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Purpose

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

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

Business Overview

Who is Optum Medical Network?

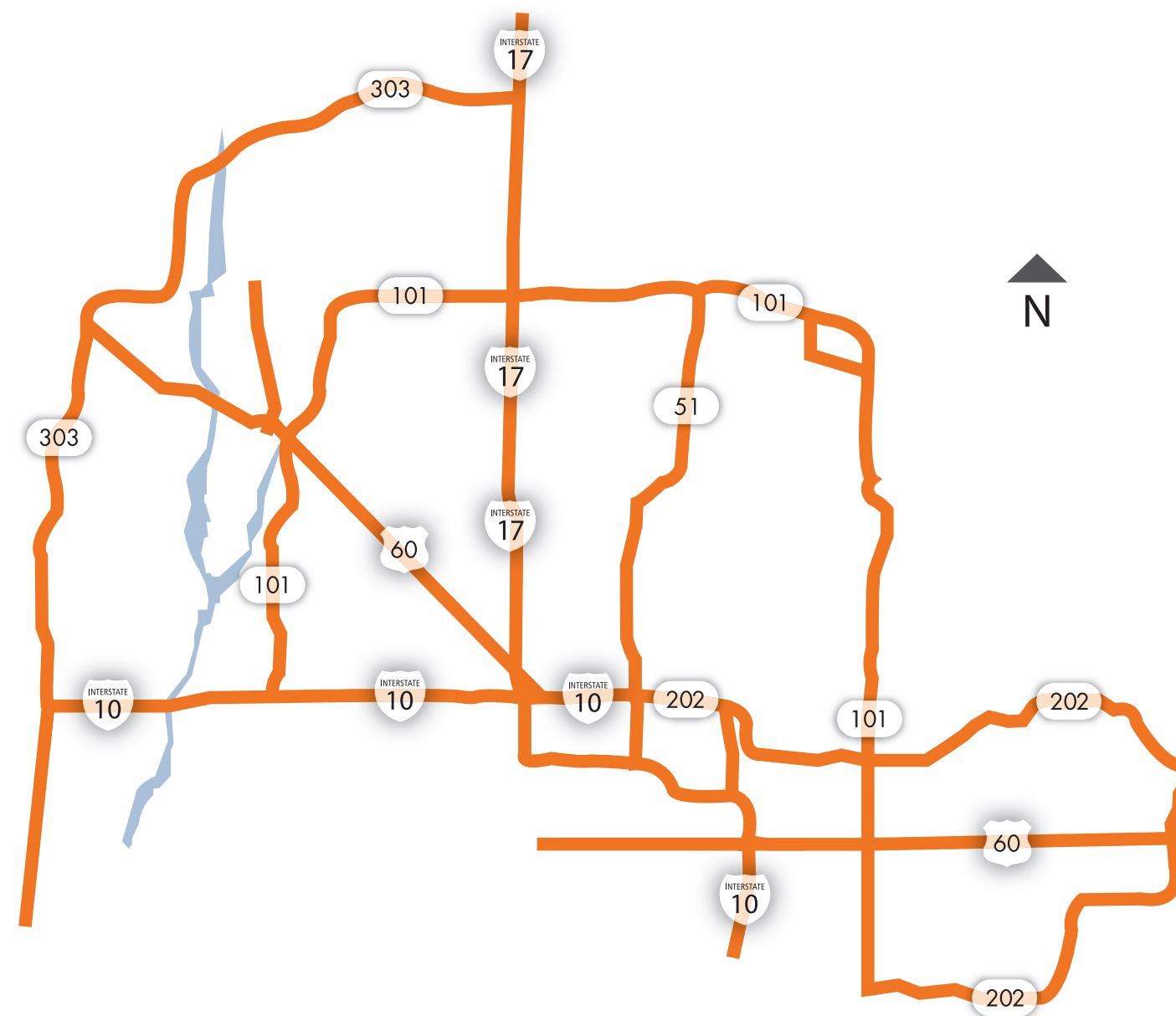
Optum Medical Network is an Independent Physician's Association. We offer a full range of services to assist physicians and other providers in their managed care and business operations. The network is a health care innovator, with a track record for quality, financial stability and extraordinary services. We are well positioned to continually invest in new infrastructure and systems for the benefit of our contracted physicians and to accommodate the impending changes of health care reform.

Optum Medical Network contracted providers represent a network of over 350 primary care physicians (PCPs), 1,000 specialists and 15 hospitals serving all of Maricopa County.

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



The Optum Medical Network serves the entire Maricopa County area.



Mission

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

Vision

To improve lives by transforming health care in Phoenix: one patient, one family, one community at a time.

Values

Integrity. Compassion.
Relationships. Innovation.
Performance.

Optum Medical Network Contact Information

Network Contact Information

Optum Medical Network Service Center:

(877) 370-2845 or visit us online: [OptumMedicalNetwork.com/arizona/providers](https://www.optummedicalnetwork.com/arizona/providers)

Service Advocates are available to answer questions Monday thru Saturday.

Provider Relations Team

Optum Medical Network assigns a provider relations representative to each practice, in order to give you personal service. They will get to know your business needs, make sure your practice understands the network's best practices and assist with your questions and requests. Below is a full listing of provider network managers:

| | | | |
|-------------------------|----------------|--------------------|----------------|
| Elise Riccio | (623) 707-0859 | Mary Ward | (623) 707-0809 |
| Janice Chavarria | (623) 707-0842 | Karen Jones | (623) 707-0826 |
| Kathy Moreno | (623) 707-0808 | Mark McLean | (623) 707-0861 |

Prior Authorization (Urgent & Routine): (877) 370-2845

Prior Authorization Fax #: (888) 992-2809

Rx Prior Authorization For UnitedHealthcare Patients:

Phone: (800) 711-4555

Fax: (800) 527-0531

Online: [www.OptumRx.com](https://www.optumrx.com) > [Health Care Professional](#) > [Prior Authorizations](#)

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

Pharmacy Help Desk For SCAN Patients: (800) 824-0898

Transplant Prior Authorization: (888) 936-7246

Optum Community Center: (623) 707-0800

For more information on classes and events at the Optum Community Center,

visit our patient website: [OptumMedicalNetwork.com/arizona/providers>communitycenter](https://www.optummedicalnetwork.com/arizona/providers>communitycenter)

Specialty, Facility and Ancillary Contact Information

Laboratory:

Laboratory Corporation of America (LabCorp)

Phone: (800) 788-9743

Online: www.LabCorp.com

LabCorp is the exclusive participating laboratory for Optum Medical Network patients.

In-Home (Mobile) Laboratory:

1st Choice Phlebotomy: (480) 593-9192

Mental Health:

Please refer to the back of the patient ID card for information on the mental health provider network.

Durable Medical Equipment and Infusion Services:

Preferred Homecare

Phone: (480) 446-9010

Home Health Care (includes Nursing, PT/ OT/ ST, Social Work, Aide):

Professional Health Care Network (PHCN)

Phone: (602) 395-5100

Note: Referral forms for Home Health Services can be found on the Optum Medical Network website:

OptumMedicalNetwork.com/arizona/providers > **Provider Resources**

Physical, Occupational, Speech Language Therapy, and covered Chiropractic Services:

Optum® Physical Health

Phone: (800) 873-4575

Ophthalmology Services:

For locations and contact information, please refer to the online Referral Lookup tool at OptumMedicalNetwork.com/arizona/providers > **Referral Lookup**, or contact the Service Center.

Preferred Specialty Groups:

In an ongoing effort to provide our patients with the highest level of service, Optum Medical Network has established preferred or exclusive arrangements with certain specialty groups. Preferred and exclusive specialists were chosen based on quality, performance metrics, geographic location and availability of clinical services. Please direct all patient referrals within these specialties to the groups listed below.

Nephrology Referrals:

Arizona Kidney Disease and Hypertension Centers (AKDHC)

Phone: (602) 997-0484

Online: www.AKDHC.com

AKDHC is one of the nation's leading and largest groups of private practice physicians specializing in Chronic Kidney Disease and other related conditions. They have over 15 locations throughout the Valley and 85 specialists to choose from.

Radiology & Imaging Services:

Southwest Diagnostic Imaging (SDI)

Phone: (602) 955-4734

Fax: (602) 956-9729

Online: www.sdil.net

Southwest Diagnostic Imaging is one of the largest radiology providers in the Valley. They offer over 65 board-certified radiologists available through 22 outpatient imaging centers.

Additional Specialists & Facilities:

For information on additional Optum Medical Network specialists and facilities please contact our Service Center:

Optum Medical Network Service Center

Phone: (877) 370-2845

Online: Use the provider lookup at

OptumMedicalNetwork.com/arizona/providers > **Referral Lookup**

Patient Enrollment & Assignment

To utilize services from Optum Medical Network's contracted physician and ancillary network, individual patients or employer groups can purchase health care coverage from any of our contracted health plans and select a network contracted primary care physician (PCP). In the network, patients choose their PCP; the network does not assign patients to providers. Our Service Center is available to assist patients in selecting providers if they need help.

Health Plan Contact Information

Optum Medical Network proudly accepts the following health plans:



AARP® MedicareComplete® insured through UnitedHealthcare®

Plan Name:

AARP® MedicareComplete® (HMO)

CMS Contract:

H0303-015



UnitedHealthcare® Group Medicare Advantage

Plan Name:

UnitedHealthcare® Group Medicare Advantage (HMO)

CMS Contract:

H0303-801, H0303-804, H0303-805



SCAN® Health Plan Arizona

Plan Name:

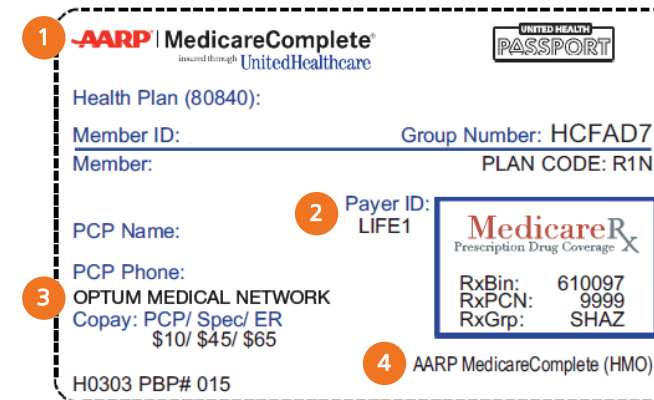
SCAN Classic (HMO)

CMS Contract:

H9385-002-0

UnitedHealthcare Plan ID Card

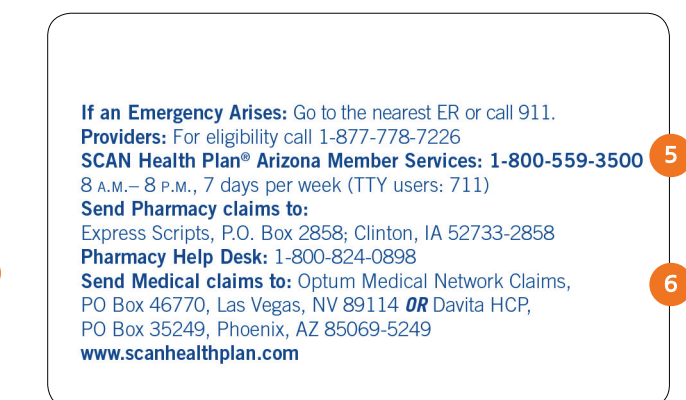
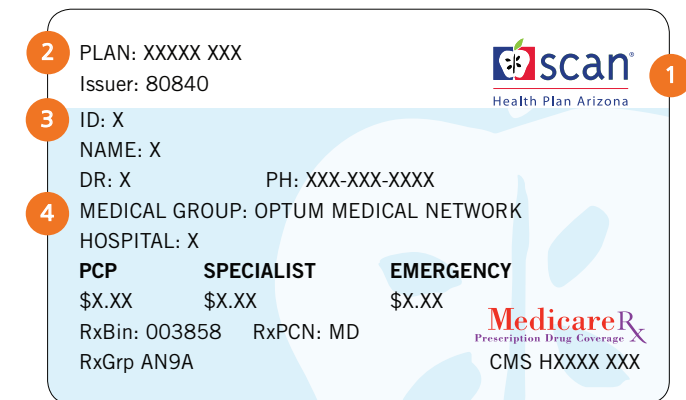
Example ID Card



1. Participating Health Plan Logo
2. Payer ID
3. Network Name
4. Plan Name
5. Provider Services Toll Free Number
6. Medical Claims Address

SCAN Plan ID Card

Example ID Card



1. Participating Health Plan Logo
2. Plan Name
3. Member ID
4. Network Name
5. SCAN Health Plan Member Services Toll Free Number
6. Medical Claims Address (ONLY send to Optum Medical Network address)

Optum Medical Network Website

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

Patient Website

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

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

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

Provider Website

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

- > Prior authorization forms and electronic processing
- > Home health and care coordination order forms
- > Referral reference guides for various specialties, including locations for Cardiac Services, Nephrology, and Skilled Nursing Facilities
- > User guide for creating an account for the Optum Medical Network Provider Portal
- > Coding tips and tools

Optum Medical Network Provider Portal

About the Provider Portal

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

Using the Provider Portal, provider staff can:

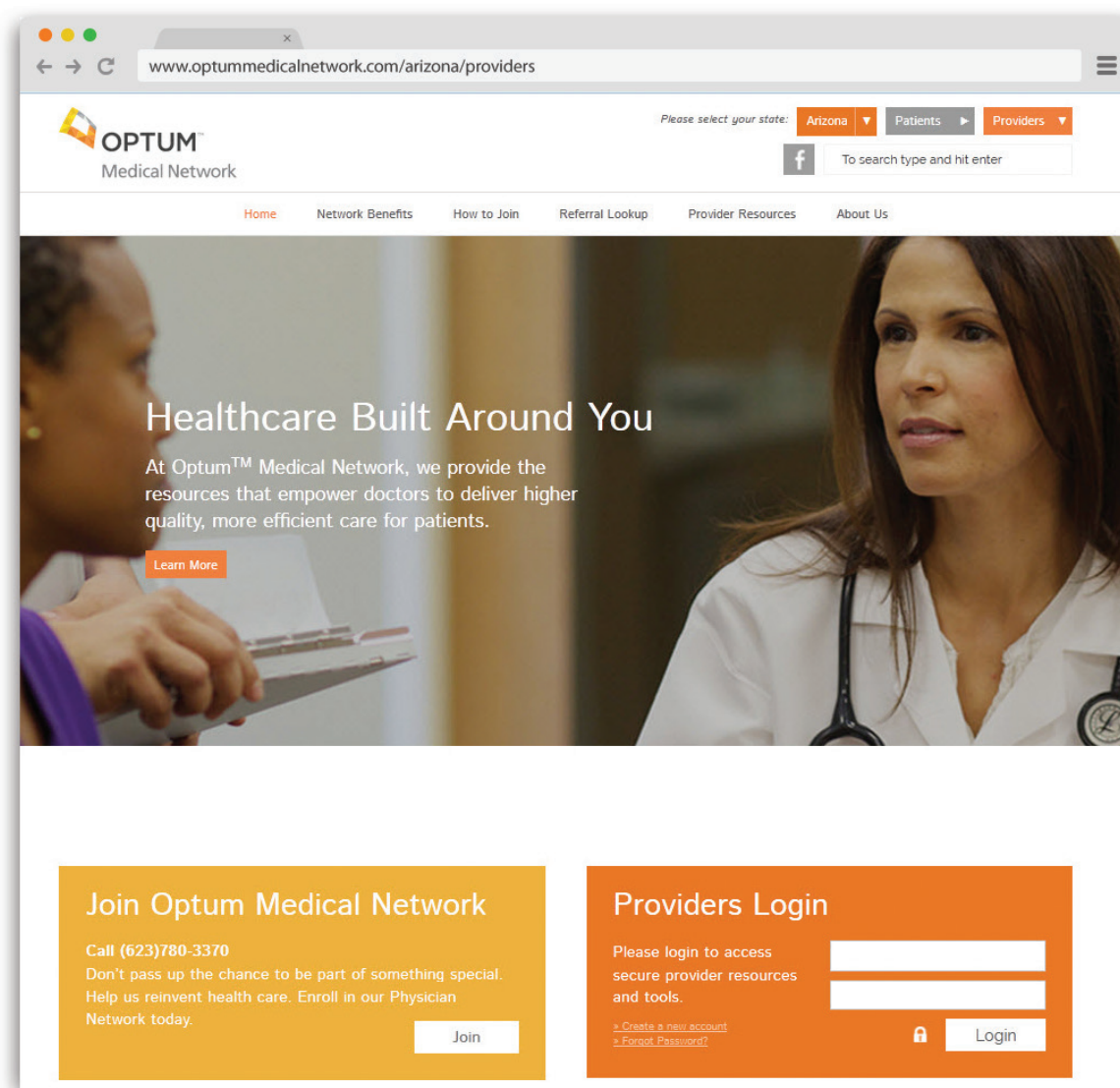
- > Verify patient eligibility
- > Search prior authorizations and claims
- > Send secure emails to our Service Center, Utilization Management, Eligibility and Claims staff
- > Search for contracted physicians to refer patients for services
- > Submit requests for prior authorization
- > Submit notification of patient hospitalization
- > Select data by TIN for multi-TIN providers
- > Obtain reports and helpful forms
- > Update your account profile and reset your passwords

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

How to Get Access

To gain access to the Provider Portal, visit OptumMedicalNetwork.com/arizona/providers

If your office does not currently have portal access, you will need to designate an Account Administrator and have them create a new account. The Account Administrator will be responsible for creating and editing user profiles for your providers, as well as resetting passwords and editing accounts. Once the designated Account Administrator fills out and submits the registration form found under the "Create Account" link, your account information will be delivered via email in about two business days.



Optum Medical Network Customer Service

By Phone

The phone number for providers to contact Customer Service is (877) 370-2845. Service Advocates are available to answer questions Monday thru Friday.

Online

For faster service regarding claims or authorization inquiries, access the secure Provider Portal at OptumMedicalNetwork.com/arizona/providers.

Experience the benefits of online access:

- > No wasted time on the phone, holding for information
- > Accessible 24 hours a day, 7 days a week
- > Quick and easy access to view claim, authorization and eligibility information
- > No additional cost/fee for this feature

Secure Email

Service Center advocates can also be reached by secure email through the Provider Portal at OptumMedicalNetwork.com/arizona/providers.

Our secure email allows contracted providers to submit questions on important topics such as correcting claims payments, submitting or inquiring about prior authorizations and more. Any provider who has access to the secured portal can use this feature. When you submit a question via the web portal, you will receive a response within 24 hours. Emails received on weekends will be responded to the following business day. All questions and replies sent through this system are encrypted to ensure safe transfer of personal health information.

Language & Hearing Impaired Assistance

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

Language Assistance

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

Hearing Impaired Assistance

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

For more information call Optum Medical Network at (877) 370-2845. The TTY/711 and language lines are open 24 hours a day, 7 days a week. The Service Center is available Monday thru Saturday 8am – 8pm.

Eligibility

The Eligibility Department receives patient information from the health plans on a daily basis. Once this information has been received, it is loaded electronically into the system.

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

Claims

ATTENTION: Office Managers and Billing Managers

Provided in the following sections is key information for claim submission and re-submission to initiate claims payment.

Topics addressed:

- > Claim submission and field requirements
- > EDI (Electronic Data Interchange) Claim Payment Policy & Processing Standard Billing
- > Reading a Provider Remittance Advice (PRA)
- > Timeframes Definitions Helpful Hints

Optum Medical Network's preferred method of claim submission is electronic, known as Electronic Data Interchange (EDI). EDI is the computer-to-computer transfer of data transactions and information between trading partners (payers and providers). EDI is a fast, inexpensive and safe method for automating the business practices that take place on a daily basis. There is no charge from Optum Medical Network for submitting claims electronically to Optum Medical Network.

Electronic Data Interchange (EDI)

Optum Medical Network encourages and supports Electronic Data Interchange (EDI), particularly claims and encounters. Electronic claims submission allows the provider to eliminate the hassle and expense of printing, stuffing and mailing your claims to the network. It substantially reduces the delivery, processing and payment time of claims. There is no charge for submitting claims electronically to the network. Providers are able to use any major clearinghouse.

Payer ID: LIFE1

Benefits of EDI:

- > Reduces costs
 - No more handling, sorting, distributing or searching paper documents
 - Keeps health care affordable to the end customer
- > Reduces errors
 - Improves accuracy of information exchanged between health care participants
 - Improves quality of health care delivery and its processes
- > Reduces cycle time
 - Enhanced information is available quicker
 - Ensures fast, reliable, accurate, secure and detailed information

EDI Format:

EDI has a standardized format, which ensures that data can be sent quickly and is interpreted on both sides. EDI transactions adhere to HIPAA regulations and American National Standards Institution (ANSI) standards. The EDI specifications are like blueprints for the data that guide the data to make the transitions between different data trading partners as smooth as possible.

As of March 31, 2012 health care providers must be compliant with version 5010 of the HIPAA EDI standards. The current format that is used is 837, ANSI x12.

- > 837i – Institutional claims
- > 837p – Professional claims

Additional transactions performed by Optum Medical Network:

- > 997 – Functional acknowledgement (claim receipt acknowledgement via clearinghouse)

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

Paper Submission:

- > Professional vendors must submit on a CMS 1500
- > Ambulatory surgery centers with appropriate modifier SG or TC
- > Hospital and facility vendors must submit on a CMS 1450

Claim Submission Address

Optum Medical Network Claims

PO Box 46770
Las Vegas, NV 89114

Billing

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

A claim form that contains:

- > A description of the service rendered using valid CPT, ICD-9 (or its successor), HCPCS, and/or revenue codes, the number of days or units for each service line, the place of service code/bill type and the type of service code;
- > Patient demographic information;
- > Provider of service name, address, National Provider Identifier (NPI) number and tax identification number;
- > Date(s) of service;
- > Amount billed;
- > Signature of person submitting the claim; and
- > Other documentation necessary in order to adjudicate the claim, such as medical reports, claims itemization or detailed invoice, medical necessity documentation, other insurance payment information, referring provider information, attending provider information and associated NPI as applicable

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

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

Reading the Provider Remittance Advice (PRA)

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

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

Electronic Fund Transfer (EFT)

Optum Medical Network offers EFT through ePayment. This can drastically reduce expense, shorten the reimbursement cycle, and streamline workflow. Emdeon provides payer remittance data electronically via Emdeon Payment Manager. You may call Emdeon at (866) 506-2830 and select option 1 or sign up online by visiting www.emdeon.com/eft.

Claims & Encounter Submissions

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

Anesthesia

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

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

Immunizations and Injectable Medications

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

DRG/APC Reimbursements

DRG/APC reimbursement is validated using an outside vendor to verify DRG grouping and provide appropriate CMS pricing.

DRG claims may be reviewed, post-payment, to determine necessity for DRG validation, which include complete review of medical records.

Fee Schedules

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

Modifiers

The AMA industry standard modifiers are acceptable for billing. The Correct Coding Initiative (CCI) guidelines for claims payment and use of modifiers are used when adjudicating claims.

CPT defines the standard, acceptable modifiers to be used for professional claims. HCPCS also includes acceptable modifiers for services not defined by CPT. Optum Medical Network accepts modifiers published by CPT and HCPCS.

Multiple Procedures

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

Submission Time Frames

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

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

Please see Provider Dispute section of this manual for the necessary supporting documentation needed for Proof of Timely Filing when filing a dispute.

Glossary of Claims Terminology

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

ASC: Ambulatory Surgery Classification: Used for outpatient hospital claims, paid at OPPS (outpatient perspective payment system).

ASC: Ambulatory Surgery Center: Used for payments to a surgery center.

Billed Charges: The dollar amount billed by a provider as their Usual and Customary charge.

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

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

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

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

DRG Payment Method: An approach to paying for hospital inpatient acute services that bases the unit of payment on the DRG system of classifying patients. Primarily used for Medicare patients.

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

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

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

Fee-For-Service – FFS: A traditional means of billing by health providers for each service performed, referring payment in specific amounts for specific services rendered.

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

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

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

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

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

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

Out-of-Pocket – OOP: Refers to any portion of payment for medical services that are the patient's responsibility.

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

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

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

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

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

Helpful Billing & Claims Hints

Things to remember when billing and submitting claims:

- > EDI submission is Optum Medical Network's preferred method of claims submission. It's fast, easy and cost effective. Always verify the patient's eligibility at the time of service.
- > Submit the most current information. This will increase the chance of accurate payment.
- > Provide accurate data and complete all required fields on the claim.
- > If the provider has time limits for claims submission in the contract, be sure to know what they are and submit claims accordingly.
- > Know the contract(s) – be sure all billing staff is familiar with current billing and contract information.
- > To verify and view claim status go to [OptumMedicalNetwork.com](https://www.optummedicalnetwork.com) or contact the Service Center at (877) 370-2845 and have a current TAX ID available.

Credentialing & Recredentialing

The Credentialing Department handles provider credentialing/recredentialing for the Optum Medical Network. The credentialing and recredentialing verifications are performed by the Credentialing Department.

Initial Credentialing

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

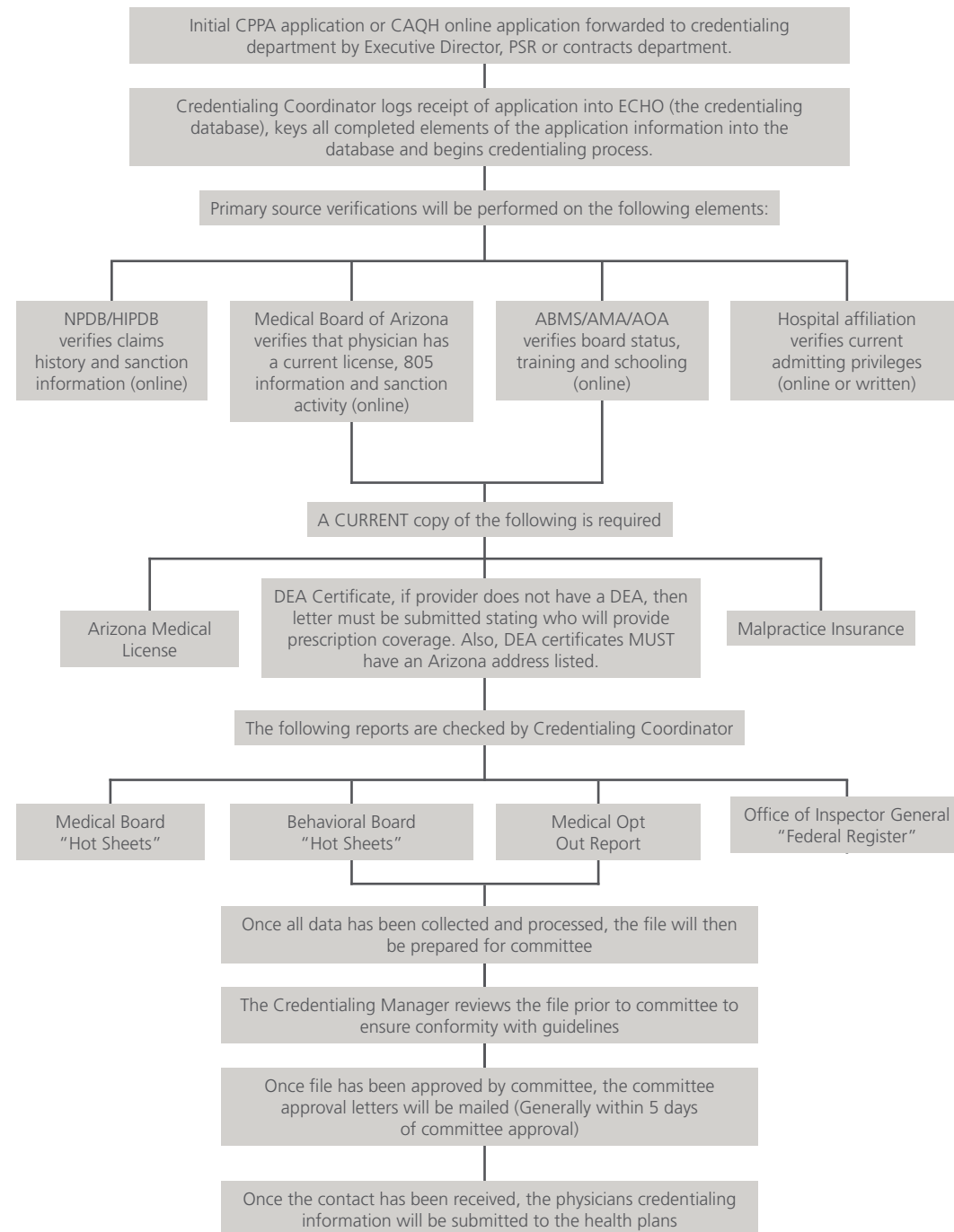
Please Note: If the provider or their group is adding a physician and/or physician extender, the credentialing must be completed and there must be an executed contract in place prior to the practitioner seeing Optum Medical Network patients. It is fraudulent practice to bill under one physician when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

Optum Medical Network has a form that can be used to report demographic changes, or update NPI information for your practice. If you are adding a provider, changing address, or deleting a provider who may have left your group, please fill out this form and submit it via fax or email. The "Physician/Provider Update Form" can be found at [OptumMedicalNetwork.com/arizona/providers](https://www.optummedicalnetwork.com/arizona/providers) > **Resources Tab** > **Forms**.

Recredentialing

Recredentialing occurs every three years. Eight months prior to the three-year credentialing anniversary the provider will receive a request to log into CAQH, a Universal Provider Datasource, and complete the online application or if provider has already done so, then verify that the attestation is current and up-to-date. The CAQH website is www.caqh.org/cred. If you need your CAQH provider ID number, please contact the credentialing department and they will provide it. Providers shall promptly notify Optum Medical Network and Credentialing Department if they no longer meet the group's credentialing criteria (e.g. medical license revoked, opt-out of Medicare).

Credentialing Flow Chart



Health Improvement

General Information

Optum Medical Network's Affirmative Statement

Our Principles of Ethics & Integrity – Code of Conduct serves as a guide to acceptable and appropriate business conduct by the company's employees and contractors.

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

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

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

Quality Improvement

Introduction to Quality Improvement (QI)

Committee Mission

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

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

Committee Goals

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

Committee Objectives

The committee shall establish a reporting calendar to support the monitoring and evaluation of the following functions:

- > Review and adoption of QI Program and annual QI Work Plan and related policies and procedures
- > Review and adoption of UM Program and related policies and procedures
- > Review and approve practice protocols and guidelines related to the use of physician extenders
- > Trending of patient and practitioner complaints
- > Review and approve Medical Necessity UM Criteria

- > Quality of clinical care and service monitoring and evaluation activities include but may not be limited to the following activities and outcomes:
 - Prior authorization
 - Concurrent review
 - Patient safety
 - UM timeliness of decisions
 - Oversight of delegated functions
- > Develop peer profiling guidelines for inpatient and outpatient utilization tracking, and methods and procedures for performing outcome and other comparative analysis
 - Monitor appropriate utilization of care and services (i.e. under- and over-utilization)
 - Design and complete selected UM studies related to managed care efficiency (referral patterns, MRI, etc.)
 - Determine clinical and service guidelines to trigger peer review cases
- > Collaborate with information systems to develop utilization management reports and data systems for the network practitioners in order to drive improvements of high quality medical care in a cost effective manner
- > Adopt and approve standards related to credentialing and recredentialing of physician and identified non-physician clinical personnel
- > Conduct an annual evaluation of the QI program to assess accomplishments, barriers and revisions for the next year's program

5-Star Measures

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

1. Consumer Assessment of Healthcare Providers and Systems (CAHPS) or patient satisfaction data;
2. Health Care Effectiveness Data and Information Set (HEDIS) or medical record and claims data;
3. Health Outcomes Survey (HOS) or patient health outcomes data; and
4. CMS administrative data on plan quality and Customer satisfaction

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

Medical Records Standards

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

Patient Identification

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

Personal/Biographical Data

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

Patient Language

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

Practitioner Identification

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

Entry Date

All entries will be dated.

Legible

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

Problem List

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

Allergies

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

Advance Directives

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

Medical Records

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

Past Medical History (for patient seen three or more times)

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

Smoking/ETOH/Substance Abuse

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

History and Physical

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

Appropriate Use of Lab and Other Studies

Laboratory and other studies ordered will be noted, as appropriate.

Working Diagnoses

Working diagnoses are consistent with findings.

Risk Factors

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

Plan/Treatment

Treatment plans are consistent with diagnoses.

Return Visit

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

Follow-up

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

Appropriate Use of Consultants

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

Continuity of Care

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

Consultants/X-Rays/Lab and Imaging Report Initials

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

Medication Documentation

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

Immunization Record

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

Preventive Services

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

Addendum to Record

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

Appointment Access Criteria

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

Preventive Care Recommendations

Preventive Care Recommendations For Men and Women Ages 50 and Older

| Appointment Access Standards Behavioral Health | |
|--|--|
| Access to non-urgent appointment with physician for routine care | Within 10 business days of request |
| Non-urgent appointments with a non-physician behavioral health care provider | Within 10 business days of request |
| Access to urgent care | Within 48 hours of request |
| Access to non-life-threatening emergency care | Within 6 hours of request |
| Access to life-threatening emergency care | Immediately |
| Access to follow-up care after hospitalizations for mental illness | Within 7 business days of request (initial visit). Within 30 business days of request (second visit) |

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

| 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 (chickenpox) | 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 effects 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 50-75 |
| Depression | For all adults |

| Screenings/Counseling/Services (continued) | |
|--|---|
| Diabetes | Recommend type 2 diabetes screening for individuals with sustained blood pressure greater than 135/80 mm Hg |
| Domestic violence and abuse | Screening and counseling for interpersonal and domestic violence |
| Gonorrhea | Recommended for all sexually active women who are at increased risk for infection |
| HIV | For all adults at increased risk for HIV infection |
| HPV | Recommended for all sexually active women 65 and younger |
| Lipid disorder | Screening periodically |
| Obesity | Screening, counseling, and behavioral interventions |
| Osteoporosis | Recommend routine screening for women 65 and older; routine screening for women under age 64 if at increased risk |
| Prostate cancer | 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 heart disease, osteoporosis, obesity, and diabetes. Patients should consult a physician before starting a new vigorous physical activity.

| Other Topics to Discuss with Patients |
|--|
| <p>Nutrition</p> <ul style="list-style-type: none"> > 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. |
| <p>Sexual health</p> <ul style="list-style-type: none"> > Sexually transmitted infection (STI)/HIV prevention, practice safer sex (use condoms) or abstinence. |
| <p>Substance abuse</p> <ul style="list-style-type: none"> > Stop smoking. Limit alcohol consumption. Avoid alcohol or drug use while driving. |
| <p>Dental health</p> <ul style="list-style-type: none"> > Floss and brush with fluoride toothpaste daily. Seek dental care regularly. |
| <p>Other topics</p> <ul style="list-style-type: none"> > Fall prevention. > Possible risks and benefits of hormone replacement therapy (HRT) for post-menopausal women. > Risks for and possible benefits of prostate cancer screening in men to determine what is best for you. > The dangers of drug interactions. > Physical activity. > Glaucoma eye exam by an eye care professional (i.e. an ophthalmologist, optometrist) ages 65 and older. |

Utilization Management & Prior Authorization

Introduction to Utilization Management (UM) & Prior Authorization

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

- > Non-urgent (routine) pre-service decisions
 - As soon as medically indicated within a maximum of 14 calendar days after receipt of request
- > Urgent pre-service decisions (expedited)
 - As soon as medically necessary within 72 hours after receipt of request (includes weekends & holidays)

More About Prior Authorization

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

The purpose of the prior authorization process is to support a review process that promotes appropriate access to care and service. This is done in an effort to promote wellness through utilization of appropriate resources, in the most appropriate setting and in the most cost-effective manner. This is achieved through the evaluation and determination of the appropriateness of the patient's and practitioner's use of medical resources prior to services being rendered.

Instances In Which Prior Authorization **Is** Required

The prior authorization procedure requirements and request form are posted on the [OptumMedicalNetwork.com](https://www.optummedicalnetwork.com) website and are updated at least annually. You can also submit requests and check status directly in our secure provider portal.

Prior authorization is required for all Skilled Nursing Facility, Acute Rehab and Long-Term Acute Care admissions. Requests should be submitted to the UM Department (see "How to Request Prior Authorization" below).

Instances In Which Prior Authorization **Is Not** Required

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

How to Request Prior Authorization

A patient, authorized representative or provider may request prior authorization. Multiple methods can be used to request prior authorization. These methods include submission via Internet, fax, phone and US postal mail:

- > Online: [OptumMedicalNetwork.com](https://www.optummedicalnetwork.com)
- > Fax: (888) 992-2809
- > Phone: (877) 370-2845

Coordinators are available to answer questions Monday thru Friday, 8am – 5pm

- > Mail:
 - Optum Medical Network
 - Attn: Prior Authorization
 - PO Box 15645
 - Las Vegas, NV 89114-5645

Instructions:

- Please complete the form located on page two. Fields with an asterisk (*) are required.
- Please include all clinical information, x-ray reports, and diagnostic test results supportive of the procedure(s) requested.

You now have several options for submitting your Prior Authorization requests to Optum Medical Network:

- If you have your own secure system, please submit authorization requests to: LCD_UM@optum.com
- If you do not have a secure email in place, please contact our Service Center at (877) 370-2845. We will ask for your email address and will send a secure email for Prior Authorization requests to be sent to our office.
- You can fax your requests to (888) 992-2809
- Or mail the completed form to:

Optum Medical Network
Attention: Prior Authorization
PO Box 46770
Las Vegas, NV 89114-6770

PLEASE MARK ONE OF THE FOLLOWING:

- ROUTINE (Normal, non-urgent request)
- DATE SENSITIVE (Date Sensitive is defined as an upcoming date of service)
- URGENT (Urgent is defined as significant impact to health of the member if not completed within 72 hours)

PATIENT INFORMATION:

LAST NAME: _____ FIRST NAME: _____ DOB: _____
 PHONE: _____ INSURED ID: _____
 ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

REQUESTING PROVIDER INFORMATION:

PROVIDER NAME: _____
 GROUP NAME: _____
 SPECIALTY: _____
 TAX ID #: _____
 ADDRESS: _____
 CITY: _____ STATE: _____ ZIP: _____
 CONTACT NAME: _____
 PHONE: _____ EXT: _____
 FAX: _____

PLACE OF SERVICE INFORMATION:

PROVIDER/FACILITY: _____
 GROUP NAME: _____
 SPECIALTY: _____
 TAX ID #: _____
 ADDRESS: _____
 CITY: _____ STATE: _____ ZIP: _____
 CONTACT NAME: _____
 PHONE: _____ EXT: _____
 FAX: _____

SERVICES: DOS: _____ DME ITEMS (CHECK ONE): RENTAL PURCHASE
 TYPE OF SERVICE: OUTPT INPT Office Surgery Ctr SNF Home Other: _____
 DIAGNOSIS CODE(S): _____
 CPT/HCPCS CODE(S) (INCLUDE NUMBER OF UNITS PER CODE): _____

- PLEASE ATTACH SUPPORTING CLINICAL INFORMATION (E.G., PLAN OF CARE, MEDICAL RECORDS, LAB REPORTS, LETTER OF MEDICAL NECESSITY, PROGRESS NOTES, ETC.)

- ALL SECTIONS OF THIS FORM MUST BE COMPLETED.
- ON ADVERSE DETERMINATIONS, A RECONSIDERATION/EXPEDITED APPEAL MAY BE REQUESTED.

This referral/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 contained in this form, including attachments, is privileged and confidential & is only for the use of the individual or entities named on 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.

Hospital Admission Notification

Requirements for Admission Notifications

Facilities are responsible for Admission Notification for the following types of admissions:

- > All planned/elective admissions for acute care
- > All unplanned admissions for acute care
- > All Skilled Nursing Facility (SNF) admissions
- > All post-acute care admissions
- > All admissions following outpatient surgery
- > All admissions following observation
- > All admissions for observation

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

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

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

Admission Notifications must contain the following details regarding the admission:

- > Patient name and health care ID number
- > Facility name and TIN or NPI
- > Admitting/attending physician name and TIN or NPI
- > Description for admitting diagnosis or ICD-9-CM (or its successor) diagnosis code
- > Actual admission date
- > Inpatient or Observation status

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

Reimbursement reductions for failure to timely provide Admission Notification

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

How to Submit Admission Notifications

Multiple methods can be used to notify Optum Medical Network of admissions. These methods include submission via Internet, fax, phone and US postal mail.

- > Online: [OptumMedicalNetwork.com](https://www.optummedicalnetwork.com)
- > Fax: (888) 992-2809
- > Phone: (877) 370-2845
Coordinators are available to answer questions Monday thru Friday, 8am to 5pm
- > Mail:
Optum Medical Network
Attn: Prior Authorization
PO Box 15645
Las Vegas, NV 89114-5645

Coordination of Benefits (COB) & Third Party Liability (TPL)

Coordination of Benefits (COB) when Optum Medical Network is not the Primary Payer

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

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

Worker's Compensation

If services rendered are Worker's Compensation related, the provider is authorized to bill the appropriate carrier. If the claim is denied by the carrier, submit confirmation and bill to Optum Medical Network for processing.

Provider Dispute Resolution Process

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

Definition of a Provider Dispute

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

Each provider dispute must contain, at a minimum, the following information:

- > Provider's name
- > Provider's TIN
- > Provider's contact information

If the provider dispute concerns a claim or reimbursement of an over payment of a claim from Optum Medical Network the following must be provided:

- > Clear identification of the disputed item, such as the claim(s) number
- > Date of service
- > Clear description of the dispute

If the provider dispute is not concerning a claim the following must be provided:

- > Clear explanation of the issue
- > Provider's position on such issue

Things to remember when submitting a provider dispute

- > Provider dispute forms must be completed in full and included with the dispute
- > To download a copy of the Optum Medical Network Provider Dispute Resolution Request visit [OptumMedicalNetwork.com](https://www.optummedicalnetwork.com)
- > All required information must be included. Disputes that are missing information will be returned to the submitter



PROVIDER DISPUTE RESOLUTION REQUEST

NOTE: SUBMISSION OF THIS FORM CONSTITUTES AGREEMENT NOT TO BILL THE PATIENT

INSTRUCTIONS

- Please complete the below form. Fields with an asterisk (*) are required.
- Be specific when completing the DESCRIPTION OF DISPUTE.
- Provide additional information to support the description of the dispute. It is not necessary to resubmit the original claim.

You now have several options for submitting your requests for reconsideration to Optum Medical Network:

If you have your own secure system, please submit reconsideration requests to: claimdispute@optum.com.

If you do not have a secure email in place, please contact our Service Center at (877) 370-2845. We will ask for your email address and will send a secure email for claim reconsideration requests to be sent to our office.

You can fax your requests to (888) 905-9495.

Or mail the completed form to: **Provider Dispute Resolution OMN
PO Box 46770
Las Vegas, NV 89114-6770**

| | |
|-------------------|----------------|
| *Provider Name: | *Provider TIN: |
| Provider Address: | |

CLAIM INFORMATION Single Multiple "LIKE" Claims **(attach spreadsheet)** Number of claims: _____

| | |
|----------------------------------|--------------------------------|
| *Patient Name: | *Date of Birth (MM/DD/YYYY): |
| *Member's Health Plan ID: | *Patient Account Number: |
| *Service From Date (MM/DD/YYYY): | *Service To Date (MM/DD/YYYY): |

Please check the description that best fits:
 Claims Authorizations Contract Issues

Description of dispute:

Contact Name: _____ Telephone Number (111-111-1111): _____

Signature: _____ Fax Number (111-111-1111): _____

(Hard Copy Only)

Care Management Overview

Care Management

Optum Medical Network's Care Management Program provides high-touch care coordination within PCP offices, hospitals, skilled nursing facilities (SNF), and patients' homes. Through a variety of programs, the network assists patients throughout their health care journey.

Providers can refer patients into these programs by completing and submitting the Member Programs Referral form found at: OptumMedicalNetwork.com/arizona/providers >

Provider Resources.

Optum Medical Network has two localized Care Management programs: Nurse Care managers & Care Coordinators. Both work in collaboration with the patient, the family/support system, providers and key stakeholders in coordinating discharge, health care services, and referrals to the appropriate next level of care and community resources. Nurse Care managers primarily work with medically complex patients in acute settings and Care Coordinators primarily work with patients who are in the SNF setting. Both teams work collaboratively when it is in the best interest of the patient.

Key Components of Optum Medical Network's Care Management and

Care Coordination Programs

- > Provide intensive care coordination for patients who are at-risk for admissions:
 - Act as a point of contact to assist with seamless transitions
 - Assist with complex discharges from the hospital and or SNFs
 - Verify that discharge plans are in place in home setting
 - Guide patient to follow up with PCP or appropriate Specialist
- > Support patients up to 30 days from referral/discharge, longer if necessary
- > Develop individualized intervention to address identified needs
- > Assist with addressing social service needs through resourcing and referrals, such as:
 - Meals on Wheels referral
 - Placement assistance
 - ALTCS and AHCCCS referrals
- > Educate on the importance of:
 - Advanced Directives through the use of The Five Wishes
 - Personal health records for consistent communication among all providers
 - Follow-up appointment to update primary provider
 - Contingency planning to determine what resources are available to the patient
- > Refers patient to appropriate next level of care at the completion of the program

Additional Care Management Resources

OptumHealth Behavioral Health

For direct referrals regarding behavioral health needs.
(Call Mental Health number on the back of patient's card)

Optum NurseLine: (800) 237-4936 TTY/TDD (800) 855-2880
24-hour access hotline for patient to reach a nurse to answer questions regarding health concern.

Medical Intervention Programs

Optum Palliative & Hospice Care

Palliative Care is concentrated on reducing the severity of disease symptoms in order to prevent suffering and improve quality of life. Hospice is a special way of caring for a person whose illness cannot be cured, emphasizing comfort and quality of life, rather than curative care. The primary focus of hospice care in the last 6 months of life.

Optum Complex Population Management – Transitions to Home

An intensive, in-home medical intervention program focused on the initial 30-days post discharge from acute or skilled facility.

Optum Consumer Solutions Case Management & Disease Management

Advanced Illness

A model of care that anticipates and adapts to advanced illness with telephonic encounters by RN Case Managers. The focus is on improving patient participation in care planning and informed decision-making. The goal is to improve quality of life and death for the patient and their family and to reduce disease symptoms, which may help minimize unnecessary utilization. Designed for patients with a chronic, irreversible disease and a limited life expectancy of 12-18 months.

Transplant Solution

Provides telephonic case management for transplant patients to address the complex needs of the population. The emphasis is on early identification, patient-program matching, and psycho-social management at all stages.

End Stage Renal Disease Management

Interventions that are targeted at reducing inpatient admissions and ED visits via dialysis therapy monitoring, co-morbid condition management and timely referral for transplant consideration.

High Risk Case Management

A telephonic case management program with standardized interventions to reduce unnecessary hospitalizations; reduce readmissions within 30 days of discharge; and decrease pharmacy costs by decreasing number of medication and moving to generics. This program includes a community assessment every 6 months; plan of care updates every 30 days; and post-hospital transition coaching at days 2 & 7 after any inpatient event.

Congestive Heart Failure Program


A comprehensive program that includes daily at-home monitoring; nursing assessment and support; and patient education. Immediate telephonic support is provided by an RN, if weight or symptoms change.

CAD - Diabetes Management Program

A comprehensive program that includes education materials to help patients manage their condition(s) and telephonic nurse support for patients who meet high acuity criteria. The goal for participants includes the right medication, the right provider, the right care and the right lifestyle.

Care Management Referral Process

Providers can refer patients to Optum Medical Network's Care Management programs by completing the Referral Form and sending it to referralsomnaz@optum.com or fax to (888) 405-2734. This form can be found as a writable, savable PDF on the network website under Provider Resources. Communication regarding referral will occur within 1 business day.



OPTUM™
Medical Network

REFERRAL FORM FOR PATIENT PROGRAMS
 Email: referralsomnaz@optum.com
 Fax: (888) 405-2734
 Questions? Please call (623) 707-0829

Reminder: Send in secured format as document contains confidential PHI

Date of Referral: _____
 Person Submitting Referral: _____
 Organization/Program: _____
 Phone: _____ Email: _____
 Urgent Contact to Patient Needed Exposure Concerns

OPTUM MEDICAL NETWORK PATIENT INFORMATION

Patient Name: _____
 DOB: _____ Optum ID or SSN: _____
 Phone 1: _____ Phone 2: _____
 Patient's Address: _____ Zip Code: _____
 Patient's Home Family's Home Group Home/ALF/LTC: _____

.....

Alternative Contact: _____
 Phone: _____ Relationship to Patient: _____
 Currently, who is patient's decision maker? _____

.....

PCP Name: _____ PCP Phone: _____
 *** If patient is currently in Acute Setting, planned date of discharge: _____

IDENTIFIED NEEDS

Check all NEEDS that apply:

| | | |
|--|--|---|
| <input type="checkbox"/> In-Home Medical Mgmt | <input type="checkbox"/> Medical Symptom Mgmt | <input type="checkbox"/> Chronic Disease Mgmt |
| <input type="checkbox"/> Specific Disease Mgmt (please specify): _____ | <input type="checkbox"/> Disease Education | |
| <input type="checkbox"/> Care Coordination/ Case Mgmt | <input type="checkbox"/> Behavioral Health Support | <input type="checkbox"/> Lack of Support System |
| <input type="checkbox"/> Basic Needs (food, shelter, clothing) | <input type="checkbox"/> Financial Needs (AHCCCS, ALTCS) | |
| <input type="checkbox"/> Other: _____ | | |

1 of 2

08/2014

Additional Information Regarding NEEDS: limit 1500 characters

Pertinent Medical Information Regarding NEEDS: limit 2500 characters



Email: referralsomnaz@optum.com
Fax: (888) 405-2734
Questions? Please call (623) 707-0829

Reminder: Send in secured format as document contains confidential PHI

Medicare Risk Adjustment

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

CMS Hierarchical Condition Categories (HCC) Model

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

| Hypothetical illustration payment under the adjusted average per capita cost (AAPCC): | |
|--|---|
| Mr. Smith <ul style="list-style-type: none">> Lives in Marlboro County> 78 years old | Mr. Carter <ul style="list-style-type: none">> Lives in Marlboro County> 78 years old |
| Has: <ul style="list-style-type: none">> CHF> Diabetes> Renal Failure | Has: <ul style="list-style-type: none">> Not seen a doctor in 2 years |
| Medicare monthly payment: <ul style="list-style-type: none">> \$500 | Medicare monthly payment: <ul style="list-style-type: none">> \$500 |

| Hypothetical illustration payment under the principle inpatient diagnostic code grouping (PIP-DCG): | |
|--|---|
| <p>Mr. Smith</p> <ul style="list-style-type: none"> > Lives in Marlboro County > 78 years old <p>Has:</p> <ul style="list-style-type: none"> > CHF (with hospital admit) > Diabetes > Renal Failure <p>Medicare monthly payment:</p> <ul style="list-style-type: none"> > \$1,599 | <p>Mr. Carter</p> <ul style="list-style-type: none"> > Lives in Marlboro County > 78 years old <p>Has:</p> <ul style="list-style-type: none"> > Not seen a doctor in 2 years <p>Medicare monthly payment:</p> <ul style="list-style-type: none"> > \$500 |

| Hypothetical illustration payment under the CMS HCC: | |
|--|---|
| <p>Mr. Smith</p> <ul style="list-style-type: none"> > Lives in Marlboro County > 78 years old <p>Has:</p> <ul style="list-style-type: none"> > CHF (with hospital admit) > Diabetes > Renal Failure <p>Medicare monthly payment:</p> <ul style="list-style-type: none"> > \$1,599 | <p>Mr. Carter</p> <ul style="list-style-type: none"> > Lives in Marlboro County > 78 years old <p>Has:</p> <ul style="list-style-type: none"> > Not seen a doctor in 2 years <p>Medicare monthly payment:</p> <ul style="list-style-type: none"> > \$289 |

Keys to Success with Risk Adjustment

- > Good coding and documentation practices – the medical record documentation must support the ICD-9 (or its successor) submitted on the encounter of Annual Health Assessment Form
- > High reporting levels of encounter data
- > Patient retention

Coding and Documentation

- > Use the current version of ICD-9CM (or its successor) and code to the highest level of specificity
- > Do code all conditions when they become certain
- > Do not code probable, suspected, rule-out or working diagnoses

Documentation

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

Annual Wellness Visits

- > Face-to-face visit with all seniors
- > PCP's are reimbursed by Optum Medical Network for each senior patient for whom they conduct an Annual Wellness Visit and complete the corresponding attestation form
- > The attestation form must be completed in its entirety and submitted to Optum Medical Network for processing
- > The form itself will be used to report the encounters

Optum Medical Network will offer education to Providers and their office staff on this process.

For more information, please contact Optum Medical Network Provider Services: (877) 370-2845.

