Optum Care Network Washington

Provider Manual

2024

A message from President Dr. Imelda Dacones

Dear Colleague,

Thank you for being a participating clinician with Optum Care Network of Washington. We appreciate your partnership in providing affordable, high-quality health care for our members and communities.

As a health care provider, your primary focus should be on your patients and their care. We understand this and exist to support you in your endeavors. Our patient-centered value-based care model, with its wrap-around services and administrative functions that work with multiple payers, frees up your time for your own self-care. Our goal is to ensure that you have the resources and support you need to provide the best possible care for your patients.

With Optum Care Network of Washington, you get the support of a health care industry leader while you remain independent and able to make your own decisions. You also get a *national* team of doctors connecting you, your practice and your care delivery to the latest evidence-based breakthroughs. And you have access to *local* resources with a collaborative team always ready to help you and your patients.

This provider manual offers valuable information about the Optum Care Network of Washington and how to work effectively with us. We hope it will be a user-friendly reference guide and educational resource for you and your staff. We strive to continually improve and provide the best service and useful information to you. Please don't hesitate to reach out and share your comments and suggestions on this manual.

Our secure provider portal is located on our home page. It is available for your convenience to verify eligibility, claims status, submit, and review prior authorization status, and medical inquiries.

As your partner and support, we, Optum Care Network of Washington, are here to ensure a seamless experience for you, your staff, and our patients and enrollees.

Together, we will help people live their best lives.

Sincerely,
Imelda Dacones, MD FACP
President, OptumCare Washington

Provider Manual Overview

This provider manual is an extension of your participation agreement. It includes important information for all providers, facilities, and practice staff interacting with OCN regarding policies, procedures, claims submissions and adjudication requirements, and guidelines used to administer plans. This provider manual replaces and supersedes all previous versions and may be updated from time to time by Optum Network of Washington to meet regulatory requirements and network operations without prior notice.

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

As policies and procedures change, practices will be notified, and updates will be made to the electronic version of the provider manual available on our website.

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

Delegation Defined

Delegation is a formal process or contract granting an enterprise authority to execute specific functions on behalf of an organization. Optum Care Network (OCN) has been granted specific delegation functions by certain health plans. The health plan is the responsible party for the benefit plans it offers to its members. As the delegating party, the health plan must remain apprised of the delegate's actions, ensuring adherence to compliance standards.

In full delegation, this translates to providing certain administrative services on behalf of the plans to credential providers, provide care management services, administer utilization management, and adjudicate claims. OCN has additional plan relationships that serve to delegate specific functions of health plan work. Please refer to the Delegation by Plan table in the Appendix for full details on this delegation.

Please contact Network Relations and Contracting if you have additional questions at ocnwacontracting@optum.com

Health Plan Contracts

OCN is currently contracted with the following Plan and Benefit Plans:

- First Choice Health
- Humana Medicare Advantage Plans
- Premera Medicare Advantage Plans
- UnitedHealthcare Medicare Advantage Plans
- UnitedHealthcare Medicaid

This list is subject to change.

Delegation by Plan

Please refer to the Delegation by Plan in the Appendix.

Contact Information

OCN Main Number General Information	8 a.m. to 5 p.m., Monday to Friday Phone: 877-836-6806
OCN Resources	https://professionals.optumcare.com/resources-clinicians.html
Website Address	https://partner.optum.com/washington/
Provider Portal	https://onehealthport.com
Customer Service Eligibility, claims/auth status, general billing questions, Prior Authorization Intake	8 a.m. to 5 p.m., Monday to Friday Phone: 877-836-6806 Fax: 855-402-1684
Claims Payer ID Claims Mailing Address Claims Issue Escalation (Please first contact the Service Center)	**LIFE1** PO Box 30788, Salt Lake City, UT 84130-0788 opshelp@optum.com
Health Care Coordination Pre-authorization	https://onehealthport.com 8 a.m. to 5 p.m., Monday to Friday Phone: 877-836-6806 Fax: 855-402-1684
Health Care Coordination Hospital notifications, emergency admissions, case management	https://onehealthport.com 8 a.m. to 5 p.m., Monday to Friday Phone: 877-836-6806 Fax: 253-627-4708
Network Relations and Contracting	OCNWAContracting@optum.com
Credentialing	credentialing@optumpnw.com
Network Engagement	engagementteam@optumpnw.com
Utilization Management	**Pre-Service:** Phone: 877-836-6806 Fax: 855-402-1684 **Inpatient Admission:** Phone: 253-627-4113 Fax: 253-627-4708
Address send general information to Optum Care Network Administration	Optum Care Network Administration 904 7th Ave, 2nd Floor, Admin Office Seattle, WA 98104

Network Relations and Contracting

The Network Relations and Contracting team is responsible for contracting, onboarding, and training new providers, managing the contract lifecycle, and operational issue escalation. Please reach out to the Network Relations and Contracting team for:

- New provider onboarding and orientation
- Portal training
- Operational issue escalation

Credentialing

Credentialing refers to the process performed by OCN to verify and confirm that an applicant meets the established policy standards and qualifications for participation with OCN. There are currently no fees charged for credentialing. Upon completion of the credentialing verification process, each applicant is presented for review and recommendation to the Medical Director/Credentialing Committee Chair (or designee) or the Credentialing Committee, which is comprised of physicians and practitioners of various specialties.

OCN performs credentialing activities on behalf of health plans for which a credentialing delegation agreement has been executed. Credentialing applies across all health plan lines of business. The information provided in the table below is subject to change.

Health Plan/CarrierHealth Plan/Carrier	Providers Credentialed
Humana	Medical, Physical Rehabilitation, & Behavioral Health Providers
Premera	Medical Providers, Physical Rehabilitation, & Behavioral Health Providers
UnitedHealthcare	Medical Providers
First Choice Health	Medical, Physical Rehabilitation, & Behavioral Health Providers

Providers Joining Your Practice

Unless the practice has a credentialing sub-delegation arrangement in place with OCN where the practice has assumed all credentialing responsibility that meets OCN standards, all providers joining an existing practice must complete the credentialing process with OCN. Until the provider has successfully completed the credentialing process, claims may not be reimbursed appropriately and/or denied payment. Contact Network Relations and Contracting or OCN Credentialing at least 60 days prior to your new provider seeing patients to minimize any reduction or denial of payment.

Types of Providers Credentialed

OCN credentials the following provider types:

- MD
- DO
- DPM
- ARNP
- PA-C
- OT
- CNM
- RNFA
- OD
- PhD
- SUDP
- ST
- PharmD
- PsyD
- LMHC
- LMFT
- LSW
- RD
- PT

Providers Adding Location(s)

Unless a credentialing sub-delegation arrangement is in place with OCN, all provider locations must complete the credentialing process. Until the additional location has successfully completed the credentialing process, authorizations and claims payment will be delayed. Contact Network Relations and Contracting or OCN Credentialing at least 60 days prior to your new location seeing patients to minimize any denial of authorization or reduction in payment.

Types of Facilities Credentialed

- Ambulatory Surgery Centers
- Behavioral Health (facility)
- Birthing Centers
- Chemical Dependency Treatment Centers
- Home Health
- Home Infusion Therapy
- Hospitals
- Independent Diagnostic Testing Facility
- Laboratories
- Radiology (except therapeutic/interventional radiologists who are credentialed individually)
- Skilled Nursing Facilities
- Urgent Care Centers

Sub-Delegation of Credentialing

OCN may delegate specific credentialing and recredentialing responsibilities to practice entities. Determination of whether a practice can be delegated is dependent on the successful results of a pre- delegation audit and execution of a credentialing sub-delegation agreement. Contact OCN Credentialing for additional information regarding eligibility and qualification.

Recredentialing

The recredentialing cycle occurs at least every thirty-six (36) months for providers and facilities. Non-response or failure to return a completed recredentialing application(s) and supporting documentation may be considered a voluntary termination of participation, unless otherwise determined by the Credentialing Chair and/or Credentialing Committee in accordance with the credentialing program.

Exceptions to this may include active military assignment, maternity/paternity leave, or sabbatical. Please review the OCN Credentialing Program document or contact OCN Credentialing for additional information.

Credentialing Corrective Action

Should OCN determine a provider or facility has failed to meet performance expectations, as laid out in OCN's Credentialing Program, pertaining to quality of care, patient services, or established performance or professional standards, a corrective action plan may be implemented.

If a corrective action is not satisfactorily resolved within the designated period, the Credentialing Chair has authority to recommend extension of the corrective action plan or suspension/termination from network participation.

Providers/facilities who are suspended or terminated may have the right to appeal. Where an appeal is not reversed, OCN will notify the National Practitioner Data Bank and network affiliated entities (health plans) as required by law and contractual agreements.

The OCN Credentialing Program I may be provided upon request for additional details regarding corrective action, suspensions, terminations, and appeals.

Provider/Facility Rights

Providers and facilities have the right to review information submitted in support of their credentialing application. However, this is limited to information obtained from any outside primary source such as malpractice insurance carriers and state license boards.

Providers and facilities have the right to correct erroneous information in the event credentialing information received from other sources conflicts with information provided by the provider or facility.

Providers and facilities have the right to appeal a decision made by the Credentialing Chair and/or the OCN Credentialing Committee.

For detailed information regarding your rights, you may request a copy of the OCN Credentialing Program.

Changes to Your Practice/Facility

All changes to your practice or facility should be provided to OCN in accordance with the terms of your participation agreement or as soon as reasonably possible. This includes, but is not limited to:

- Change in address
- Change in ownership/control
- Change in Tax Identification Number (TIN)
- Additions
- Deletions
- Terminations
- Changes to licensure (actual or threatened) resulting in loss, suspension, or material limitation of a provider's license
- Changes to staff membership or clinical privileges at any hospital
- Changes to formal disciplinary action, if any
- Change to any malpractice action filed against or decided adversely to provider

All changes should be sent to credentialing@optumpnw.com for processing. Please use the Provider Group/Practitioner Change Form found in the Appendix for this submission. OCN credentialing will notify health plans monthly for those plans which OCN has a delegated credentialing agreement in place.

If a provider terminates from your practice, your participation agreement requires notification to OCN via email to credentialing@optumpnw.com within 30 days of departure. You are required to inform OCN who patients should be reassigned to via e-mail. For more information on this topic, please refer to the Patient Reassignment section of the provider manual.

Termination of Participation

Providers/facilities are contractually required to provide adequate notice of termination of network participation pursuant to the contract terms and provision governing termination notice as termination will impact patient care and your credentialing status with Optum Network's contracted health plans. Upon termination with OCN, your credentialing will revert to being performed directly by the health plans with whom you are contracted. Providers/facilities should plan accordingly to ensure no disruption in services for patients. Please refer to your provider or facility participation agreement termination and continuity of care provisions.

Change in Ownership/Control

Changing ownership or control of a practice requires a conversation with OCN Provider Contracting to determine next steps and impacts to contracting and credentialing. Contact Network Relations and Contracting to begin this process.

Closing your Practice

Closing your practice due to retirement or business considerations is a complex undertaking. The process can be very

different for primary care providers and specialists. OCN would like to support you in locating resources for your transition and understanding actions required. Please contact Network Relations and Contracting for assistance planning these logistics. The table below provides a start in preparing for such a change.

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

Identifying OCN Members/Patients

In most cases, an identifier can be found on the patient's health plan identification card listing OCN by Payer ID (LIFE1). Please refer to the health plan identification card samples in the Appendix. Additionally, providers and facilities can verify patient eligibility using the Provider Portal (see Portal Access section of the provider manual).

Patient Assignment and Reassignment

OCN manages patients assigned to primary care providers (PCPs) for Humana Medicare Advantage HMO, AARP Medicare Advantage HMO through UnitedHealthcare (UHC MA), UHC Medicaid, and Premera Medicare Advantage HMO. Patients are assigned to a Primary Care Provider through one of two methods. The patient either chooses a PCP at the time of enrollment, or the health plan assigns a PCP after enrollment if the patient has not designated a PCP. Practices should make every attempt to engage patients assigned to them and establish care.

In some cases, patients may be assigned to your practice in error. When this occurs, the health plan must be notified, and assignment must be corrected in their system(s). Patients who have not been seen by your practice but have been assigned to you should not be reassigned to another primary care provider unless that patient has initiated the process by following the steps below (see also Population Health section of the provider manual).

Humana:

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

UHC MA:

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

UHC Medicaid:

- Patients can call the UHC customer service number on the back of their ID card to request a different PCP, or
- Patients can complete a PCP change form by clicking here and fax to UHC.

Premera MA:

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

Releasing a Patient from your Practice

Dismissal of a patient from a practice who is covered under a Medicare Advantage HMO plan must be coordinated with the health plan and in accordance with applicable state regulations. The health plan will need the cause for dismissal and appropriate documentation. Please refer to health plan specific provider manuals for releasing a patient from your practice.

Claims

OCN is delegated to adjudicate and pay claims for certain health plans (see Delegation by Plan table in the Appendix) when the member's primary care physician is contracted with OCN. Providers and facilities are responsible for verifying patient eligibility and benefits and obtaining referrals/authorizations, if applicable, prior to services being rendered. Please refer to the table below for claims submission information by health plan.

Medicare Advantage Plans	Submit to	Claims Submission Information
United Healthcare HMO - MA • AARP Medicare Advantage Plan 1 (HMO-POS) • AARP Medicare Advantage Plan 2 (HMO-POS) • AARP Medicare Advantage Plan 3 (HMO-POS) AARP Medicare Advantage Walgreens (HMO-POS) • AARP Medicare Advantage Patriot (HMO-POS) • HARRISON ELECTRICAL SH-WA • CEMENT MASONS – WASHINGTON • MACHINIST H&W TRUST • UFCW LOCAL 555/WA • CITY OF SEATTLE • PACIFIC COAST SHIPYARDS • CARPENTERS HEALTH & SECURITY • RETIREE'S WELFARE TRUST	OCN	**Electronic Claims:** Payer ID# LIFE1 **Clearing House:** Any clearing house that sends claims to Optum360 **Paper Claims:** PO Box 30788, Salt Lake City, UT 84130-0788
UHC Medicare Advantage Choice PPO: • AARP Medicare Advantage Choice (PPO) • AARP Medicare Advantage Choice Plan 1 (PPO) • AARP Medicare Advantage Patriot (PPO) • AARP Medicare Advantage Choice Plan 2 (PPO) • AARP Medicare Advantage Walgreens (PPO)	OCN	**Electronic Claims:** Payer ID# LIFE1 **Clearing House:** Any clearing house that sends claims to Optum360 **Paper Claims:** PO Box 30788, Salt Lake City, UT, 84130-0788
Humana HMO • Gold Plus HMO (HMO-MAPD Plan)	OCN	**Electronic Claims:** Payer ID# LIFE1 **Clearing House:** Any clearing house that sends claims to Optum360 **Paper Claims:** PO Box 30788, Salt Lake City, UT 84130-0788
Humana PPO • HumanaChoice PPO (PPO-MAPD Plan) • Humana Honor PPO (PPO-MA only Plan)	Humana	**Electronic Claims:** Payer ID# 61101 **Clearing House:** Availity **Paper Claims:** PO Box 14601, Lexington, KY 40512

Premera Blue Cross HMO • Medicare Advantage (HMO-MAPD Plan) • Medicare Advantage Classic (HMO–MAPD Plan) • Medicare Advantage Classic Plus (HMO- MAPD Plan) • Medicare Advantage Core (HMO-MAPD Plan) • Medicare Advantage Core Plus (HMO-MAPD Plan) • Alpine (HMO-MA Only Plan) • Peak + Rx (HMO-MAPD Plan) • Sound + Rx (HMO-MAPD Plan) • Charter + Rx (HMO-MAPD Plan)	OCN	**Electronic Claims:** Payer ID# LIFE1 **Clearing House:** Any clearing house that sends claims to Optum360 **Paper Claims:** PO Box 30788, Salt Lake City, UT 84130-0788
D-SNP Plans	**Submit to**	**Claims Submission Information**
United Healthcare • Dual Complete (HMO D-SNP Plan)	UHC	**Electronic Claims:** Payer ID# 95959 **Paper Claims:** See back of patient's ID card
Humana • Gold Plus SNP-DE (HMO D-SNP Plan)	OCN	**Electronic Claims:** Payer ID# LIFE1 **Clearing House:** Any clearing house that sends claims to Optum360 **Paper Claims:** PO Box 30788, Salt Lake City, UT 84130-0788
Medicaid Plan	**Submit to**	**Claims Submission Information**
United Healthcare (Apple Health) • Community Plan • SCHIP	OCN	**Electronic Claims:** Payer ID# LIFE1 **Clearing House:** Any clearing house that sends claims to Optum360 **Paper Claims:** PO Box 30788, Salt Lake City, UT 84130-0788

Claims Submission

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

OCN Paper Claims
PO Box 30788
Salt Lake City, UT 84130-0788

OCN Electronic Claims
Payor ID#: LIFE1
Clearinghouse: Optum 360

Calling OCN Regarding Claims

- **Provider Call Center**: For claim or general inquiries, you may contact OCN by calling 1-877-836-6806
- **Calling Clearinghouse**: If utilizing a clearinghouse, you must contact them directly for filing requirements and/or status inquiries.

Claim Receipt Verification

For verification of receipt of paper claim by OCN within fifteen (15) working days of receipt, you may utilize one of the following options:

Telephone – You may call the provider service telephone number at 1-877-836-6806
Website – https://onehealthport.com for information about access to this website, please contact your OCN Practice Engagement Manager (PEM) representative.

You may verify the receipt of your electronic claims by contacting your clearinghouse directly.

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 provided 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 standard CMS coding.

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 or facility participation 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.

Dispute Resolution Process for Contracted Providers

Definition of a provider dispute – A provider dispute is a provider's written notice challenging and requesting the 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.

Examples of types of disputes:

- Underpayment and/or overpayment
- Denials
- Provider contracts
- Provider credentialling
- Eligibility

Each provider dispute must contain the following information:

- Member demographic information
- Provider's name, TIN, and contact information
- If the provider dispute concerns a claim or reimbursement of an overpayment of a claim from Optum
- Care the following must be provided:
- Clear identification of the disputed item, such as the claim(s) number, medical records, and
- invoices if applicable
- 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 such issue
- Helpful provider dispute submission tips
- Provider dispute forms must be completed in full and included with the dispute.
- All required information must be included; disputes that are missing information will be returned to the submitter.

To submit a provider dispute you can –

- **Contact the Optum Care service center at:**
  1-877-836-6806
  Monday – Friday, 8 a.m. – 5 p.m., PST
- **Send an email to our team at -** ocndisputewa@optum.com
- **Download a copy of the Optum Care provider dispute resolution request form:**
  - https://www.optum.com/business/hcp-resources/page.hub.provider-dispute-resolution-form-washington.html

Dispute escalations - In the event a provider has not been able to achieve timely or reasonable resolution on a submitted dispute they can escalate to Optum Care Market Operations Research and Escalation department for triage and intervention. For example:

- Resolution is not being met and/or additional research is required
- Complexity of the issue requires cross functional teams to drive resolution
- Level of provider escalation requires urgent action and/or resolution

In order to submit a request to the Research and Escalation team, it is required to complete the standard dispute submission process first and include the original dispute tracking number provided by the Provider Services or Claims Resolution departments with your escalation request. Send an email to our Market Operations Research and Escalation department at opshelp@optum.com.

Provider escalation process

1. Market Operations receives provider and claim escalations disputes via email from internal and external customers. Examples may include incorrect rates, provider contract status, incorrect claim denials.
2. Research Analysts are responsible for triaging and researching inquiries to determine root cause and identify potential trends.
3. Once the root cause is identified the Research Analyst will engage the appropriate operational team to assist with resolution. A communication is extended to the submitter to notify of findings and next steps for resolution.
4. Upon confirming resolution, the Research Analyst validates the issue has been remediated, and documents findings.
5. Research Analyst communicates resolution to the submitter.

Past Due Payments

If the contracted provider dispute or amended contracted provider dispute involves a claim and is determined in whole or in part in favor of the provider, OCN, as agent for the health plan, will pay any outstanding monies determined to be due, and all interest and penalties required by law, within five (5) working days of the issuance of the written determination.

Dispute Resolution Process for Non-Contracted Providers

A. **Definition of Non-Contracted Provider Dispute**: A non-contracted provider dispute is a non-contracted provider's written notice to OCN challenging, appealing, or requesting reconsideration of a claim (or a bundled OCN of substantially similar claims that are individually numbered) that has been denied, adjusted, or contested or disputing a request for reimbursement of an overpayment of a claim. Each non-contracted provider dispute must be submitted on a completed Provider Dispute Resolution Form and:

   i. If the non-contracted provider dispute concerns a claim or a request for reimbursement of an overpayment of a claim from OCN to provider the following must be provided: A clear identification of the disputed item, the date of service, and a clear explanation of the basis upon which the provider believes the payment amount, request for additional information, contest, denial, request for reimbursement for the overpayment of a claim, or other action is incorrect.

ii. If the non-contracted provider dispute involves an enrollee: The name and identification number(s) of the enrollee or enrollees, a clear explanation of the disputed item including the date of service, provider's position on the dispute, and an enrollee's written authorization for provider to represent said enrollees.

B. **Dispute Resolution Process**: The dispute resolution process for non-contracted providers is the same as the process for contracted providers.

Overpayment Recovery Process

OCN will seek reimbursement from any entity, as appropriate, for claims that were overpaid.

Misrouted Claims

If claim is misrouted to OCN that is not part of payer group that OCN processes, OCN shall either forward claims to appropriate payer for processing or send the provider a denial, notifying the provider that the claim was sent to OCN in error.

Electronic Funds Transfer

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

Enroll in Optum Financial automated clearing house (ACH) at www.optum.com/enroll to receive electronic payments. The following information is required to complete your enrollment:

- Current bank account information (account number and routing number)
- A copy of a voided check
- A W-9 or bank letter

Once you have submitted your Optum Financial enrollment, it may take up to 10 business days for your enrollment to be activated.

Optum Financial Support:

- Enrollment: 877-620-6194 and 888-477-0256 M-F 7am-6pm CT
- Payment Support: 888-477-0256 M-F 7am-7pm CT

Optum Financial URLs:

- Enrollment: www.optum.com/enroll
- Optum Financial Provider Portal: www.optum.com/optumpay

Charging Members

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

Additionally, 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 the 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 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.

Medicaid Claims

Coordination of Benefits (UHC Medicaid/Apple Health)

Our Medicaid benefits contracts are subject to coordination of benefits (COB) rules:

- COB: We coordinate benefits based on the member's benefit contract and applicable regulations. We do this during claims adjudication.

All other health insurance, including Medicare and Tricare, are primary over Medicaid. Medicaid is only primary to any Tribal Health coverage unless the member is employed by a tribe and is self-insured. When billing UnitedHealthcare Community Plan, submit the primary payer's Explanation of Benefits (EOB) or remittance advice with the claim.

HCA enrolls some fee-for-service Apple Health members who have other primary health insurance.
The HCA covers some members under the fee-for-service Apple Health program, such as dual-eligible members whose primary insurance is Medicare. This means:

- Affected members will have three ID cards: a ProviderOne card, a primary insurance card, and a UnitedHealthcare Community Plan card.
- You must verify eligibility. To verify member COB, please verify with UnitedHealthcare, not ProviderOne.
- If you bill us as a secondary payer, we will not require prior authorization. However, if the member's primary health insurance does not cover the service, you must follow our requirements.
- When COB payment is equal to or more than the allowable rate, the primary insurance has no patient responsibility, and the claim is paid in full, we require no additional payment.
- When COB payment is equal to or less than allowable rate with a patient responsibility from the primary insurance, we reimburse the patient responsibility up to the allowable rate.
- When the COB payment is less than primary's allowable rate for services performed, we pay for the difference between the primary payment and our allowable rate.
- Claims received with pediatric preventive, private duty nursing procedure codes and ABA procedure codes follow our Pay & Chase policy.
- We may bill or adjust claims with COB within 30 months of the initial process date.

Utilization Management

The OCN Utilization Management (UM) team works in concert with PCPs, specialists, and ancillary providers of care around the appropriate and efficient use of healthcare resources. The UM team also works collaboratively with discharge planners in hospitals and skilled nursing facilities to ensure positive patient outcomes.

OCN is not delegated for Utilization Management for all plans. Please refer to the Delegation by Plan table in the Appendix.

Referrals/ Prior Authorizations

Prior authorizations are not required for office visits, when referring to a specialist or facility that is directly contracted with OCN **or** the patient's health plan.

If your patient requires a specialist or facility that is not within OCN **or** the patient's health plan, a prior authorization is required. An authorization request form can be found on the Optum Care Provider Center and submitted online (via https://www.onehealthport.com/sso-payer/optum) or faxed to 1-855-402-1684.

- **Contracted OCN and/or Health Plan Providers:** Follow Health Plan Prior Authorization requirements for services/CPT codes requiring a Prior Authorization.
- **Non-Contracted Providers:** Prior Authorization is required for all services, excluding emergencies, dialysis, and urgently needed services when the network is not available.

2023 Prior Authorization Requirements:		
	Servicing Provider: OCN Contracted/ Plan Contracted (Provider is contracted with OCN or the health plan)	**Servicing Provider: Non-Contracted/Non-Par** (Provider is not contracted with OCN or the health plan)
UnitedHealthcare (Medicare PPO/HMO and Medicaid)	Follow UHC PA Guidelines UHC PA List Applies	All services provided by non-contracted providers require prior authorization (except for emergencies, urgently needed services when the network is not available, and dialysis).
Premera	Follow Premera PA Guidelines Premera PA List Applies	
Humana	Follow Humana PA Guidelines Humana PA list applies	
Please note: Not all plans have out-of-network benefits.		

Utilization Management Annual Criteria Notification

The following is informational only and is required to be sent annually to all providers.

The OptumCare Network (OCN) Utilization Management Department is provided with nationally established criteria for the range of services and procedures that we examine for an appropriate use of resources. Upon request, the specific criterion used to make a decision is available for both the provider and the patient.

OCN Utilization Management decision making is based only on medical necessity, efficiency and appropriateness of healthcare services and treatment plans required by member benefit plans and protocols. OCN employees and vendors are not rewarded either financially or in non-monetary items of value (“Incentives”) for issuing denials of coverage or care. Incentives for UM decision-makers do not encourage decisions that result in under-utilization and do not encourage creating barriers to care and service and Decisions to hire, promote or terminate OCN employees and vendors are not based upon the likelihood or the perceived likelihood that the individual will support or tend to support the denial of coverage.

All providers have the opportunity to discuss any utilization management denial decision with an OCN Medical Director. If you wish to participate in developing, adding to, or reviewing these established criteria policies, please contact

Portal Access

Summary

The Optum Care Provider Center (OCPC) is a secure, internet-based, customized experience that assists providers in caring for OCN patients. It is a one-stop shop offering claims insights, prior authorization submission and status, and population health performance data. These tools can help providers improve patient care and lower costs.

The OCPC provides access to the following:

- Eligibility status
- Claims status
- Prior authorization status
- Prior authorization submission
- Attestation review and submission
- Secure messaging with OCN teams

User Access

To access the OCPC, providers will need to perform one of the following steps. Using One Health Port (option 1) is the easiest and preferred method to gain access.

1. Navigate to the OCPC website via https://onehealthport.com using OHP user ID and single sign-on and choose Optum logo.

   OR

2. Navigate to the OCPC website at https://professionals.optumcare.com/portal-login.html. This is the same site you will use to log on once your registration is processed.
   - Complete the fields under the 'Provider Registration – New User' section. The request will then be reviewed by an OCN system administrator.
   - Once account registration is approved, an e-mail will be sent to the provider with login information and instructions.
   - Login to OCPC and finalize setup.

Care Management

OCN's Care Management team consists of registered nurses, licensed mental health counselors, social workers, and LPN care coordinators. Primary care offices can refer patients with complex care needs by submitting the referral form located in the Appendix.

OCN also identifies patients appropriate for care management via utilization management, pre-authorization trends, transitions of care (i.e., Hospital to Skilled Nursing), and members can self-refer.

Care Management has oversight of the following programs:

- Transition Management
- Complex Care Management (medical/behavioral health)
- Disease Management/Condition Support
- Behavioral Health

For additional information, please contact Network Relations and Contracting.

Behavioral Health

OCN manages behavioral health authorizations and adjudicates claims for some payers. Please refer to Delegation by Plan table in the Appendix for additional information.

Network Engagement

Your OCN Practice Engagement Manager and Network Medical Director work to help you succeed in all areas of quality, patient experience, accurate coding and documentation, affordability, and growth. This program applies specifically to Primary Care Practices with attributed membership.

- Primary OCN relationship owner with clinic
  - Partners with clinic leadership to strive for optimal performance in quality, accurate coding and documentation, patient experience, and affordability to improve long-term clinical outcomes while lowering the total cost of care
  - Leads and schedules meetings with the clinic
  - Ensures clinic has tools and data needed for success in patient care delivery
  - Communicates Quality Incentive Program (QIP) elements and achievements

- Population Health Performance
  - Provides point of care tool delivery, training, and submission tracking
  - Provides performance and incentive reporting
  - Supports MA marketing and growth coordination

- Supports care management service coordination
- Provides clinics with information on new and existing wraparound services

- Training/Education
  - Assesses practice training needs
  - Coordinates Primary Care Provider (PCP), staff, and clinic administrator education on accurate coding and documentation, quality, and affordability

Population Health

OCN has developed programs and resources in concert with health plans to support your practice around population health management. These resources include, but are not limited to, complex care management, clinical education, Electronic Medical Record (EMR) optimization, and programs supporting quality, accurate documentation and coding, and patient experience.

These are the four guiding principles of OCN's population health programs:

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

Quality & Risk Adjustment

OCN is committed to supporting our partners in delivering the highest quality of care. To that end, tools and resources are available to help providers identify quality care gaps and outreach to patients to close these gaps. OCN also offers education around best practices and tactical support to help practices meet requirements in accordance with Medicare's quality standards.

To ensure all data is captured and reported to health plans, OCN performs chart reviews through remote EMR access, fax, and site visits. Only data for your OCN attributed patients is reviewed and processed. The purpose of the chart abstraction process is to capture documentation to close care gaps and to identify potential coding trends, which contribute to Quality Incentive Program (QIP) performance. Practices can support quality initiatives and clinical documentation accuracy by granting OCN remote access to their Electronic Medical Record (EMR).

What does this mean for your practice?

- OCN will deploy chart abstractors to facilitate the capture of clinical documentation to close quality care gaps.
- OCN will work with your practice to collect records either directly via fax or EMR, or through a third party to facilitate accurate capture of quality care gaps and conditions.
- Your Practice Engagement Manager and Network Medical Director will provide tools, resources, and information on best practices to help you achieve quality goals.

Risk Adjustment Factor

Risk Adjustment Factor (RAF) is a numeric measurement based on a patient's chronic health conditions (specifically those that fall within a CMS-assigned Hierarchical Condition Category or HCC) as well as demographic factors such as Medicaid status, gender, age/disabled status, and whether the patient has resided in an institution for longer than 90 days.

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

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

Ongoing Education

OCN is focused on capturing whole-person health through accurate documentation and coding. OCN has a team of clinical educators that can help your practice stay up to date on coding and documentation so that you can provide the most accurate and complete status for each of your patients.

Opportunities and Services

- OCN will perform reviews of medical documentation to ensure that practices accurately capture chronic hierarchical condition categories (HCCs) that impact quality performance, and patient outcomes.
- OCN also analyzes data from inpatient hospitalizations, diagnostic testing, outpatient procedures and services, home health care services, rehabilitative therapies, and pharmacy reviews for the possibility of chronic codes that have not been addressed in the calendar year.
- OCN will prepare feedback and training materials to educate providers and staff on any audit outcomes and will help with accurate documentation procedures.
- OCN will communicate coding and documentation trends to providers and staff and help implement correct diagnosis reporting.
- OCN will perform routine audits of documentation and coding in accordance with compliance policies and procedures and communicate the results to practices.
- OCN will follow up with written and verbal education regarding coding and compliance to physicians, clinical staff, and non-clinical staff. You may also request OCN educators to come to your clinics and help with any coding or documentation issues.
- OCN educators will remain apprised of the latest coding guidelines and relay that information to clinics and staff. OCN will send emails with webinars, coding materials, and any other education needed.

What does this mean for your practice?

- OCN can provide consultation and education to help network partners improve their patient outcomes and systems and processes to ensure complete, accurate, and compliant documentation and coding.
- Our educators can evaluate documentation and coding behavior and identify areas for improvement.

Provider Attestations

An Attestation is a point of care tool used during a patient encounter to identify and address current chronic conditions and evaluate potential new chronic conditions. Attestations are electronic and paper forms customized to each patient that list known chronic conditions and suspected chronic conditions based on prior years claims, pharmacy data, lab data, and clinical chart reviews. Each condition is either listed by the ICD-10-CM code or by the appropriate Hierarchical Condition Category (HCC).

Attestations help clinicians quickly identify important patient conditions that require action and a plan of care. Accurate identification of conditions for each patient coupled with supporting clinical documentation in clinician chart notes ensures applicable resources are available and appropriately allocated to manage the needs of the patient throughout the year in order to improve patient outcomes. Practices receive payment for completed Attestations through the Quality Incentive Program (QIP).

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 fraud, waste, and abuse (“FWA”) requirements to their “first tier, downstream, and related entities” (FDRs). FDRs include contracted physicians, health care professionals, and 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 > About > Ethics & Integrity > UnitedHealth Group's Code of Conduct. Provide the materials annually and within 90 days of hire for new employees.
- Maintain records of distribution standards (i.e., in an email, website portal or contract) for 10 years. We, our plan sponsors, or CMS, may request documentation to verify compliance.

Fraud, Waste, and Abuse; and General Compliance Training

What you need to do

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

Exclusion Checks

Prior to hiring or contracting with employees, you must review federal (HHS-OIG and GSA) and state exclusion lists, as applicable. This includes the hiring or engaging 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.

What you need to do

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

- Health and Human Services – Office of the Inspector General OIG List of Excluded Individuals and Entities (LEIE) at oig.hhs.gov/.
- General Services Administration (GSA) System for Award Management at sam.gov/sam.
- Review the exclusion lists every month and disclose to 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.

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

As contracted health care providers of OCN, you must ensure that payments for health care services or items are not made to individuals or entities on the Preclusion List, including employed or contracted individuals or entities.

For more information on the preclusion list, visit cms.gov

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 and additional plan sponsor reporting information below.

Reports may be made anonymously, where permitted by law:

- For UHC members at https://www.uhc.com/fraud or by calling 1-844-359-7736.
- For Humana members at www.ethicshelpline.com or by calling 1-877-584-3539.
- For Premera members by emailing SIUReferrals@premera.com or by calling 1-888-844-8985.

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.

Other regulations to follow include:

- HIPAA Privacy and Security regulations as a Covered Entity
- The Cures Act
- Information Blocking Rules
- Telephone Consumer Protection Action 47 USC Section 227.

Non-discrimination

You must not discriminate against any patient with regard to quality of service or accessibility of services because they are our member. You must comply with all applicable state and federal non-discrimination regulations, specifically, you must not discriminate against any patient protected under state and federal including, but not limited to on the basis of:

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

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

Marketing Compliance

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

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

Appointment Wait Standards

CMS requires MA organizations to continuously monitor access to care and member services. OCN may need to take corrective action, as necessary, to ensure that appointment wait times in the provider network comply with the CMS standards. The minimum standards for appointment wait times for primary care and behavioral health services are as follows for appointments:

(A) Urgently needed services or emergency—immediately;
(B) Services that are not emergency or urgently needed, but the enrollee requires medical attention—within 7 business days; and
(C) Routine and preventive care—within 30 business days.

If a member calls your office after hours, we ask that the recording played, or individual answering provides emergency instructions. Tell callers with an emergency to do one of the following:

- Hang up and dial 911 or local equivalent.
- Go to the nearest emergency room.

When it is not an emergency, but the caller cannot wait until the next business day, advise them to do one of the following:

- Go to a network urgent care center
- Stay on the line to connect to the physician on call
- Leave a name and number with your answering service (if applicable) for a physician or qualified health care professional to call back within specified timeframes
- Call an alternative phone or pager number to contact you or the physician on call.

Health Equity in MA and Cultural Competency

OCN expects you to provide services in a culturally competent manner. CMS expects MA organizations to ensure equitable access to Medicare Advantage services. This includes:

- People with limited English proficiency and reading skills
- People of ethnic, cultural, racial, or religious minorities
- People with disabilities
- People who identify as lesbian, gay, bisexual, or other diverse sexual orientations
- People who identify as transgender, nonbinary, and other diverse gender identities, or people who were born intersex
- People who live in rural areas and other areas with high level of deprivation
- People otherwise adversely affected by persistent poverty or inequality

Provider Manual 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.

Service Standards

Care Coordination

All providers will work with OCN and with other providers of OCN patients to effectively collaborate and manage care of members and to actively implement best clinical practices and clinical pathways as set forth by OCN policies and procedures.

The Primary Care Provider (PCP) is responsible for providing or overseeing comprehensive healthcare services for

Primary care physician	
Type of visit	**Time frame**
Emergency setting	Immediate disposition of member to appropriate care
Urgent visit	Forty-eight (48) hours
Urgent visit, requiring authorization	Ninety-six (96) hours
Routine non-urgent visit	Within ten (10) business days of request
Preventive health services	Thirty (30) days
Follow-up exam	As directed by physician

members. The PCP is the manager and medical home of a member's total health care needs. This includes:

- Providing care services and authorizing referrals for consultation, specialty, and hospital services
- Having 24-hour call coverage for the medical care of assigned members
- Coordinating the entire spectrum of care to their assigned members including direct provision of all primary healthcare services, including preventive services

When tests, labs, or x-rays are ordered, it is the responsibility of the ordering provider, along with the primary care provider, to educate the patient on how and when results will be communicated, as well as to explain the meaning of the results. If follow-up is required, appointments should be scheduled and completed in a timely manner.

Office Availability & Wait Times

We encourage providers to implement procedures and make reasonable efforts to ensure that:

- Members are seen by a clinician within 15 minutes of the member's appointment time
- Telephone hold times are less than 15 minutes
- Back-office lines are provided for network communication

The following information delineates the access standards for availability of services to members including primary care, specialty care, after-hours care, emergency services, waiting times for appointments, and proximity of specialists and hospitals to primary care (definitions of types of visits, access standards for behavioral health, and recommended preventative care services are provided in Appendix).

Optum

Specialist	
Type of visit	**Time frame**
Emergency	Immediate disposition of member to appropriate care
Urgent visit	Forty-eight (48) hours
Urgent visit, requiring authorization	Ninety-six (96) hours
Non-urgent appointments with specialist physician	Within fifteen (15) business days of request
Non-urgent ancillary services (for diagnosis and treatment)	Within fifteen (15) business days of request
Follow-up exam	As directed by physician

Appendix

Prior Authorization Request Form

The most up to date version can be found here - [Prior Authorization Form for Washington | Optum]

Optum

Fax cover sheet

professionals.optumcare.com/portal-login

Fax: 1-855-402-1684
1-253-627-4708 (SNF and Inpatient)

Phone: 1-877-836-6806
1-253-627-4113 (Clinical Team for SNF)

Requestor contact:

Phone: Ext:

Fax:

☐ Routine
☐ Urgent

Urgent is defined as a medical or behavioral health condition manifesting itself by acute symptoms of sufficient severity such that if services are not received within the required review time frame, the person's situation is likely to deteriorate to the point that emergent services are necessary.

Patient name: DOB:

Insurance ID: ☐ Medicaid ☐ Medicare ☐ Commercial

Phone: Address:

Requesting provider

Name:
Tax ID:
NPI:
Address:
Phone: Fax:
PCP: ☐ Same as above
Name:
PCP notified? : ☐ Yes ☐ No

Servicing provider

Name:
Tax ID:
NPI:
Address:
Phone: Fax:

Servicing facility

Name:
Tax ID:
NPI:
Address:
Phone:
Fax:

Type of service:

☐ Part B ☐ Home health ☐ Other
☐ DME: $_____ purchase/ $_____ rental

Date of service:

Location of service:

☐ Inpatient ☐ Outpatient ☐ Office
☐ SNF ☐ Home ☐ Other

Must attach supporting clinical information
(e.g., plan of care, medical records, lab reports, letter of medical necessity, progress notes, etc.)

Diagnosis description:
ICD-10 code(s):
CPT code(s) X quantity: ex.90213x10:
Laterality (if appropriate): ☐ Left ☐ Right
Comments:
If out-of-network request, provide reason:

This authorization is not a guarantee of payment. Payment is contingent upon eligibility, benefits available at the time the service is rendered, contractual terms, limitations, exclusions, and coordination of benefits, and other terms & conditions set forth in the member's Evidence of Coverage.

The information in this form, including attachments, is privileged and confidential & is only for the use of the individual entities named in this form. If the reader of this form is not the intended recipient or the employee or the agent responsible to deliver to the intended recipient, the reader is hereby notified that any dissemination, distribution, or copying of this communication is strictly prohibited. If this communication has been received in error, the reader shall notify sender immediately and shall destroy all information received.

Care Management Referral Form

The most up to date version can be found here - [care-management-referral-form_OR-WA.pdf (optum.com)]

Optum

Optum Care Network
17930 International Blvd #1000
SeaTac, WA 98188
optum.com

CARE MANAGEMENT REFERRAL FORM

Date: Click or tap to enter a date.

MEMBER INFORMATION

Member Name:	Member DOB:	Member Health Plan ID:	Member Phone:
Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.

If primary contact is not the member, provide the following:

Contact Name:	Relationship to Member:	Contact Phone:
Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.

REFERRED BY

Name:	Title:	Phone:
Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.

LINE OF BUSINESS

Choose an item.

If Other, please specify:
Click or tap here to enter text.

PRIMARY CARE PROVIDER INFORMATION (OPTIONAL)

PCP Name:	PCP Office Address:	PCP Phone:
Click or tap here to enter text.	Click or tap here to enter text.	Click or tap here to enter text.

DIAGNOSIS AND REASON FOR CARE MANAGEMENT REFERRAL

Diagnosis(s):	Reason or Need for Assistance:
Click or tap here to enter text.	Click or tap here to enter text.

PROJECTED OUTCOME FROM CARE MANAGEMENT (OPTIONAL)

Reason or Need for Assistance:
Click or tap here to enter text.

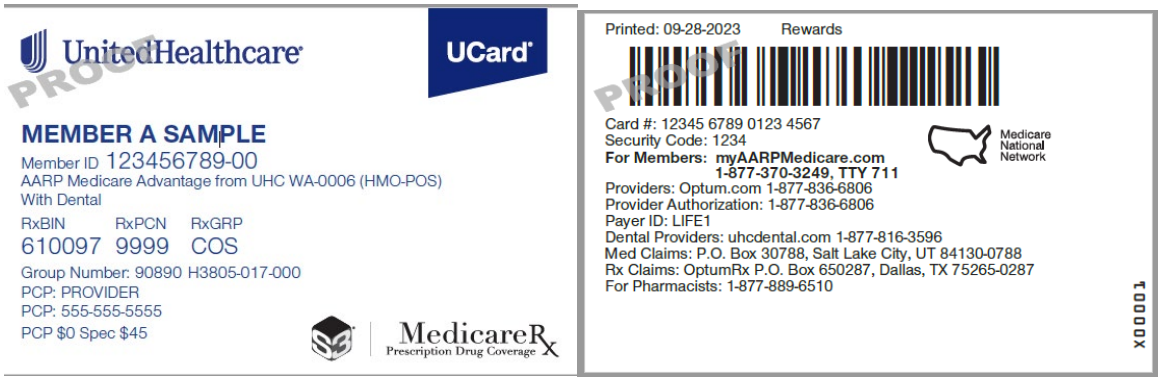
INSTRUCTIONS FOR REFERRAL SUBMISSION:

Complete this referral form and fax to

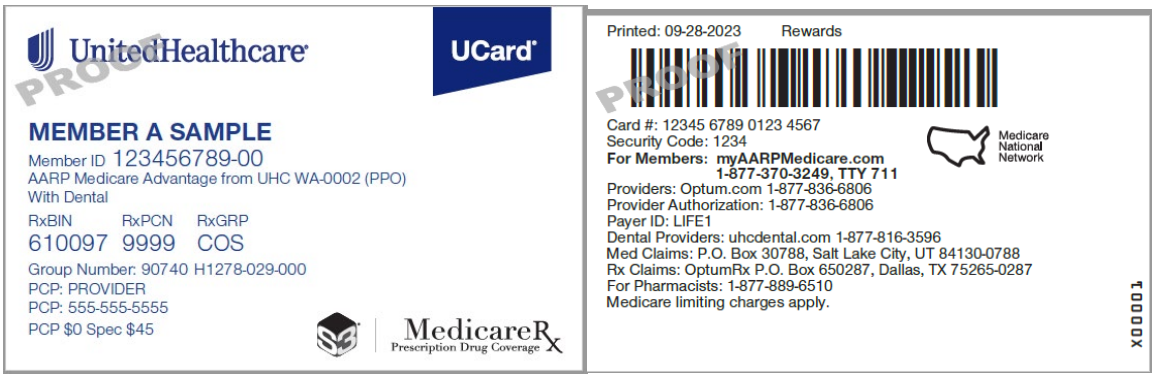
253-356 5778

ID Card Samples

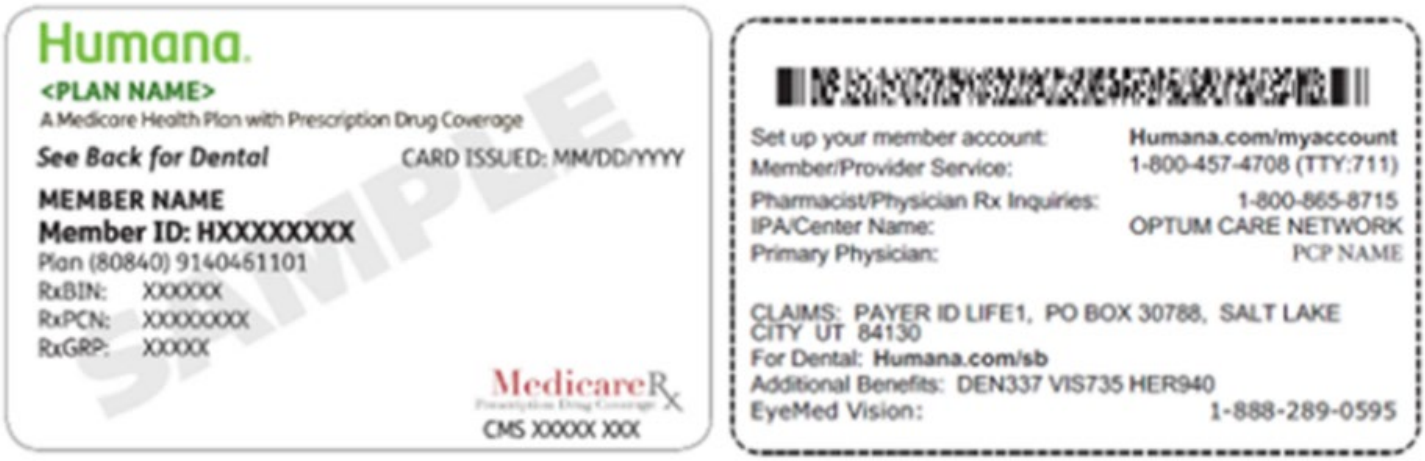
United Healthcare MA-HMO



United Healthcare MA-PPO



Humana MA- HMO



Premera MA – HMO

United Healthcare (Apple Health) – Medicaid

Delegation by Plan

Health Plan		UHC	UHC	UHC	Humana	Humana	Premera	First Choice Health
Benefit Plan		Medicare Advantage HMO & PPO	Medicare Advantage DSNP*	Medicaid	Medicaid Advantage HMO & DSNP	Medicare Advantage PPO	Medicare Advantage HMO	N/A
Behavioral Health		UHC	UHC	UHC	Optum Care Network	Humana	Premera	First Choice Health
Claims		Optum Care Network	UHC	Optum Care Network	Optum Care Network	Humana	Optum Care Network	First Choice Health
Credentialing		Optum Care Network	UHC	Optum Care Network	Optum Care Network	Optum Care Network	Optum Care Network	Optum Care Network
Population Health	Quality	Optum Care Network	Optum Care Network	Optum Care Network	Optum Care Network	Optum Care Network	Optum Care Network	First Choice Health
	Risk Adjustment	Optum Care Network	Optum Care Network	Optum Care Network	Optum Care Network	Optum Care Network	Optum Care Network	First Choice Health
	Care Management	Optum Care Network	UHC	Optum Care Network	Optum Care Network	Humana	Optum Care Network	First Choice Health
Utilization Management		Optum Care Network	UHC	Optum Care Network	Optum Care Network	Humana	Optum Care Network	First Choice Health

Behavioral Health - Plan Resources

United Healthcare Medicare Advantage
https://provider.liveandworkwell.com/content/laww/providersearch/en/home.html?siteId=10275&lang=1
Enter patient zip code, on Provider Listing Page, select “Medicare”
Behavioral Health Claims and Authorizations 866-673-6315

Humana Medicare Advantage
Behavioral Health provider assistance **1-866-900-5021 - Non-patient facing number.** 8 a.m. – 6 p.m., Eastern time.
Patients may call the number on the back of their Humana member ID card.
Behavioral Health Claims and Authorizations - **OCN Utilization Management**

Premera Medicare Advantage
Find a Behavioral Health provider https://www.premera.com/visitor/find-a-doctor or call the “mental health” phone number on the back of the member’s card.

United Medicaid - Behavioral Health Claims and Authorizations 1-800-711-4577

Access Standards

OCN will annually assess the access standards of PCP, high volume specialists, behavioral health, and ancillary providers. For PCPs, OCN will not perform a sampling of the providers. Instead, OCN will survey all active PCPs. OCN will report a rate of compliance for its service area annually for PCPs, non-physician behavioral health providers, specialty and ancillary care providers. OCN may utilize a third-party survey vendor to implement all or part of the survey.

Definition of Types of Visits within Access Standards

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

Emergency services – OCN has continuous availability and accessibility of adequate numbers of institutional facilities, service locations, service sites, and professional, allied, and supportive paramedical personnel to provide covered services including the provision of all medical care necessary under emergency circumstances. OCN physicians and hospitals must provide access to appropriate triage personnel and emergency services twenty-four (24) hours a day, seven (7) days a week.

- OCN evaluates inappropriate use of emergency room services, issues regarding member access to health care, and under- or over-utilization of services through assessment of encounter data, special studies, claims information, and medical record audits with oversight of the quality management (QM) committee.

Emergency medical condition – This is a medical condition (including labor) that is manifested by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: (a) placing the patient’s health (or in the case of a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (b) serious impairment to bodily functions; or (c) serious dysfunction of any bodily organ or part.

Urgent care services – These are health care services needed to diagnose and/or treat medical conditions that are of sufficient severity that care is needed within forty-eight (48) hours but are not emergency medical conditions.

Urgent visit – These are referrals to health care professionals who have advance education and training in a specific area but are not emergency medical conditions. Visit requires prior authorization within ninety-six (96) hours

Follow-up of ED or urgent care visits – OCN is responsible for informing PCPs of members that receive an ED or urgent care visit when notified, including information regarding needed follow-up, if any. PCPs are responsible for obtaining any necessary medical records from such a visit and arranging any needed follow-up care.

Routine non-urgent visit – These are health care services needed to diagnose and/or treat medical conditions that do not need urgent care or non-emergent attention. These visits are used for routine check-ups and can be scheduled within ten (10) business days of request.

Preventive health services – Primary care physicians are expected to schedule and provide preventive health services which may include, but is not limited to, initial preventive physical exams, annual health assessments, and adult preventive services.

Non-urgent specialist appointment – These are referrals to a health care professional who has advanced education and training in a specific area. The appointment to the specialist is to be scheduled within fifteen (15) business days of request unless otherwise indicated by the referring physician.

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

Hospital standards – All contracted hospitals must provide timely access for members accessing emergency departments, being admitted for an inpatient stay, or utilizing hospital-based diagnostic or treatment services. Hospital-based clinics must meet all the primary care and specialty access standards delineated above.

Provider shortage – If timely appointments within the time or distance standards required are not available, then OCN shall refer member to or assist in locating available and accessible contracted provider to obtain the necessary health care services in a timely manner appropriate for the member's needs.

After-hours care

We ask that you and your practice have a mechanism in place for after-hours access to make sure every member calling your office after-hours is provided emergency instructions, whether a line is answered live or by a recording. Callers with an emergency are expected to be told to:

- Hang up and dial 911 or its local equivalent, or
- Go to the nearest emergency room.

In non-emergency circumstances, we would prefer that you advise callers who are unable to wait until the next business day to:

- Go to an in-network urgent care center;
- Stay on the line to be connected to the practitioner on call;
- Leave a name and number with your answering service (if applicable) for a practitioner or qualified health care professional to call back within a specified time frame;
- Call an alternate phone or pager number to contact you or the practitioner on call.

Substitute coverage

If you are unable to provide care and are arranging for a substitute, we ask that you arrange for care from other in-network practitioners and health care professionals so that services may be covered under the patient's network benefit.

Go to: professionals.optumcare.com to access the provider lookup tool to find the most current directory of our network practitioners and health professionals.

After-hours access for behavioral health care

All behavioral health providers are required to have an automated answering system twenty-four (24) hours a day, seven (7) days a week, to direct members to call 911 or to go to the nearest emergency room for any life-threatening medical or psychiatric emergencies.

Preventive Care Recommendations

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
Td booster (tetanus, diphtheria)	Recommended once every 10 years
Varicella	Recommended for adults without evidence of immunity; should receive 2 shots
Zoster (shingles)	Recommended for all adults 60 and older

Screenings/counseling/services	
AAA (abdominal aortic aneurysm)	For men ages 65–75 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 well visit, annually
Breast cancer	Recommended mammogram every 1-2 years for women ages 50-74
Breast cancer chemoprevention	At least every 3 years if cervix present; after age 65. Pap tests can be discontinued if previous tests have been normal.
Cervical cancer	Recommended for all adults 60 and older
Colorectal cancer	Recommended for adults ages 50–75
Depression	For all adults

Diabetes	Recommended type 2 diabetes screening for individuals with sustained blood pressure greater than 125/80 mm Hg
Domestic violence and abuse	Screening and counseling for interpersonal domestic violence
Gonorrhea	Recommended for all sexually active women who are at increased risk of infection
HIV	For all adults at increased risk of HIV infection
HPV	Recommended for all sexually active women 65 and younger
Lipid disorder	Screening periodically
Obesity	Screening, counseling, and behavioral interventions
Osteoporosis	Recommended routine screening for women 65 and older; routine screening for women under age 64 if at increased risk
Prostate cancer	Prostate-specific antigen (PSA) test and digital rectal exam
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

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 artery 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 postmenopausal 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 (HPT) for post-menopausal women.
- Risks for and possible benefits of prostate concern 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 (i.e., an ophthalmologist, optometrist) for ages 65 and older.

Provider Group/Practitioner Change Form

The most up to date version can be found here - [Provider Change Form WA | Optum]

Optum

Provider Group/Practitioner Change Form

Please use this form for demographic changes or to update your NPI information.
Please make sure that all the information is complete as we cannot process incomplete forms.
Please email your completed form to **credentialing@optumpnw.com** or fax to **253-573-9511.**

Select the changes being submitted. Then only complete the necessary corresponding section(s).

- ☐ Practice Name
- ☐ Practitioner Name
- ☐ Tax ID Number
- ☐ Office Location/Address
- ☐ Billing Address
- ☐ Correspondence Address
- ☐ Telephone Number
- ☐ Fax Number
- ☐ Email Address
- ☐ Adding New Provider(s)
- ☐ Terminated Provider(s)

Section II – Group Demographics

Practice/organization name: _____
Current Tax ID (TIN): _____
National Provider Identifier (NPI): _____ Date issued:

Basis for NPI (applies to organizations only, select only 1 per NPI):

☐ Provider Name ☐ Tax ID only (entity whose name is in the W-9 form)
☐ License Number ☐ NUCC Taxonomy Code ☐ Place of service address ☐ Department
☐ Other (please explain)

☐ Please check here if you have multiple NPIs representing your practice or organization.

Section III - Practice/Organization change

☐ New tax ID number is: _____ Effective:
(please attach a copy of the W-9)

☐ We have moved. Our new address is effective:
This new address is a:

☐ Practice address ☐ Billing address ☐ Both practice & billing address
☐ Correspondence address

Should this new address be in the directory? ☐ Yes ☐ No

New	Old
Address:	Address:
Telephone:	Telephone:
Fax:	Fax:
Email:	Email:

☐ We have changed our practice name to: _____
Effective:
Change pertains to all practitioners under the Tax ID (TIN): _____
Specify physicians/health care providers affected by the change:

Section IV - Adding a New Practitioner

☐ These physicians/health care providers have joined our practice (please attach a copy of the W-9).

Name: _____ Degree: _____ E-mail _____
Practice address:
_____
Specialty: _____ Individual NPI: _____
Effective Date:

Name: _____ Degree: _____ E-mail _____
Practice address:
_____
Specialty: _____ Individual NPI: _____
Effective Date:

Name: _____ Degree: _____ E-mail _____
Practice address:
_____
Specialty: _____ Individual NPI: _____
Effective Date:

☐ Check this box if you do not have a private office and only see patients at the hospital

Section V - Terming a Practitioner
☐ These physicians/health care providers have left our practice. Name: _____ Degree: _____ Practice Address: _____ Specialty: _____ Individual NPI: _____ Effective Date: Reason for Leaving: _____ Name: _____ Degree: _____ Practice Address: _____ Specialty: _____ Individual NPI: _____ Effective Date: Reason for Leaving: _____ Name: _____ Degree: _____ Practice Address: _____ Specialty: _____ Individual NPI: _____ Effective Date: Reason for Leaving: _____

Name of individual completing this form: _____

Signature_____ Date:

Telephone: _____ E-mail: _____