OPTUM™ Medical Network
Provider Guide Utah Market

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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^{TM} 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 a division of talented professionals with a mind toward collaboration. We are passionate about assisting physicians in improving the quality, affordability and integration of the care they provide. Our role is to support the provider-patient relationship. Optum Medical Network does this by providing physicians with tools, information and expertise to assist your practice in the ever changing health care environment. We also provide incentives that are designed to compensate for providing quality care to patients and recognize the complexity and intensity of individual patients.

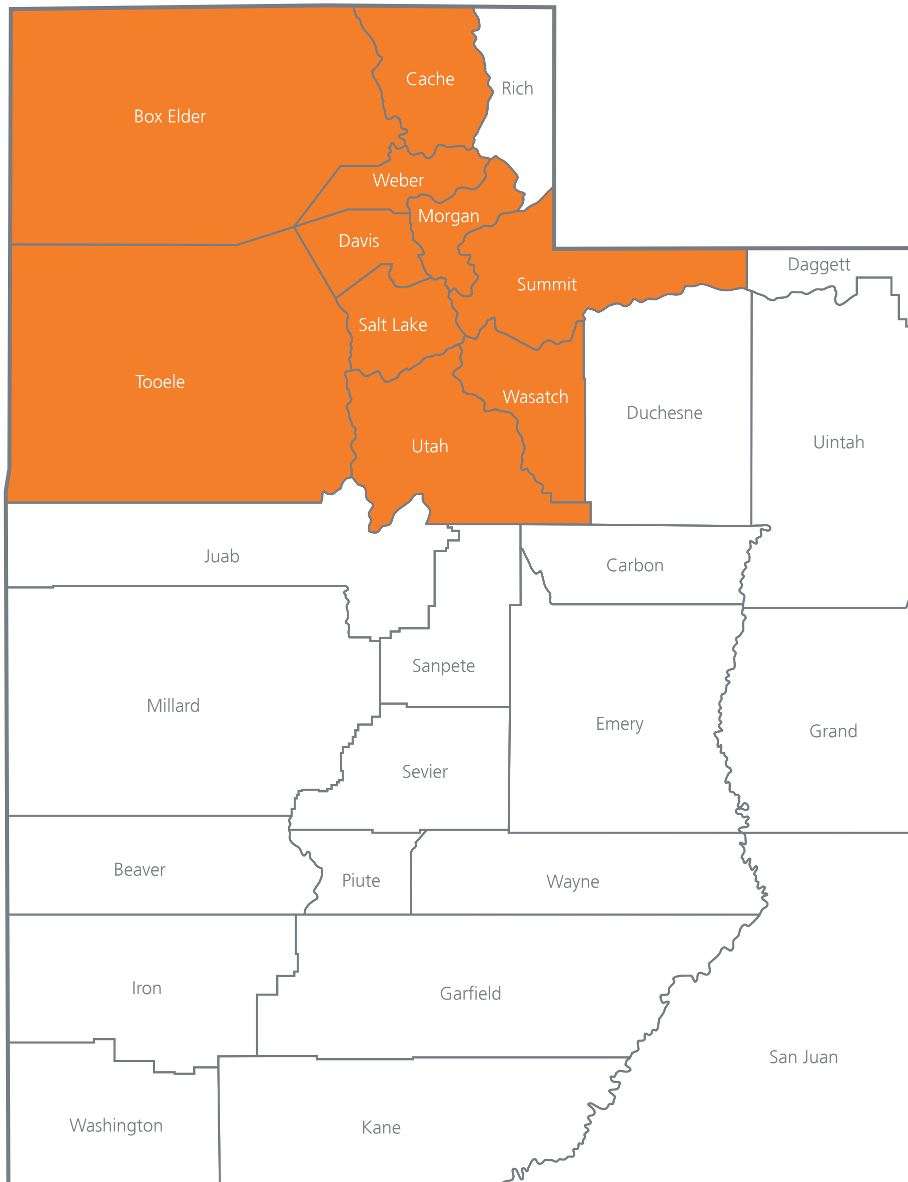
Optum Medical Network contracted providers represent a network of over 2,100 primary care physicians (PCPs), 5,100 specialists and 47 hospitals serving the AARP Medicare Complete membership in Utah. Optum Medical Network is a fully delegated entity, assuming both institutional and professional financial risk which allows us to enhance the coordinated care model. The network currently administers agreements with providers for the provision of medical services for its Medicare Advantage patients.

OPTUM™ Medical Network

Service Area

Optum Medical Network serves the following Utah counties:

Box Elder, Cache, Davis, Morgan, Salt Lake, Summit, Tooele, Utah, Wasatch and Weber



Mission

In Utah, We strive to give selflessly, innovate endlessly, and always collaborate. We take responsibility and demand quality. Above all else, we care about people, their health, and their happiness.

Vision

To improve lives by transforming health care in Utah: 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 > 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 service representatives:

Dave Gardineer	(801) 982-3401	**Shawnda Estrada**	(801) 982-4056
Grace Perry	(801) 982-4054	**Karla Grigsby**	(801) 982-4061

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

Fax: (888) 992-2809

Online: optummedicalnetwork.com/>Provider>Utah>Provider Resources>Prior Authorizations

Email: If you have your own secure system,
please submit authorization requests to: LCD_UM@optum.com

Rx Prior Authorization:
Phone: (800) 711-4555
Fax: (800) 527-0531
Online: 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.

Transplant Prior Authorization: (888) 936-7246

Specialty, Facility and Ancillary Contact Information

Laboratory:

Visit our website OptumMedicalNetwork.com > Providers > Provider Resources
for a list of contracted labs or do a search through the Provider Referral Look-up Tool.

Urgent Care:

Visit our website OptumMedicalNetwork.com > Providers > Provider Resources for a list of contracted urgent care centers or do a search through the Provider Referral Look-up Tool.

Mental Health:

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

Ophthalmology Services:

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

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/utah/providers > Referral Lookup

Patient Enrollment & Assignment

To utilize services from Optum Medical Network's contracted physician and ancillary network, 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.Medicare Advantage members can select UnitedHealthcare Medicare Complete, in the following counties:

- Salt Lake
- Davis
- Box Elder
- Cache
- Morgan
- Summit
- Tooele
- Utah
- Wasatch
- Weber

If a member has coverage through an AARP Medicare Complete health plan they are automatically a member in the network and can take advantage of what Optum Medical Network has to offer.

Health Plan Contact Information

Optum Medical Network proudly accepts the following health plans:

AARP® MedicareComplete® insured through UnitedHealthcare®

Plan Name:

AARP® MedicareComplete® (HMO)

UnitedHealthcare® Group Medicare Advantage

Plan Name:

UnitedHealthcare® Group Medicare Advantage (HMO)

UnitedHealthcare Plan ID Card

The below cards represent the plans OMN manages under UHC Medicare Advantage. You can confirm the plan is managed by OMN by identifying the UHC Medicare assigned H Number on the bottom left hand corner of the 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
7. UHC Medicare Assigned H Contract Number

Card #1

1 AARP | MedicareComplete insured through UnitedHealthcare — PASSPORT

Health Plan (80840): **911-87726-04**

Member ID: 999999999-99 Group Number:

Member:
SUBSCRIBER BROWN

2 Payer ID: LIFE1

PCP Name:
PROVIDER BROWN
PCP Phone: (999) 999-9999

MedicareRx Prescription Drug Coverage
RxBin: 610097
RxPCN: 9999
RxGrp: COS

Copay: PCP/ Spec/ ER
$ / $ / $

4

7 H4604 PBP# — **Optum Medical Network** 3

Customer Service Hours: 8 a.m. - 8 p.m. local time, 7 days a week

For Members
Website: www.myAARPMedicare.com
Customer Service: 1-800-643-4845 TTY 711
NurseLine: 1-877-365-7949 TTY 711
Behavioral Health: 1-800-985-2596 TTY 711
Provider UM: 1-877-370-2845

6 **For Providers** www.optummedicalnetwork.com 1-877-370-2845 5
Medical Claim Address: P.O. Box 46770 Las Vegas, NV 89114

Medicare Solutions SilverSneakers UHC OPTUM Medical Network

Pharmacy Claims OptumRx PO Box 29045, Hot Springs, AR 71903
For Pharmacists 1-877-889-6510

Card #2 (Referrals required)

1 AARP | MedicareComplete insured through UnitedHealthcare — PASSPORT

Health Plan (80840): **911-87726-04**

Member ID: 999999999-99 Group Number:

Member:
SUBSCRIBER BROWN

2 Payer ID: LIFE1

PCP Name:
PROVIDER BROWN
PCP Phone: (999) 999-9999

MedicareRx Prescription Drug Coverage
RxBin: 610097
RxPCN: 9999
RxGrp: COS

Copay: PCP/ Spec/ ER
$ / $ / $

4

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Customer Service Hours: 8 a.m. - 8 p.m. local time, 7 days a week

For Members
Website: www.myAARPMedicare.com
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NurseLine: 1-877-365-7949 TTY 711
Behavioral Health: 1-800-985-2596 TTY 711
Provider UM: 1-877-370-2845

6 **For Providers** www.optummedicalnetwork.com 1-877-370-2845 5
Medical Claim Address: P.O. Box 46770 Las Vegas, NV 89114

Medicare Solutions SilverSneakers UHC Referral Required

Pharmacy Claims OptumRx PO Box 29045, Hot Springs, AR 71903
For Pharmacists 1-877-889-6510

Card #3

1 UnitedHealthcare | Medicare Solutions — PASSPORT

Health Plan (80840): 911-87726-04

Member ID: 999999999-99 Group Number:

Member:
Subscriber Brown — KENNECOTT RETIREE VEBA

2 Payer ID: LIFE1

PCP Name:
Doctor M.D., KATHRYN
PCP Phone: (999) 999-9999

MedicareRx Prescription Drug Coverage
RxBin: 610097
RxPCN: 9999
RxGrp: COS

Copay: PCP/ Spec/ ER
$ / $ / $

4

7 H4604 PBP# — Optum Medical Network 3

Customer Service Hours: Monday - Friday 8:00 a.m. to 8:00 p.m.

For Members
Website: www.UHCRetiree.com
Customer Service: 1-800-457-8506 TTY 711
NurseLine: 1-877-365-7949 TTY 711
Behavioral Health: 1-800-985-2596 TTY 711
Provider UM: 1-877-370-2845

6 For Providers www.optummedicalnetwork.com 1-877-370-2845 5
Medical Claim Address: P.O. Box 46770 Las Vegas, NV 89114

Medicare Solutions UHC OPTUM Medical Network

PharmacyClaims OptumRx PO Box 29045, HotSprings, AR 71903
For Pharmacists 1-877-889-6510

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:

- 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, laboratory and urgent care locations, 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, electronic processing, referral form, dispute form, and provider update/request forms.
- Referral reference guides for various specialties, including locations for Laboratories and Urgent Care Centers.
- 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:

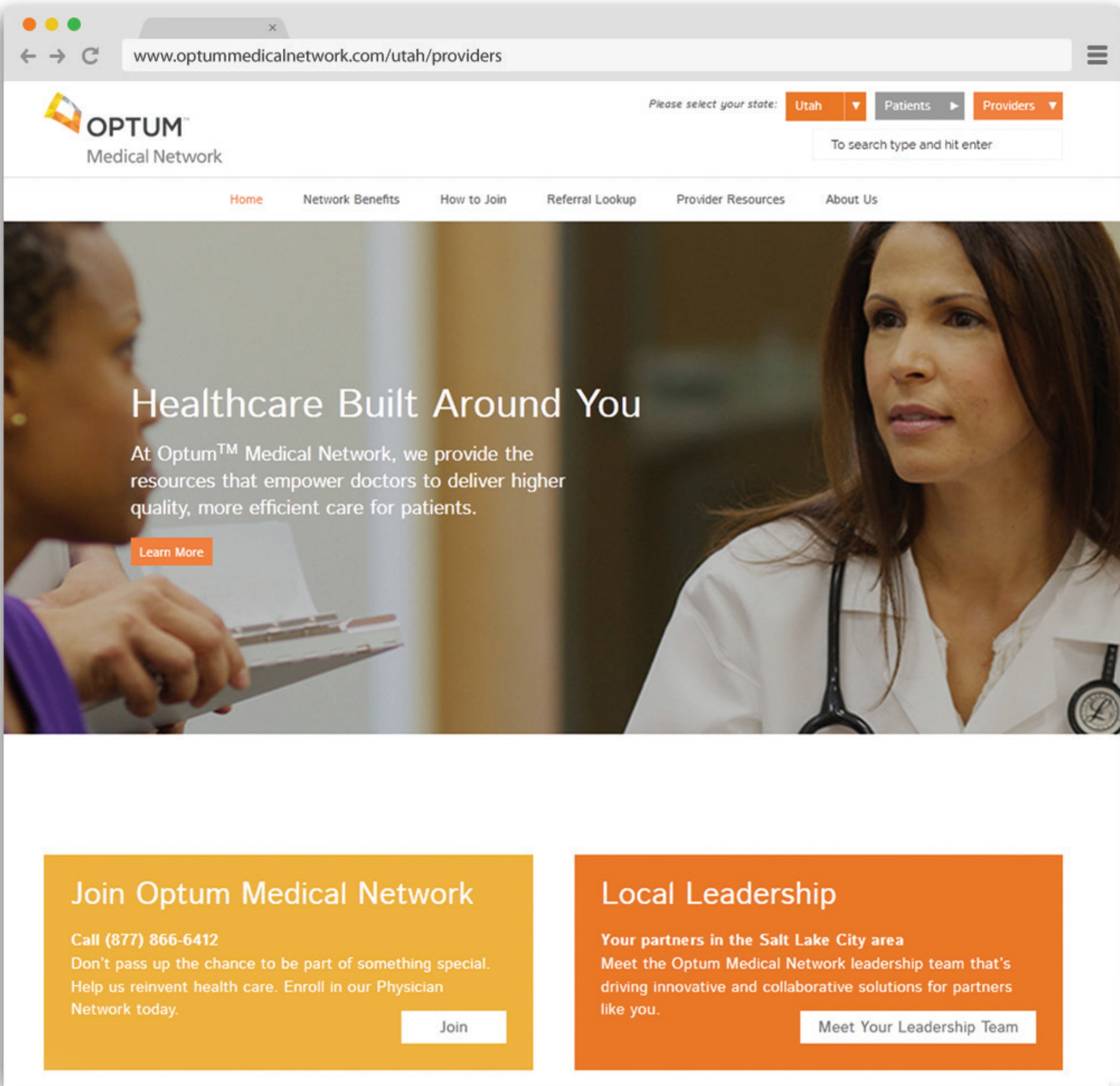
- Verify patient eligibility
- Search prior authorizations and claims
- Send secure emails to our Service Center, Utilization Management, Eligibility and Claims staff
- Search for contracted physicians to refer patients for services
- Submit requests for prior authorization
- Submit notification of patient 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 > 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 > 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 > 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.

For electronic submissions, use 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 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 89114-6770

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**.

Client Number: 3059

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

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) edits for claims payment and use of modifiers are employed when adjudicating claims, including services for surgery assists. In addition, CMS rules on multiple surgery reduction will be applied on these reductions.

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** or contact the Service Center at (877) 370-2845 and have a current TAX ID available.

Credentialing & Recredentialing

We are dedicated to providing our Customers with access to effective health care and, as such, we credential physicians and other health care professionals who seek to participate in our network and get listed in our provider directory, and then re-credential them at least every 36 months thereafter in order to maintain and improve the quality of care and services delivered to our Customers. Our credentialing standards are more extensive than (though, fully compliant with) the National Committee for Quality Assurance (NCQA) and Centers for Medicare & Medicaid Services (CMS) requirements.

We are a member of the Council for Affordable Quality Healthcare (CAQH), and we use the CAQH Universal Provider DataSource (UPD) for gathering credentialing data for physicians and other health care professionals. The CAQH process is available to physicians and other health care professionals at no charge. The CAQH process results in cost efficiencies by eliminating the time required to complete redundant credentialing applications for multiple health plans, reducing the need for costly credentialing software, and minimizing paperwork by allowing physicians and other health care professionals to make updates online.

We have implemented the CAQH process as our single source credentialing application nationally, unless otherwise required in designated states. All physicians and other health care professionals applying to begin participating in our network and those scheduled for re-credentialing are instructed on the proper method for accessing the CAQH UPD.

Participating physicians and other health care professionals are responsible to verify licensure and other credentials, as applicable, of their clinical support staff.

Rights related to the credentialing process

Physicians and other health care providers applying for the UnitedHealthcare network have the following rights regarding the credentialing process:

- To review the information submitted to support your credentialing application;
- To correct erroneous information; and
- To be informed of the status of your credentialing or re-credentialing application, upon request. You can check on the status of your application by calling the Enterprise Voice Portal at (877) 842-3210.

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/Providers > Resources Tab > Forms.**

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, and Milliman Care Guidelines). The criteria is applied in a flexible manner based on current 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**.

The PCP is Key

At Optum Medical Network, we believe that establishing a relationship with a primary care provider is the key to overall health. The PCP is trained to care in a holistic way that encompasses all physical, emotional, social and behavioral health needs of the patient. The PCP understands how life's stressors (i.e. family, friends, economy, occupations, etc…) can affect the patient's health in both positive and negative ways. Understandably, the PCP is a valuable resource for preventative health screenings and physicals for patient's with no current health issues, as well as a resource for patient's with chronic medical conditions (i.e. diabetes, coronary artery disease, COPD, high blood pressure, etc…). For medication review, the PCP is essential in reviewing all of the patient's medication to ensure they are safe to take together. Additionally, He/She reviews medications for interactions, advises against potential side effects and can reduce medication cost by substituting equally effective generic medications when appropriate. He/She will provide urgent and emergency care recommendations and appropriate places of care for those issues. Through building a long standing relationship with the PCP, the patient's journey through life and the healthcare system can be much less stressful and at times an enjoyable experience. We all utilize the healthcare system at some point, and a PCP guided experience is much more rewarding and critical to better health outcomes.

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, OMN requires that 10% of all physician assistant (PA) and/or nurse practitioner (NP) signatures 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 for all non-electronic records.

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 follow-up appointment after discharge from inpatient facility	Required within 5 business days of discharge
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 appointments with a specialist	Within 30 business days of request
In-office wait time for scheduled appointments (PCP and Specialist)	Not to exceed 30 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

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 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)
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

Preventive Care Recommendations

Preventive Care Recommendations For Men and Women Ages 50 and Older

Immunizations	
Influenza	Recommended annually
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 (unless documented counter indication)
Tdap booster (pertussis)	One dose recommended
Varicella (chickenpox)	Recommended for adults without evidence at 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 screening every 5-10 years, fmore frequently for at risk individuals
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 annually
Sexually transmitted infections	Recommended for all sexually active adults at risk for infections. Screening, counseling, and behavioral interventions
Syphilis	Recommended for individuals at increased risk for infection
Tobacco use and cessation	Screening for tobacco use and cessation intervention

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 one business day 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 our website **OptumMedicalNetwork.com> I'm a provider>Utah>Provider Resources>Prior Authorization list.** This list is 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 Inpatient Rehab and Long-Term Acute Care admissions or Home Health Care services with visit frequency three times daily or greater. 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**

> Fax: (888) 992-2809

> Phone: (877) 370-2845, Option #2
Coordinators are available to answer questions Monday thru Friday, 8am – 5pm

> Email: If you have your own secure system, please submit authorization requests to: LCD_UM@optum.com

> Mail:
Optum Medical Network
Attn: Prior Authorization
PO Box 46770
Las Vegas, NV 89114-5645

PRIOR AUTHORIZATION FORM
Phone: (877) 370-2845 opt 2
Fax: (888) 992-2809

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

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PRIOR AUTHORIZATION FORM
Phone: (877) 370-2845 opt 2
Fax: (888) 992-2809

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.

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Referral Policy 2015

UnitedHealthcare and Optum Medical Network feel that establishing a relationship with a primary care provider (PCP) is the key to a patient's overall health. A PCP is trained to care for a patient in a holistic way. Through building a long standing, trusted relationship with a PCP, a patient's journey through life and the healthcare system can be much less stressful and more enjoyable. Let's face it, we all are going to utilize the healthcare system, an established PCP relationship can be much more rewarding and critical to ensure better outcomes for health. In order to complete a referral quickly and easily, our providers can navigate to the portal at: www.optummedicalnetwork.com.

PCP to Specialist Referrals:

After evaluation by and in consultation with their PCP, the next step in care is evaluation and or treatment by a specialist.

- Referrals to specialists for evaluation and treatment (Eval &Treat) are good for six months from the date of referral.
- At the end of the six month period, re-evaluation by the patients' PCP and a second referral is required.
- OMN recognizes there are occasions when the best physician for ongoing treatment of a patient is a specialist. Therefore, any subsequent referral back to the specialist is good for three years.
- Referrals ensure the PCP is aware of any ongoing needs of his or her patient and provides an opportunity for the PCP to address routine health and wellness issues.
- Referrals are required for all in-network specialty services regardless of group affiliation.
- All in network referrals are approved on the same business day if completed on the OMN portal at: www.optummedicalnetwork.com.

Example: For instance, if you are a PCP at ABC Medical Group and believe your patient should be evaluated by ABC Medical Group podiatrist, a referral is required.

Specialist to Specialist Referrals:

- OMN requires specialists to complete a referral if the continued treatment of a patient requires expertise beyond their scope.
- This direct specialty to specialty referral process avoids unnecessary delays in treatment by allowing the specialists to make the referral on behalf of the PCP.
- **Example:** If a neurologist at Better Health Group in consultation with his or her patient believes the next step in care is evaluation by a neurosurgeon, the neurologist is required to complete a referral.
- As with the PCP to specialist guidelines, the initial referral is good for 6 months and, if continued treatment is required beyond that time a subsequent referral from the PCP is required.
- This subsequent referral is good for three years.

What's the difference between a Referral and an Authorization?

- **Referral** - When a Medical professional suggests that you receive additional care from another provider, such as a specialist or facility.
- **Authorization** - Approval to receive medical treatment or equipment. For example; surgeries, in home care, medical tests, medical equipment, etc.
- It is important to note a referral to a specialist does not supersede the need for prior authorization for treatment/equipment. Please see the OMN prior authorization list at: www.optummedicalnetwork.com.
- If you have completed a referral for services that require prior authorization, you will be notified if further information is required.
- **Prior authorization is required for any out of network services.**

Items not requiring referral

- Laboratory tests for management of chronic disease may be obtained without a referral at any in network facility
- Screening Mammogram
- Screening Colonoscopy
- Screening retinopathy/glaucoma or routine eye exam
- Bone density screening
- Bladder control screening
- Fall risk assessment
- Influenza and Pneumovax vaccination

Dental Services are not a covered benefit of Optum Medical Network and is managed on a separate plan.

How to Submit a Referral

Providers can refer patients to an Optum Medical Network Specialist by submitting a referral through our secure online referral tool available in the Provider Portal. Go to www.optummedicalnetwork.com/utah/providers. Or, providers can complete the Written Referral Form and send it to LCD_UM@optum.com or fax to (888) 992-2809. This form can be found as a writable, savable PDF at optummedicalnetwork.com under Provider Resources. For more information, please contact our Service Center at 1-877-370-2845.

Policy is subject to change.

OMN Primary Care Provider (PCP) Written Referral Form

INSTRUCTIONS

- Please complete the below form.
- Required fields are marked with an *.
- Return the form through one of the methods listed below.

Mail the completed form to:
OMN PCP Referral
PO Box 46770
Las Vegas, NV 89114-6770

Fax the completed form to: **888-992-2809**

Email the completed form to: **LCD_UM@optum.com**

If you have your own secure email system, please submit the form to LCD_UM@optum.com. If you do not have your own secure email system, please contact our service center at 1-877-370-2845. We will ask for your email address and will send a secure email for the form to be sent to our office.

Providers may also submit referrals through the OMN Portal, found at www.optummedicalnetwork.com.

SECTION 1: Member Information	
*Member Name	*Member ID Number
*Address (City, State, ZIP Code)	
*Telephone Number	Extension
SECTION 2: Primary Care Provider (PCP) Information	
*Primary Care Provider Name	PCP Tax Identification Number (TIN)
Address (City, State, ZIP Code)	
*Telephone Number	Extension
*Fax Number	*Contact Name
In-Network Provider Specialty (if other than PCP)	
SECTION 3: Referred Specialist Information	
*Specialist Name	Specialist Tax Identification Number (TIN)
*Address (City, State, ZIP Code)	
*Telephone Number	Extension
Fax Number	In-Network Provider Specialty
SECTION 4: Referral for Evaluation and Treatment Information	
Start Date XX/XX/20XX (Initial referrals are valid for six (6) months after start date)	Referring Diagnosis (Enter a general diagnosis that explains why the patient needs to see the specialist.)
Type of Request ☐ Initial Referral Request	☐ Subsequent Referral Request

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 Home Health care admissions with visit frequency three times daily or greater
- All LTAC and AIR admissions

Unless otherwise indicated, Notification of admission must be received within 1 business day 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**
- Fax: (888) 992-2809
- Phone: (877) 370-2845
  Coordinators are available to answer questions Monday thru Friday, 8am to 5pm
- Email: If you have your own secure system, please submit authorization requests to: LCD_UM@optum.com
- Mail:
  Optum Medical Network
  Attn: Prior Authorization
  PO Box 46770
  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**
- 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

Optum Medical Network is a local network of talented health care professionals who go beyond basic care management by working together at a personal level to ensure patients achieve optimal outcomes. By working together, closer and smarter, we are changing the way health care has been managed in the past to benefit both patients and providers.

Our Care Management Program provides individualized care coordination to assist patients as they transition within hospitals, skilled nursing facilities (SNF), PCP offices and home. Optum Medical Network's Transition Program helps meet changing needs by focusing on progress toward treatment goals, overall health improvement, and helping to take care of the important details. As goals are met, we coordinate health care needs for a timely and easy transition back to home.

Local services we provide:

- RN Case Managers
- Social Workers
- Pharmacists
- RN Care Coordinators
- Concurrent Review Coordinators
- Medical Director management
- Additional Care Management Resources

Case Managers, Care Coordinators, and Concurrent Review Coordinators work in collaboration with the patient, the family/support system, and providers in coordinating discharges, health care services, and referrals to the appropriate next level of care. Nurse Care Coordinators primarily work with medically complex patients in acute settings. Nurse Case Managers primarily work with patients who are in the SNF and Community setting. Concurrent Review Coordinators assist with coordination of services in all areas.

Social Workers manage the socially dynamic and difficult cases to problem solve and utilize community resources to protect the health and well being of our patients. They also specialize with Palliative Care and transitions for acute and chronic symptom management.

The Pharmacist is personally available to assist with medication management. Our pharmacist reviews medications to identify high risk drugs, conflicting or duplicating orders, and potential adverse interactions. Medication reconciliations are performed on patients with complex needs, especially during transitions between facilities to home. They can contact patients to discuss the new or changed medications to ensure they are being taken as ordered.

Our Medical Director can collaborate with physicians to mutually review and discuss cases, facilitating best practice and optimal outcomes. Prior authorizations that require medical director approval will have a personal review at a local level that is line with care practices in our community.

Most importantly, all team member work collaboratively with our providers focused on the best interest of the patient.

Other Key Components of Optum Medical Network's Care Management Program: 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
  - Hospital and or SNFsVerify that discharge plans are in place in home setting
  - Ensure Primary Care Providers are informed of changes of condition and medications following inpatient staysGuide patient to follow up with PCP or appropriate Specialist
- Support patients up to 30 days from referral/discharge, longer if necessary
- Medication Reconciliations between providers

Health and Wellness Education

- Assist with addressing social service needs through resourcing and referrals, such as:
  - Meals on Wheels referral
  - Placement assistance
  - Transportation Issues
  - ALTCS and AHCCCS referrals
- Educate on the importance of:
  - Advanced Directives
  - Personal health records for consistent communication among all providers
  - 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

Health & Wellness Education

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 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.

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.

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 > Lives in Marlboro County > 78 years old	Mr. Carter > Lives in Marlboro County > 78 years old
Has: > CHF > Diabetes > Renal Failure	Has: > Not seen a doctor in 2 years
Medicare monthly payment: > $500	Medicare monthly payment: > $500

Hypothetical illustration payment under the principle inpatient diagnostic code grouping (PIP-DCG):	
Mr. Smith > Lives in Marlboro County > 78 years old Has: > CHF (with hospital admit) > Diabetes > Renal Failure Medicare monthly payment: > $1,599	Mr. Carter > Lives in Marlboro County > 78 years old Has: > Not seen a doctor in 2 years Medicare monthly payment: > $500

Hypothetical illustration payment under the CMS HCC:	
Mr. Smith > Lives in Marlboro County > 78 years old Has: > CHF (with hospital admit) > Diabetes > Renal Failure Medicare monthly payment: > $1,599	Mr. Carter > Lives in Marlboro County > 78 years old Has: > Not seen a doctor in 2 years Medicare monthly payment: > $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

- Documentation should meet CMS guidelines: patient name, date of service, face to face visit, provider credential and validation must be present.
- 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.

OPTUM™
Medical Network