will begin. The credentialing time frame directly depends on receiving verifications from the primary source verification sources in a timely manner. If receipt of those verifications is delayed, it will hold up completion of the process. If the packet is not complete (e.g., required documents are not attached, fields on application not filled in, etc.), this will also delay the processing of the application. The credentialing department has a streamlined verification process that enables short turn-around times. An overview of the initial credentialing process is on the following page.

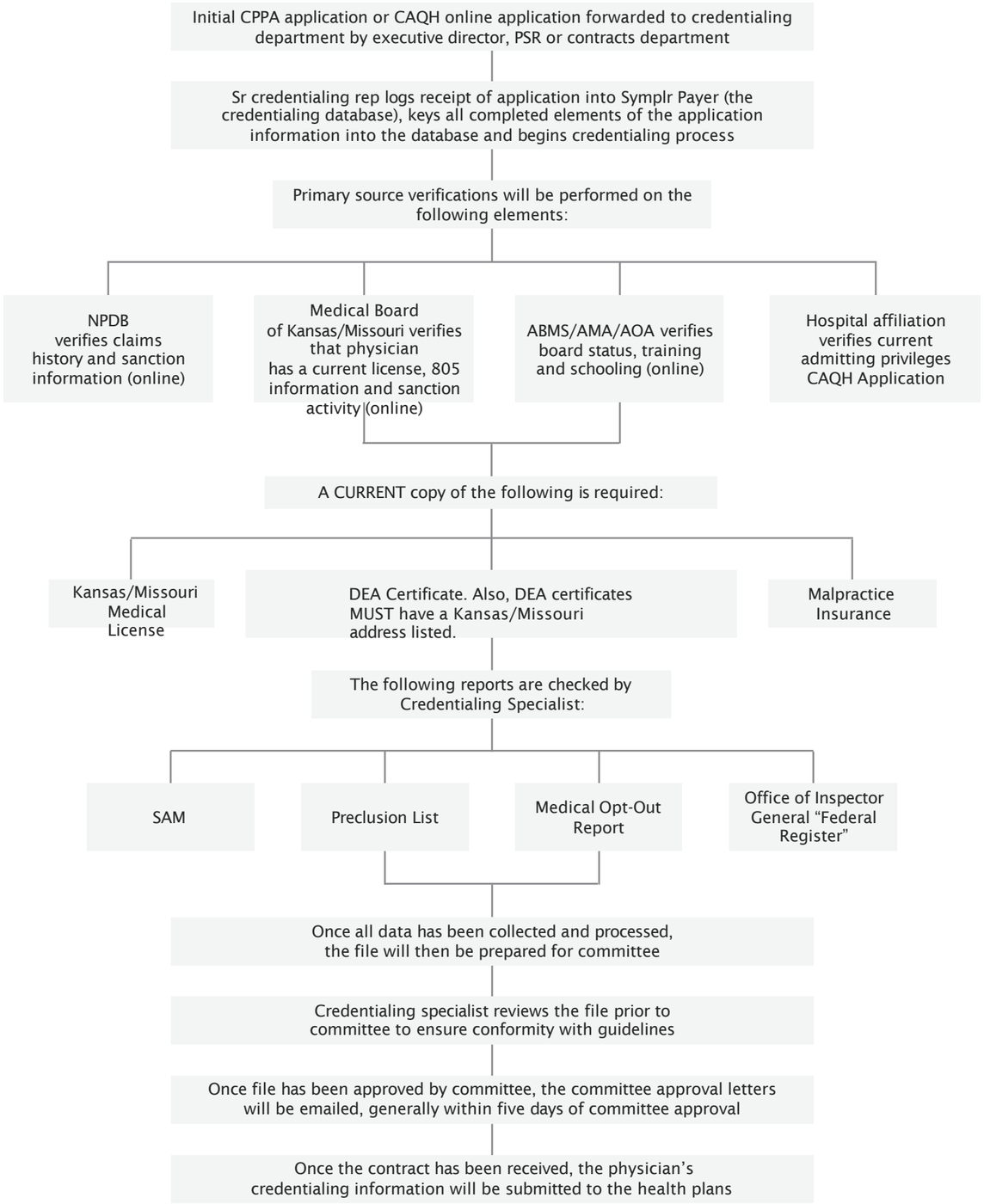
Recredentialing

Recredentialing occurs every three years. Five months prior to the three-year credentialing anniversary, the provider will be required to log in to 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. The CAQH website is **proview.caqh.org**. If you need your CAQH provider ID number, please contact the credentialing department and they will provide it. Providers shall promptly notify Optum and the credentialing department if they no longer meet the group's credentialing criteria (e.g., medical license revoked or opted out of Medicare).

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

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

Credentialing flow chart



Health improvement

General information

Optum affirmative statement

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

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

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

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

Quality improvement

Introduction to quality improvement (QI)

Committee mission

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

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

Committee goals

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

Committee objectives

- The committee shall oversee the following functions:
- Review and adoption of QI program and related policies and procedures
- Review and adoption of UM program, UM work plan and related policies and procedures
- Review and adoption of Complex Care Management (CCM) program and related policies and procedures
- Review and adoption of Population Health Management (PHM) 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

CMS quality measure overview

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

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

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**.

CAHPS measures

Consumer Assessment of Healthcare Providers and Systems (CAHPS) is an annual survey that asks consumers and members to report on and evaluate their experiences with health care. The CAHPS survey is governed by CMS and NCQA. Details include:

- The survey is given annually between March and June to adults ages 18 and older who have been enrolled in a health plan during a continuous six-month period for Medicare and Medicaid, or a 12-month period for commercial. For Medicaid only, guardians of children ages 17 and younger are also given the survey if they've been enrolled in a plan for a continuous six-month period.
- Respondents are asked a core set of questions determined by NCQA and CMS, in addition to a series of optional supplemental questions crafted by a health plan and approved by NCQA and CMS.
- If a member doesn't respond to the survey, they're given the option to complete it by phone.
- Results are calculated and released between August and November.

HOS measures

Health Outcomes Survey (HOS) is a health plan member survey by CMS that gathers health status data specific to the Medicare Advantage program. Respondents are given a baseline survey between late August and November and then asked to complete a follow-up survey two years later.

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

Medical records standards

In an effort to promote the optimal health of each patient through complete and accurate medical record documentation, Optum has a standard set of guidelines for patient medical records. The guidelines have been established by the National Committee of Quality Assurance (NCQA) and state and federal regulators, for medical record documentation (protected health information or PHI).

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

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

Patient language
Each patient's health record will include the patient's primary language, as well as any linguistic services needed for non- or limited-English proficient or hearing impaired persons. Use and/or refusal of interpreters will be documented.

Practitioner identification
All entries will be identified as to the author. It is suggested that this is by full signature (first and last name, and title), but electronic identifier or initials are acceptable. Further, all physician assistant (PA) and/or nurse practitioner (NP) signatures must be cosigned by the supervising physician.

Entry date
All entries will be dated.

Legible
The record will be legible to someone other than the writer. Any record judged illegible by one practitioner reviewer may need to be evaluated by a second reviewer before it is deemed illegible.

Working diagnoses
Working diagnoses are consistent with findings.

Problem list
Significant illnesses and medical conditions will be identified on the problem list. If the patient has no known medical illnesses or conditions, the medical record will still include a flow sheet for health maintenance.

Allergies
Medication allergies, adverse reactions, and/or the absence of allergies (NKA) will be noted on the front of the chart. A stamp, with red ink, may be provided to each primary care physician office, if requested.

Advance directives
Presence of an advance directive or evidence of education about advance directive of patients over the age of 18 must be noted. Patients will be provided information as to making their own health decisions. Advance directives supplied to the practitioner must be included in the medical record.

Medical records
Patient charts will be maintained in an area secure from public access, located for easy retrieval of both active and inactive charts. Each chart should be well organized in a standard format with the contents fastened and/or secured and containing only one individual's information.

Past medical history (for patient seen three or more times)
Past medical history will be easily identified, including serious accidents, operations, and illnesses. It is recommended to include sexual activity and mental health status, if applicable. For children and adolescents (18 years or younger), past medical history will be noted as above and will include childhood illnesses, immunizations, and prenatal care and births, if applicable.

Smoking/ETOH/substance abuse
Medical records for patients who are 14 years of age and older must contain a notation that the patient has been asked about depression, violence, alcohol, substance and cigarette use, and counseled as necessary.

History and physical
Appropriate subjective and objective information will be obtained for the presenting complaints.

Appropriate use of lab and other studies
Laboratory and other studies ordered will be noted, as appropriate.

Risk factors
Possible risk factors for the patient relevant to the particular treatment will be noted.

Plan/treatment
Treatment plans are consistent with diagnoses.

Return visit
Progress notes will have a notation concerning follow-up care, calls, or visits. A specific time to return for an appointment will be noted in weeks, months, or as needed.

Follow-up
Encounter forms or notes will have a notation, when indicated, regarding follow-up care, calls, or visits. Missed appointments will be noted in the medical record, including outreach efforts. Unresolved problems from previous office visits will be addressed in subsequent visits. Follow-up of referrals with any lab or test results should be maintained as well.

Appropriate use of consultants
Review for under- and over-utilization will be noted. For example, repeated visits with a PCP for an unresolved problem might lead to a request for consultations with a specialty physician.

Continuity of care
For example, if a consultation is requested, a note from the consultant, after the visit, must be documented in the record. If the visit does not occur (e.g., failed visit by the patient) the failure to visit should be documented as well.

Consultants/X-rays/lab and imaging report initials
Consultations, lab and X-ray reports filed in the chart will have the primary care physician's initials and date signifying review. Consultation and abnormal results will have an explicit notation in the record of follow-up plans. Recommendation that date report/results received will be noted.

Medication documentation
Current medication is documented, including complete dosage information, dates, and refill information.

Immunization record
For adult immunization, physicians will follow the guidelines from the United States Preventive Services Task Force. For pediatric records (age 18 and under), there will be a completed immunization record or a notation that "immunizations are up-to-date."

Preventive services
There will be evidence that preventive screenings and services are offered. A suggested checklist may be provided to each office for use and inclusion in the medical record.

Addendum to record
Any adult patient who inspects his/her record will have the right to provide to the physician a written addendum with respect to any item or statement in the record that the patient believes to be incomplete or incorrect. The addendum, which should be written on a separate page and include all applicable requirements (such as patient name, ID number, etc.) will be limited to 250 words per alleged incomplete or incorrect item and will clearly indicate, in writing, that the patient wished the addendum to be a part of the record. The physician will attach the addendum to the record and will include the addendum whenever the physician makes a disclosure of the alleged incomplete or incorrect portion of the record to any third party. The receipt of information in an addendum that contains defamatory or otherwise unlawful language, and the inclusion of this information in the record, will not, in and of itself, subject the physician to liability in any civil, criminal, administrative, or other proceeding.

Appointment access criteria

PCP and specialty access standards	
Access type	**Standard**
Access to non-urgent appointments for primary care-regular and routine care (with a PCP)	Within 10 business days of request
Access to urgent care services (with a PCP or SCP) that do not require prior authorization	Within 48 hours of request
Access to urgent care (specialist and other) services that require prior authorization	Within 96 hours of request
Access to after-hours care (with a PCP)	Ability to contact on-call physician after hours within 30 minutes for urgent issues (appropriate after-hours emergency instructions)
Access to non-urgent appointments with a specialist	Within 15 business days of request
In-office wait time for scheduled appointments (PCP and specialist)	Not to exceed 15 minutes
Access to preventive health services	Within 30 days of initial request
Non-urgent appointments for ancillary services for the diagnosis or treatment of injury, illness, or other health condition	Within 15 business days of request
Appointment rescheduling	The provider must promptly reschedule the appointment in a manner that is appropriate for the patient's health care needs

Appointment access standards behavioral health	
Access to non-urgent appointment with physician for routine care	Within 10 business days of request
Non-urgent appointments with a non-physician behavioral health care provider	Within 10 business days of request
Access to urgent care	Within 48 hours of request
Access to non-life-threatening emergency care	Within six hours of request
Access to life-threatening emergency care	Immediately
Access to follow-up care after hospitalizations for mental illness	Within seven business days of request (initial visit); within 30 business days of request (second visit)

Exceptions	
Extending appointment waiting time	May extend waiting time for an appointment if the appropriate health care provider has determined and noted in the relevant record that a longer waiting time will not have a detrimental impact on the health of the member
Advance access	Implementation of standards, processes, and systems providing same or next business day appointments from the time an appointment is requested will demonstrate compliance for a PCP practice (includes advance scheduling of appointment at a later date if the member prefers not to accept the appointment offered within the same or next business day)
Advance scheduling	Preventive care services and periodic follow-up care may be scheduled in advance consistent with professionally recognized standards of practice as determined by the treating licensed health care provider

Appointment access criteria

Preventive care recommendations for men and women ages 50 and older

Immunizations	
Flu, annual	Recommended
Hepatitis A	For individuals with risk factors; for individuals seeking protection
Hepatitis B	For individuals with risk factors; for individuals seeking protection
Pneumococcal (pneumonia)	Recommended for individuals 65 and older and individuals under 65 with risk factors
Td booster (tetanus, diphtheria)	Recommended once every 10 years
Varicella (chicken pox)	Recommended for adults without evidence of immunity; should receive two shots
Zoster (shingles)	Recommended for all adults 50 and older

Screenings/counseling/services	
AAA (abdominal aortic aneurysm)	For men ages 65 to 75 who have ever smoked; one-time screening for AAA by ultrasonography
Alcohol misuse	Behavioral counseling
Aspirin	Visit to discuss potential benefit of use
Blood pressure, depression, height, weight, BMI, vision and hearing	At wellness visit, annually
Breast cancer	Recommended mammogram every one to two years for women ages 50 to 74
Breast cancer chemoprevention	Covered for women at high risk for breast cancer and low risk for adverse effects from chemo prevention
Cervical cancer	At least every three years if cervix present; after age 65. Pap tests can be discontinued if previous tests have been normal
Colorectal cancer	Recommended for adults 45 to 75
Depression	For all adults

Screenings/counseling/services (continued)	
Diabetes	Recommend Type 2 diabetes screening for individuals who are overweight, obese, have sustained blood pressure greater than 135/80 mm Hg, or diagnosed HTN
Domestic violence and abuse	Screening and counseling for interpersonal and domestic violence
Gonorrhea	Recommended for all sexually active women who are at increased risk for infection
HIV	For all adults at increased risk for HIV infection
HPV	Recommended for all sexually active women 65 and younger
Lipid disorder	Screening periodically
Obesity	Screening, counseling, and behavioral interventions
Osteoporosis	Recommend routine screening for women 65 and older; routine screening for women under age 64 if at increased risk
Prostate cancer	Men 55–69 should have a discussion with their PCP to determine if screening is appropriate for them
Sexually transmitted infections	Behavioral counseling as needed
Syphilis	Recommended for individuals at increased risk for infection
Tobacco use and cessation	Screening for tobacco use and cessation intervention

Heart health

For heart health, adults should exercise regularly (at least 30 minutes a day on most days), which can help reduce the risks of coronary heart disease, osteoporosis, obesity, and diabetes. Patients should consult a physician before starting a new vigorous physical activity.

Other topics to discuss with patients

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

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

Substance abuse
- Stop smoking; limit alcohol consumption; avoid alcohol or drug use while driving

Dental health
- Floss and brush with fluoride toothpaste daily; seek dental care regularly

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

Prior authorizations

Introduction to utilization management (UM) and prior authorization

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

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

More about prior authorization

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

We strongly encourage you to use the provider portal to submit prior authorizations where you can check the status of your submissions without any follow-up phone calls or faxes.

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

Instances in which prior authorization is required

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

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

Instances in which prior authorization is not required

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

How to request prior authorization

A patient, authorized representative, or provider may request prior authorization via internet, fax, phone, and U.S. postal mail:

- Online: **https://optumcare.com/provider-login**
- Fax: **1-888-992-2809**
- Phone: **1-855-822-4325**

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

Utilization management

Requirements for hospital 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 skilled nursing facility (SNF) admissions
- All post-acute care admissions
- All admissions following outpatient surgery
- All admissions following observation
- All admissions for observation

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

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

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 TIN or NPI
- Admitting/attending physician name and TIN or NPI
- Description for admitting diagnosis or ICD-10-CM (or its successor) diagnosis code
- Actual admission date
- Inpatient or observation status

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

Online submission

Online: **https://optumcare.com/provider-login**

Requirements for discharge notification

Hospitals must notify us of a discharge from an acute facility within 24 hours after a weekday discharge (or by 5 p.m. local time on the next business day if the 24-hour limit would require notification on a weekend or holiday). For weekend or holiday discharges, we must receive the notification by 5 p.m. local time on the next business day.

Reimbursement reductions for failure to provide timely admission notification

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

How to submit admission notifications

You can notify Optum of admissions via internet and phone.

- Online: **secure.optumcare.com/provider/account/logon**
- Phone: **1-855-822-4325**
- Fax: **1-888-822-4325**

All skilled nursing facility (SNF) and post-acute care admissions can be submitted to Navi Health.

- nH Access Portal: To enroll in nH Access, please visit **https://partners.navihealth.com/partner/nh-access**
- Fax: **1-844-244-9482**
- Phone: **1-855-851-1127**

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

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

Coordination of benefits (COB) when Optum is not the primary payer

If a patient presents current proof of other primary insurance making Optum the secondary payer, the provider has the right to bill the primary insurance and collect the applicable copays from the patient. The provider should bill Optum 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. Please include COB information on electronic claim submissions.

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

Workers' compensation

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

Provider dispute resolution process

The goal of Optum is to provide affiliated physicians and providers with readily accessible information that expedites interaction with our organization and assists providers in their managed care and business operations.

Definition of a provider dispute
A provider dispute is a provider's written notice challenging or 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.

Each provider dispute must contain, at a minimum, the following information:
- Provider's name
- Provider's TIN
- Provider's contact information

If the provider dispute concerns a claim or reimbursement of an overpayment of a claim from Optum, the following must be provided:
- Clear identification of the disputed item, such as the claim(s) number
- Date of service
- Clear description of the dispute

If the provider dispute is not concerning a claim, the following must be provided:
- Clear explanation of the issue
- Provider's position on the issue

Things to remember when submitting a provider dispute:
- Provider dispute forms must be completed in full and included with the dispute.
- To download a copy of the Optum provider dispute resolution request, visit
- **https://www.optum.com/business/hcp-resources.html?selectedFilters=Kansas**
- All required information must be included; disputes that are missing information will be returned to the submitter

Medical management and center for service coordination

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

Medical management request process
To refer members to Optum medical management programs, submit a completed Optum request form via secure email to the CSC at **KCM.CAC.General@optum.com** or fax to **1-844-249-0919.**

Requests will initiate a response within two business days unless otherwise indicated as urgent, for which we will respond within one business day.

Medical management services

Complex Case Management:
- Dedicated RN case manager and social worker (LMSW or LCSW)
- In-person and telephonic support
- Health goal development
- Coordinate access to community resources and services
- Disease management education and medication review
- Post-discharge follow-up
- Coordination of community resources to address social determinants of health
- Coordinate access to community resources and services

Disease Management:
- Dedicated to RN case manager
- Support patients dealing with new diagnosis or uncontrolled diabetes, COPD, CAD, CHF, or CKD
- In-person and telephonic support
- Coordinate access to community resources and services
- Reduce or eliminate health risk factors
- Disease education (diet, medication management, complications, exercise, and self-management techniques)
- Facilitate diabetic wound care

Medical Behavioral Integration:
- Dedicated RN case manager
- In-person and telephonic support
- Integrated process to meet the patient's medical and behavioral health needs
- Education on available community and behavioral health resources
- Medication review
- Interventions for behavioral and substance abuse disorders

For more information, or if you have questions regarding any of these programs, please call the CSC at **1-913-215-7400** or email **KCM.CAC.General@optum.com**

Additional care management resources

Optum Behavioral Health
For direct referrals regarding behavioral health needs, call the behavioral health number on the back of patient's card.

Optum NurseLine: Call number on the back of patient's card
24-hour access hotline for patient to reach a nurse to answer questions regarding health concerns

Healthy Mindsets!®

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

Following areas of medical care:

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

Members determine how much they want to participate. The program was created for efficiency, offering them the help they need in as little time as possible. To get started, visit **healthy-mindsets.com**. Use the wellness code **OCAZPC** to sign in and start using the tools and trainings today.

Medicare risk adjustment

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

CMS hierarchical condition categories (HCC) model

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

Hypothetical illustration payment under the CMS HCC:

Mr. Smith	**Mr. Carter**
• Lives in Marlboro County • 78 years old	• Lives in Marlboro County • 78 years old
Has: • CHF (with hospital admission) • Diabetes • Renal failure	**Has:** • Not seen a doctor in two years
Medicare monthly payment: • $1,599	**Medicare monthly payment:** • $289

Keys to success with risk adjustment:

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

Coding and documentation:

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

Documentation:

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

Annual Wellness Visits:

- Face-to-face visit with all seniors
- PCPs are reimbursed by Optum for each senior patient for whom they conduct an annual wellness visit (AWV) and complete the corresponding attestation form
- The attestation form must be completed in its entirety and submitted to Optum for processing.
- The form itself will be used to report the encounters
- AWV can be conducted in the PCP office and in an Optum Community Center

Optum will offer education about this process to providers and their office staff. For more information, please contact Optum provider services at **1-877-488-5582**.

Medicare compliance

Expectations and training

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

As a delegate that performs administrative or health care services, CMS and other federal or state regulators require that you and your employees meet certain FWA and general compliance requirements. FDRs are expected to have an effective compliance program, which includes training and education to address FWA and compliance knowledge. As of January 1, 2019, FDRs are no longer required to complete the specific CMS FWA training modules or retain documentation of the training. However, Optum Care Network–Kansas & Missouri's expectation remains that FDRs, and their employees, are sufficiently trained to identify, prevent, and report incidents of non-compliance and FWA. This includes temporary workers and volunteers, the CEO, senior administrators or
managers, and subdelegates who are involved in or responsible for the administration or delivery of UnitedHealthcare MA or Part D benefits or services.

We have general compliance training and FWA resources available at **unitedhealthgroup.com**

What you need to do

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

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

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

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

Reporting misconduct

If you identify compliance issues and/or potential fraud, waste or abuse, please report it to us immediately so we can investigate and respond appropriately. Please see the reporting misconduct section of the UnitedHealth Group code of conduct. Reports may be made anonymously, where permitted by law at **unitedhealthgroup.com/about/ethics-integrity.html**. Optum expressly prohibits retaliation if a report is made in good faith.

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

Preclusion list policy

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

- Are revoked from Medicare, are under an active re-enrollment bar, and CMS has determined that the underlying conduct that led to the revocation is detrimental to the best interests of the Medicare program
- 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 CMS deems this detrimental to the best interests of the Medicare program

Care providers receive a letter from CMS notifying them of their placement on the preclusion list. They can appeal with CMS before the preclusion is effective. There is no opportunity to appeal with Optum Care Network–Kansas & Missouri.

CMS updates the preclusion list monthly and notifies MA and Part D plans of the claim rejection date, which is the date on which we reject or deny a care provider's claims due to precluded status. Once the claim-rejection date is effective, a precluded care provider's claims will no longer be paid, pharmacy claims will be rejected and the care provider will be terminated from the Optum Care Network–Kansas & Missouri. Additionally, the precluded care provider must hold Medicare beneficiaries harmless from financial liability for services provided on or after the claim rejection.

Notes