Provider Manual

2023

Optum Care Network, Washington

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Welcome Letter

Optum Washington

A message from Dr. Imelda Dacones

President

Optum

Dear Colleague,

Happy New Year! Thank you for being a participating clinician with Optum Care Network of Washington. We really appreciate you as our partner in providing affordable, high-quality health care for our members and communities.

We exist to support you so you can focus on patients and patient care first and foremost. Our patient-centered value-based model, with its wrap services, and administrative functions that work with multiple payers, free up clinicians for more time for their own self-care.

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 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 most effectively with us. We hope it will serve as a user-friendly reference guide and educational resource for both 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 provider 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 providers, facilities and practice staff regarding policies, procedures, claims submissions and adjudication requirements, and guidelines used to administer plans. This provider manual replaces and supersedes all previous versions.

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

As policies and procedures change, updates will be issued via *e-newsletter* and/or practice alert and will be incorporated into this electronic version of the provider manual.

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

Delegation Defined

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

In full delegation, this translates to providing services on behalf of the aforementioned 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 appendix for delegation by plan.

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

Contact Information

OCN Main Number General Information	8 a.m.–5 p.m., Monday–Friday Phone 877-836-6806 Fax 888-205-1128
OCN Resources	https://professionals.optumcare.com/resources-clinicians.html
Website Address	https://www.optumcare.com/state-networks/locations/washington.html
Provider Portal	https://onehealthport.com
Customer Service Eligibility, claims/auth status, General billing question Prior Authorization Intake	8 a.m.–5 p.m., Monday–Friday Phone 877-836-6806 Fax 888-205-1128 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.–5 p.m., Monday–Friday Phone: 877-836-6806 Fax: 855-402-1684
Health Care Coordination Hospital notifications, emergency admissions, case management	 https://onehealthport.com 8 a.m. – 5 p.m Monday – Friday Phone: 877-836-6806 Fax: 253-627-4708
OCN Directory Searches (Provider, Facilities)	OCNProvider.com/Washington
Contracting	OCNWAContracting@optum.com
Credentialing	credentialing@optumpnw.com
Network Relations and Contracting	engagementteam@optumpnw.com
Address (For claims mailing see address in 'Claims' section)	Send general information to: 17930 International Blvd, Suite 1000 SeaTac, WA 98188

Network Engagement

Summary

The Network Engagement team, together with their network medical director partner, work to help you succeed in 5-Star quality, patient experience, risk adjustment, care management, affordability, and growth.

Network Engagement

- Primary Point of Contact with Clinic
    - Partners with clinic leadership to strive for optimal performance in quality, accurate risk adjustment, and affordability initiatives to improve long-term clinical outcomes while lowering the total cost of care
    - Assess and coordinate training needs
    - Lead and schedule meetings with clinics
    - Ensures clinic has data and analytics needs met for success in patient care delivery
    - Communicates incentive program elements and achievements
- Performance
    - Delivery of monthly strategic packets
    - Attestation point of care tool delivery and tracking
    - Dashboard performance and incentive reporting
    - Coordinate MA marketing and growth
    - Care management service coordination
    - Updates clinics on new wrap around services
- Training/Education
    - Primary Care Provider (PCP), staff, and clinic administrator education on risk adjustment, quality, and affordability
    - Event coordination
- Member Focus
    - Wraparound services utilization, education, and tracking
    - Data and analytics

Network Relations and Contracting

Summary

The Network Relations and Contracting team is responsible for contracting with new providers and managing the contract life-cycle, onboarding and training new providers, and acting as the point of contact for operations-related issue escalation.

Network Relations

- New provider onboarding and orientation
- Portal training
- Claims issue escalation
- Member eligibility issues and resolution
- Roster management

Contracting

OCN is delegated to contract for the following Plan and Benefit Plans:

- Humana Medicare Advantage Plans
- Premera Medicare Advantage Plans
- UnitedHealthcare Medicare Advantage Plans
- UnitedHealthcare Apple Health Plan

This list is subject to change. OCN contracted providers must also hold a direct contract with the Plan for these Benefit Plans in order for OCN to include them in its provider contract.

Delegation by Plan

Please see appendix for the Delegation by Plan matrix.

Credentialing

Credentialing refers to the process performed by OCN to verify and confirm that an applicant meets the established policy standards and qualifications for consideration in the OCN Network. There are currently no fees charged for credentialing. Upon completion of the credentialing verification process, each applicant is presented to a Medical Director or the Credentials Committee, which is comprised of physicians of various specialties, for review and recommendation.

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/Carrier	Providers/Facilities Credentialed
Humana	Medical & Behavioral Health Providers
Premera	Medical Providers Ambulatory Surgery Centers All Facilities
UnitedHealthcare	Medical Providers Facilities
First Choice Health	Medical Providers

Providers Joining Your Practice

Unless the practice has a credentialing sub-delegation arrangement in place with OCN, all providers joining an existing practice must complete the credentialing process. Until such time as 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

Facilities Adding Location(s)

Unless a credentialing sub-delegation arrangement is in place with OCN, all facility locations must complete the credentialing process. Until such time as the additional location has successfully completed the credentialing process, authorizations and claims payment may 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
- Durable Medical Equipment
- 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 Credentials Committee.

Exceptions to this may include active military assignment, maternity/paternity leave or sabbatical. Contact OCN credentialing for additional information.

Corrective Action

Should OCN determine a provider or facility has failed to meet performance expectations 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 manual 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.

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

For detailed information regarding your rights, you may request a copy of the OCN credentialing program manual.

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
- 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. 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 provider agreement requires notification to OCN via email to credentialing@optumpnw.com within 30 days of departure. You are required to inform OCN via e-mail to whom patients should be re-assigned to. For more information on this topic, please refer to the Patient Re-assignment section below.

Termination of Participation

Providers/facilities are contractually required to provide adequate notice of termination of network participation as this may impact patient care and your credentialing status with the health plans. Upon termination with the OCN Network, your credentialing will revert to being performed directly with the health plans. Clinics should plan accordingly to ensure no disruption in services for patients. Please refer to your provider or facility agreement.

Closing your Practice

Closing your practice due to retirement or business considerations is a complex undertaking. OCN would like to support you in locating resources for your transition and identifying actions needed. The process can be very different for primary care providers and specialists. Please utilize your resources with OCN by contacting your Network Relations and Contracting to assist in planning the 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)	☐	☐

Contracting

OCN is contracted with the following Plan and Benefit Plans:

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- Humana Medicare Advantage Plans
- Premera Medicare Advantage Plans
- UnitedHealthcare Medicare Advantage Plans
- UnitedHealthcare Apple Health Plan

This list is subject to change. OCN contracted providers must also hold a direct contract with the Plan for these Benefit Plans in order for OCN to include them in its provider contract.

Delegation by Plan

Please see appendix for the Delegation by Plan matrix.

Claims

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

Medicare Advantage Plans	Submit to	Claims Submission Information
United Healthcare HMO - MA • AARP Medicare AdvantageComplete • Plan 1 (HMO-MAPD Plan) • Plan 2 (HMO-MAPD Plan) • Plan 3 (HMO-MAPD Plan) • Walgreens (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
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)	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

	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 • Gold Plus SNP-DE (HMO D-SNP Plan)		
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

Calling OCN/Medical OCN: For claim filing requirements or status 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's Provider Relations 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 without prior approval/authorization, if authorization is required.
- Patient copayments, coinsurance, deductibles, and other cost-share amounts due from the patient and coordination of benefits with third-party payors as applicable.
- Adjustments of payments based on ~~coding~~ 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/Facility Agreement for additional terms.

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

Dispute Resolution Process for Contracted Providers

A. **Definition of Contracted Provider Dispute**. A contracted provider dispute is a provider's written notice to OCN and/or the Enrollee's applicable health plan challenging, appealing or requesting reconsideration of a claim (or bundled claims of substantially similar multiple claims that are individually numbered) that has been denied, adjusted or contested or seeking resolution of a billing determination or other contract dispute (or bundled disputes of substantially similar multiple billing or other contractual disputes that are individually numbered) or disputing a request for reimbursement of an overpayment of a claim. Each contracted provider dispute must contain, at a minimum the following information: provider's name; provider's identification number, provider's contact information, and:

   i. If the contracted provider dispute concerns a claim or a request for reimbursement of an overpayment of a claim from OCN to a contracted provider the following must be provided: a clear identification of the disputed item such as the claims number, the date of service and a clear explanation of the basis upon which the provider believes the payment amount, request for additional information, request for reimbursement for the overpayment of a claim, contest, denial, adjustment or other action is incorrect;
   ii. If the contracted provider dispute is not about a claim, a clear explanation of the issue and the provider's position on such issue; and
   ii. If the 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 and provider's position on the dispute, and an Enrollee's written authorization for provider to represent said Enrollees.

B. **Sending a Contracted Provider Dispute to OCN**. Contracted providers must use the **Provider Dispute Resolution Form,** copies may be obtained at www.optumcare.com**.** Contracted provider disputes submitted to OCN must include the information listed above, for each contracted provider dispute. All contracted Provider Dispute Resolution Form(s) must be sent to the attention of Provider Dispute Resolution Unit for OCN at the following address:

   Via Mail:

   OCN
   Attn: Provider Dispute Resolutions
   PO Box 30788
   Salt Lake City, UT 84130-0788

C. **Time Period for Submission of Provider Disputes**.

i. Contracted provider disputes must be received by OCN within three hundred sixty-five (365) calendar days from action of the OCN (such as the remittance explanation of payment date), or
ii. In the case of inaction, contracted provider disputes must be received by OCN within three hundred sixty-five (365) calendar days after the OCN's time for contesting or denying a claim (or most recent claim if there are multiple claims) has expired.
iii. Contracted provider disputes that do not include all required information as set forth above. may be returned to the submitter for completion. An amended contracted provider dispute which includes the missing information may be submitted to OCN within thirty (30) working days of your receipt of a returned contracted provider dispute.

D. **Acknowledgment of Contracted Provider Disputes**. OCN will acknowledge receipt of all contracted provider disputes as follows:
   i. Contracted provider disputes submitted according to Section B. above, will be acknowledged by OCN within fifteen (15) working days of the date of receipt by OCN.

E. **Contact OCN Regarding Contracted Provider Disputes**. All inquiries regarding the status of a contracted provider dispute or about filing a contracted provider dispute must be directed to the Provider Dispute Resolution Unit for OCN at
   OCN
   Attn.: Provider Reconsiderations
   PO Box 30788
   Salt Lake City, UT 84130-0788

F. **Instructions for Filing Substantially Similar Contracted Provider Disputes**. Substantially similar multiple claims, billing or contractual disputes, may be filed in batches as a single dispute utilizing the **Provider Dispute Resolution Form along with the Multiple ("LIKE") Claim Form**, submitted in the following format:

   i. Sort provider disputes by similar issue
   ii. Submit Provider Dispute Resolution form for each batch of similar issues
   iii. You may choose to include your own log for multiple issues but it must contain all field elements as found in the enclosed multiple form along with the Provider Dispute Resolution Request form.

G. **Time Period for Resolution and Written Determination of Contracted Provider Dispute**. OCN will issue a written determination stating the pertinent facts and explaining the reasons for its determination within forty-five (45) working days after the date of receipt of the contracted provider dispute or the amended contracted provider dispute.

H. **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 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:

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;

If the non-contracted provider dispute involves an Enrollee or OCN of Enrollees, 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. Please refer to RCW 48.43.600.

Electronic Funds Transfer

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

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

Toll Free Telephone:

(866) INSTAMED or (866) 467-8263

Email:

support@instamed.com

Help Portal:

https://help.instamed.com/providers/s/

Training Tools:

https://www.instamed.com/support/providers

Charging Members

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

Additionally, per your OCN participation agreement, practices and facilities shall not charge a Medicare Advantage patient for non-covered services under the patient's plan unless the patient has received a pre-service organization determination notice of denial from OCN or health plan before any such services

are rendered. Please refer to your participation agreement for complete language.

Clinical Claims Review

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

Releasing a Patient from your Practice

Please refer to health plan specific provider manuals for releasing a patient from your practice.

Patient Re-Assignment

Optum Care Network manages patients assigned to primary care providers (PCPs) for Humana Medicare Advantage HMO, AARP Medicare Advantage HMO through UnitedHealthcare (UHC MA), UHC Medicaid, and Premera Medicare Advantage HMO. 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 re-assigned to another primary care provider unless that patient has initiated the process. *See also Population Health.*

For Humana patients:

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

For UHC MA patients:

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

For UHC Medicaid patients:

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

For Premera MA patients:

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

Compliance

Medicare Compliance Expectations and Training

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

FDRs are expected to have an effective compliance program, which includes training and education to address FWA and compliance knowledge. OptumCare Network'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 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 OptumCare Network.

What You Need to Do

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

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

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 at:
Reports of suspected Fraud, Waste and Abuse may be made to the Special Investigations Unit (SIU) by calling the Anti-Fraud Hotline at 1-888-844-8985; sending an email to SIUReferrals@premera.com.

Privacy

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

Non-discrimination

You must not discriminate against any patient with regard to quality of service or accessibility of services because they are our member. You must not discriminate against any patient on the basis of:

- Race
- Gender identity
- Ethnicity
- National origin
- Religion
- Sex and gender
- Age
- Mental or physical disability or medical condition
- Sexual orientation
- Claims experience
- Medical history
- Evidence of insurability
- Disability

- Genetic information
- Source of payment
- Medicaid status for Medicare members

You must maintain policies and procedures to demonstrate you do not discriminate in the delivery of service and 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. A summary of the rules are as follows, however please refer to https://www.cms.gov/Regulations-and-Guidance/Regulations-and-Guidance.html for the most current and in-force information.

Guide Updates

Optum Care Network 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 within OCN and with other OCN Providers to effectively collaborate and manage care of members, and to actively implement best clinical practices and clinical pathways as set forth by the Policies and Procedures.

The Primary Care Provider (PCP) is responsible for providing or overseeing comprehensive healthcare services for 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
- Coordinate 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 explain the meaning of the results. If follow-up is required, appointments should be scheduled and completed in a timely manner.

Referrals

Referral Requests for care outside the scope of the PCP's practice are initiated by the PCP. Referral turn-around-times follow the guidelines set forth by NCQA.

Primary Care Providers: When requesting authorization of a referral, the PCP should provide complete information on the referral request form including but not limited to applicable recent visit notes, nature of services, etc. PCP is responsible for:

- Identifying any current specialists the member is seeing
- Supporting Network by making in-network referrals
- Reviewing or establishing a mechanism for reviewing authorizations for hospitalizations and outpatient/short stay services
- Serving as in-house resource for promoting managed care

Specialist: The Specialist provides consultation and/or specialty services for members who have been referred by their PCP. The specialist plays a pivotal role in assisting the PCP in managing patients' care by communicating effectively with the PCP and OCN about referrals and patients' treatment plans. They are responsible for:

- Promptly communicating findings and treatment recommendations/outcomes to the PCP
- Note closure and communication to appropriate care teams, including PCP, are expected within seven days of the appointment
- If the Specialist determines a need to provide services not requested by the PCP, the Specialist must obtain authorization prior to rendering these services except in the case of a medical emergency

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 (access standards for behavioral health and recommended preventative care services provided in appendix).

Primary care physician	
Type of visit	**Time frame**
Emergency	Immediate disposition of member to appropriate care setting
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

Specialist	
Type of Visit	**Time Frame**
Emergency	Immediate disposition of member to appropriate care setting
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 requets
Non-urgent ancillary services (for diagnosis and treatment)	Within fifteen (15) business days of requets
Follow-up exam	As directed by physician

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.

Population Health

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

Patients are assigned to a Primary Care Provider through one of two methods. The patient 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 the patient and establish care. A change in PCP assignment can only be made by the patient who must contact the health plan. Dismissal of a patient from a practice who is covered under a Medicare Advantage HMO plan must be coordinated with the health plan. The health plan will need the cause for dismissal and appropriate documentation.

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

- Promoting activities that drive quality outcomes.

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

Quality & Risk Adjustment

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

All contracted providers are required to allow OCN access to patient charts, for OCN-attributed patients, as part of supporting quality initiatives and clinical documentation accuracy. As an essential part of ensuring all data is captured and reported to health plans, OCN performs chart reviews through remote EMR access, fax, and onsite access to your practice. Data for only your OCN attributed patients is reviewed and processed. The chart abstraction and review process can capture documentation to close care gaps and potential coding trends, which contribute to incentive payment measurements under the Quality Incentive Program.

What does this mean to your practice?

- OCN will deploy chart abstractors to facilitate the capture of clinical documentation to close quality care gaps; or
- 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.
- Network Relations and Contractings will work with practices to provide education, consultation, and materials to help our providers improve their systems and processes to impact highest quality of care.

Risk Adjustment Factor

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

RAF is a relative measure of probable costs to meet the healthcare needs of the individual. RAF is used by Centers for Medicare and Medicaid Services (CMS) to adjust capitation payments to payors and thus to 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, and attestation forms.

Coding and Documentation Ongoing Education

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

analytics.

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

What does this mean to your practice?

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

Opportunities and Services

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

Provider Attestations

To submit accurate documentation and coding, OCN provides a point of care tool for primary care providers, including:

- A living (continuously refreshed) presentation that displays suspected relevant gaps in care that have not been addressed in the current calendar year.
    - Gaps in care include historical chronic conditions, suspected conditions, screenings, and quality measures.
    - Providers determine which are valid and address the gap.
    - Serves as a guide to be used at each face-to-face encounter.
- Sources of data on an attestation:

- Diagnoses, procedures, and results reported in prior years.
- Diagnoses and results found by nurses or coders (or, in some cases, M.D.) performing a chart review.
- Data inferred from labs tests, medication fills, and CMS Return files.

EMR Optimization

OCN has a full-time EMR optimization specialist who can assist your practice in utilizing your system more efficiently to compliantly enhance data collection and reporting opportunities. For more information, contact your Network Relations and Contracting.

Utilization Management

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 works collaboratively with discharge planners in hospitals and skilled nursing facilities to ensure positive patient outcomes.

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

Health Plan	UM Managed by	Contact Information
UHC – Medicare Advantage (HMO) • AARP Medicare Advantage o Washington ▪ Plan 1 ▪ Plan 2 ▪ Plan 3 ▪ Walgreens ▪ Harrison Electrical ▪ Cement Masons ▪ Machinist H&W Trust ▪ Western Teamsters Welfare ▪ UFCW Local 555/WA ▪ City of Seattle ▪ Pacific Coast Shipyards ▪ Carpenters Health & Security ▪ Retiree's Welfare Trust	OCN	Phone: 877-836-6806 Fax: 855-402-1684
UHC – Medicare Advantage (PPO) • AARP Medicare Advantage o Washington ▪ Choice ▪ Plan 1 ▪ Plan 2 ▪ Patriot	OCN	Phone: 877-836-6806 Fax: 855-402-1684
UHC – Medicare Advantage (Dual) • Medicare Solutions Dual Complete	UHC	Phone: 877-842-3210
Humana – Medicare Advantage (HMO) • Gold Plus HMO • Value Plus HMO	OCN	Phone: 877-836-6806 Fax: 855-402-1684

Health Plan	UM Managed by	Contact Information
Humana – Medicare Advantage (PPO) • HumanaChoice PPO	Humana	www.Humana.com Phone: 800-457-4708
Humana – Medicare Advantage (MMP) • Gold Plus – HMO D-SNP	OCN	www.Humana.com Phone: 800-457-4708
Premera – Medicare Advantage (HMO) • Medicare Advantage (HMO-MAPD Plan) • Medicare Advantage Classic (HMO–MAPD Plan) • Medicare Advantage Classic Plus (HMO-MAPD Plan) • Soundpath Health Alpine (HMO-MA Only Plan) • Soundpath Health Peak + Rx (HMO-MAPD Plan) • Soundpath Health Sound + Rx (HMO-MAPD Plan) • Soundpath Health Charter + Rx (HMO-MAPD Plan)	OCN	Phone: 877-836-6806 Fax: 855-402-1684

Referrals/ Prior Authorizations

Prior authorizations are not required as long as the referred to and referred from provider is contracted with the patient's health plan.

If your patient requires a specialist or facility that is not within the OCN Network, then we recommend that the specialist/facility is contracted with the patient's health plan. If the specialist/facility is not contracted with the plan, prior authorization is required. An authorization request form can be found on the Optum Care Provider Center and submitted online (via our website or OneHealthPort) or faxed to 1-855-402-1684.

In-Network (Office Visits) (OCN or Plan contracted):
OCN PCP to OCN or Plan contracted specialist referrals for office visits do **not** require precertification
OCN or Plan contracted specialist to OCN or Plan contracted specialist do **not** require precertification

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.

Physical Therapy

Please note that an authorization may not be required for physical therapy. However, there is a 24-unit benefit limit per member per calendar year for United Healthcare Community Plan (Medicaid) members aged 21 and older.

Women's Health

A referral from a PCP is not required for covered women's health care services when the services are provided by a women's health care provider. However, the member must self-refer within her contracted plan's network. Female-related diagnosis, urinary tract infections and disorders of the breast will be allowed under women's self-referral for women on an OCN plan.

If you have further questions, please contact your Network Relations and Contracting.

Please refer to the appendix for sample forms and additional information. Please see instructions on how to access the prior authorization management link to request authorization electronically via our provider portal logon at https://onehealthport.com.

Frequently Asked Questions

How do I check the status of a claim, authorization, or member eligibility?

Log on to OCPC via https://onehealthport.com for claims status, authorizations, and member eligibility. If you are unable to locate the claim or authorization, please contact OCN's contact center at 877-836-6806 Monday through Friday 8 a.m. – 5 p.m.

Does OCN pay claims using Electronic Funds Transfer (EFT)?

Yes, OCN encourages utilizes InstaMed for electronic funds transfer (EFT) and electronic remittance advice (ERA). 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. To register, please go to www.instamed.com/eraeft. (*For additional InstaMed information, please see the Electronic Funds Transfer section above.)*

How do I check if my provider(s) or facility are currently credentialed/ contracted with OCN?

Please go to http://www.optum.com/pnw. If you are unable to locate the provider(s) or facility and you believe that you are/should be listed in the directory, please contact OCN's contact center at 877-836-6806, Monday through Friday 8 a.m. – 5 p.m., so that they may further research for you.

How do I submit a prior authorization?

Complete an authorization request form through OCPC via https://onehealthport.com with all member information, specialist and/or facility information and requested service information, including diagnosis (ICD0-10-CM), service or procedure (CPT or HCPCS) being requested. Alternative care (acupuncture, chiropractic, massage and naturopathic) may not be a benefit under the member's plan and may require prior authorization from OCN or the health plan network.

All completed request forms can be submitted electronically via the OCPC via https://onehealthport.com *(For additional information on OCPC, please see the Portal Access section above.)* Alternatively, forms can be faxed to 855-402-1684 for outpatient authorizations, 253-627-4708 for inpatient authorizations.

Referral status can be checked in OCPC under Prior Auth Management at https://onehealthport.com. Please allow two days before calling or resubmitting referral requests.

Referrals

Referral Requests for care outside the scope of the PCP's practice are initiated by the PCP. Referral turn-around-times follow the guidelines set forth by NCQA.

Primary Care Providers: When requesting authorization of a referral, the PCP should provide complete information on the referral request form including but not limited to applicable recent visit notes, nature of services, etc. PCP is responsible for:

- Identifying any current specialists the member is seeing
- Supporting Network by making in-network referrals
- Reviewing or establishing a mechanism for reviewing authorizations for hospitalizations and outpatient/short stay services
- Serving as in-house resource for promoting managed care

Specialist: The Specialist provides consultation and/or specialty services for members who have been referred by their PCP. The specialist plays a pivotal role in assisting the PCP in managing patients' care by communicating effectively with the PCP and OCN about referrals and patients' treatment plans. They are responsible for:

- Promptly communicating findings and treatment recommendations/outcomes to the PCP
- Note closure and communication to appropriate care teams, including PCP, are expected within seven days of the appointment
- If the Specialist determines a need to provide services not requested by the PCP, the Specialist must obtain authorization prior to rendering these services except in the case of a medical emergency

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 referral, access referral forms here , also attached in the appendix on page 39. We also capture members in need of services from utilization management, pre-authorization trends, transitions of care (i.e., Hospital to Skilled Nursing), and members can also self-refer.

Care Management has oversight of the following programs:

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

For additional information, please contact Network Relations and Contracting.

Behavioral Health

OCN manages behavioral health authorizations and adjudicates claims for Humana MA HMO line of business only. Please refer to Behavioral Health Plan Resources in the appendix for additional information.

Identifying OCN Members/Patients

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

Portal Access

Summary

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

The OCPC will provide access to the following:

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

User Access

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

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

   OR

2. Navigate to the portal website, located at https://professionals.optumcare.com/portal-login.html. (This is the same site you will use to logon 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.
   - Logon to OCPC and finalize setup.

Appendix

Prior Authorization Request Form

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.

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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: Click or tap here to enter text.	Member Health Plan ID: Click or tap here to enter text.	Member Phone: Click or tap here to enter text.
If primary contact is not the member, provide the following: Contact Name: Click or tap here to enter text.	Relationship to Member: Click or tap here to enter text.	Contact Phone: Click or tap here to enter text.
REFERRED BY		
Name: Click or tap here to enter text.	Title: Click or tap here to enter text.	Phone: 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: Click or tap here to enter text.	PCP Office Address: Click or tap here to enter text.	PCP Phone: Click or tap here to enter text.
DIAGNOSIS AND REASON FOR CARE MANAGEMENT REFERRAL		
Diagnosis(s): Click or tap here to enter text.	Reason or Need for Assistance: 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.		

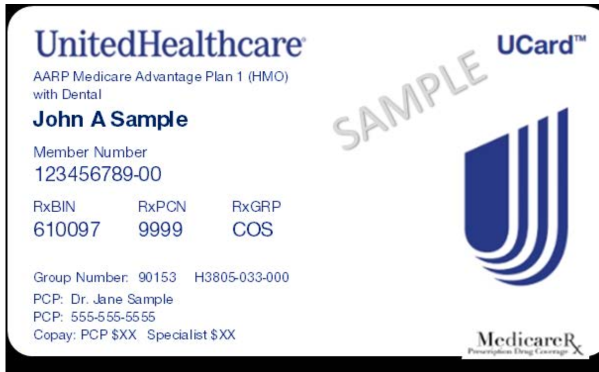
INSTRUCTIONS FOR REFERRAL SUBMISSION:

Complete this referral form and fax to

253-627-4708

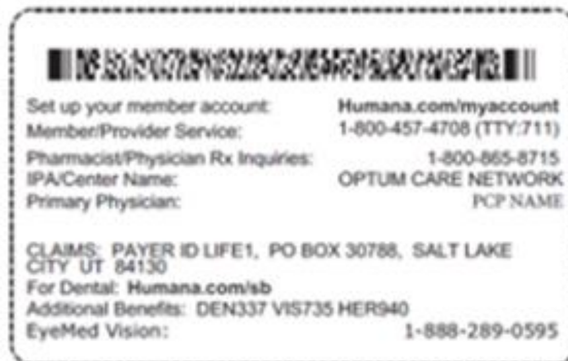
ID Card Samples

United Healthcare MA-HMO



United Healthcare MA-PPO

Humana MA- HMO



Premera MA – HMO

United Healthcare (Apple Health) – Medicaid

Delegation by Plan

Functional Areas	Humana MA HMO	Premera MA HMO	AARP MA HMO/PPO (UHC)
Utilization Management	x	x	x
Disease Management	x		x
Case Management	x	x	x
Case Management for Transplants			
Care Transitions	x	x	x
Concurrent Review Management	x	x	x
Correspondence	x	x	x
ER Notification Outreach	x	x	x
Claims	x	x	x
Credentialing	Providers; All Facility Types	Providers; All Facility Types	Providers; All Facility Types
Quality/MRA	x	x	x
Behavioral Health/Substance Use	x		
DSNP	x	x	

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.

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

Access Standards for Behavioral Health Services

The following information delineates the access standards for availability of services to members for behavioral health care and after-hours emergency services.

Appointment standards:

Behavioral health	
Type of	Time
Life-threatening emergency	Immediately
Non-life-threatening emergency	Six (6) hours
Urgent behavioral health needs	Within forty-eight (48) hours
Urgent behavioral health visit, requiring authorization	Within forty-eight (48) hours
Initial routine (non-urgent) visit with a behavioral health care provider	Within ten (10) business days of request
Non-urgent with a non-physician behavioral health provider	Within ten (10) business days of request

Follow-up routine (non-urgent)	Within ten (10) business days of request
Follow-up care after hospitalization for mental illness	Within seven (7) business days of request (initial visit)
Follow-up care after hospitalization for mental illness	Within thirty (30) business days of request (second visit)

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.

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.

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.

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 risk factors
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	Covered for women at high risk for breast cancer and low risk for adverse effect from chemoprevention
Cervical cancer	At least every 3 years if cervix present; after age 65. Pap tests can be discontinued if previous tests have been normal.
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

Screenings/counseling/services (continued)	
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 for 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 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 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.

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