OPTUM Care® | Network of Nevada

2022 provider manual

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Chapter 1: Overview

Purpose and use of this guide

The guide contains important information about Optum Care® Network of Nevada's policies and procedures, claims submission and adjudication requirement. General recommendations are provided to support and enable participating providers and their staff to deliver effective care for members of Optum Care Medicare Advantage plans.

This guide is not intended to be exhaustive nor contractually binding. In the event of a conflict or inconsistency between this administrative guide and your network contractual agreement or applicable federal and state statutes and regulations, the terms of the contractual agreement along with federal and state statutes and regulations shall control.

Optum Care reserves the right to supplement this guide to ensure that the information, terms and conditions remain in compliance with all governing Center for Medicare Service (CMS) regulations and relevant federal and state laws.

Business overview

Who is Optum Care?

Optum Care Network of Nevada is an independent physician 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 Care contracted providers represent a network of over **904+** primary care physicians, **1900+** specialists, and **20** hospitals serving all of Clark, Lyon, Nye and Washoe Counties.

Optum Care 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 delegated agreements with health plans for the provision of medical services for most of its Medicare Advantage patients.

Mission

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

Vision

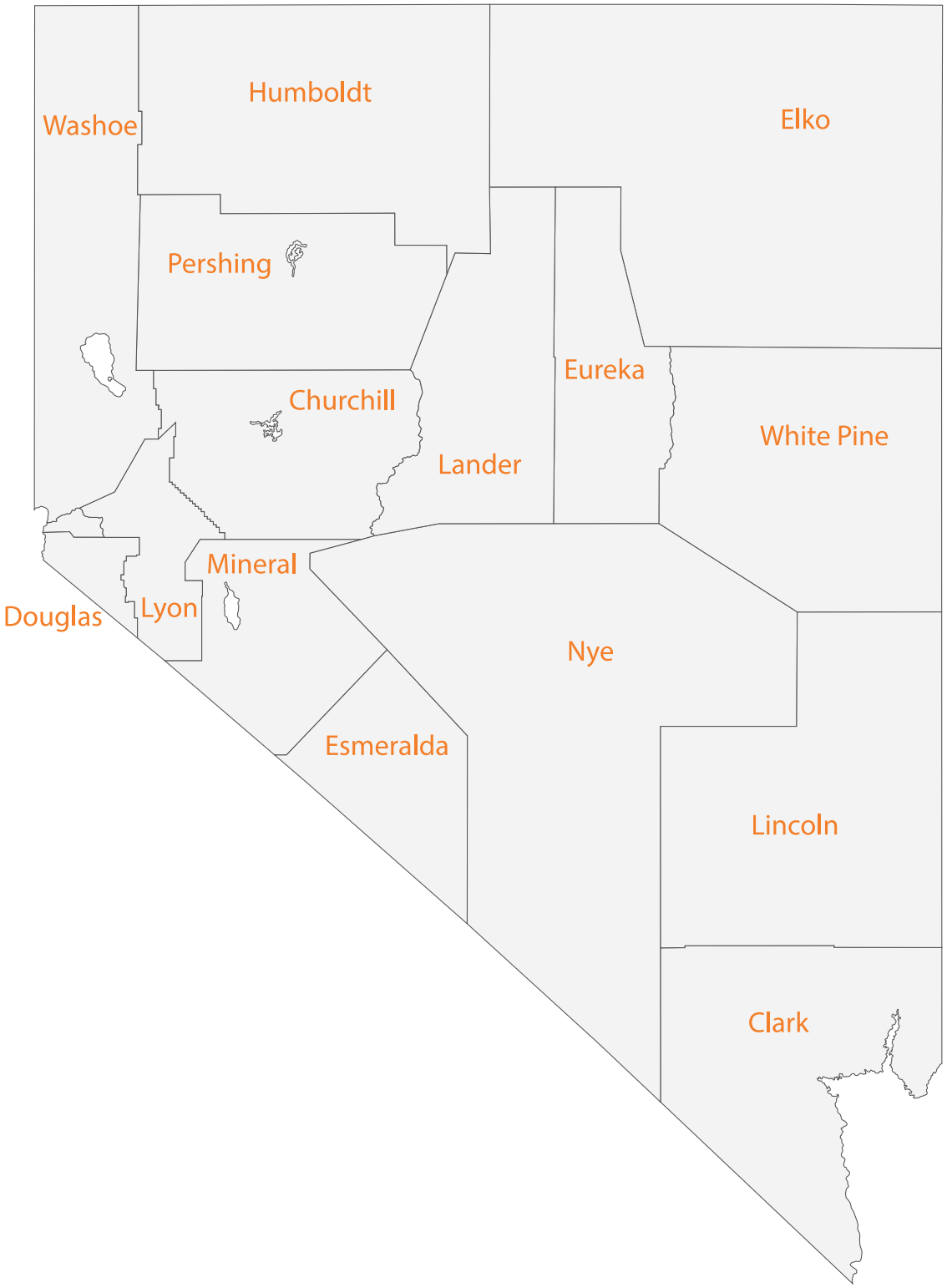
To improve lives by transforming health care in Nevada: one patient, one family, one community at a time.

Values

Integrity, compassion, relationships, innovation, performance.

Service area

Optum Care Network of Nevada serves the entire Clark, Lyon, Nye and Washoe Counties area.



Medicare Advantage products

Optum Care Nevada offers several Medicare Advantage products/plans. These plans provide all of the benefits covered under Original Medicare and more. Our plans do not have limits for pre-existing conditions, and they do not require physical exams.
The member may have multiple choices of health plans depending on where they live.

While exact benefits may vary, these plans may give:

- Access to medical care through a trusted network of care providers
- Coverage for many preventive services with no copays
- Help with financial protection with annual out-of-pocket limits
- Worldwide emergency care coverage
- Medicare Part D prescription drug coverage
- Coverage for additional benefits like routine vision and hearing exams

Some plans do not require an additional monthly premium for this coverage. The member simply continues to pay the Medicare Part B premium unless the member has coverage through Medicaid or another third party.

Preferred provider organization plans (PPO)

The PPO offers members access to a network of contracted physicians and hospitals, but also allows them the flexibility to seek covered services from outside of the contracted network (out-of-network) at a higher cost.

Members are encouraged, but not required, to see a primary care physician from the Medicare network of physicians to help coordinate their care.

Members do not need a referral for specialty care. However, Optum Care prefers providers use the normal referral process to improve communication and care for patients under these plans.

For primary care providers (PCP):

Reimbursement for services follows current/established rate structure; how they are reimbursed for the existing HMO MA business.

For specialists:

Reimbursement for services to members who are enrolled in one of the PPO plans will be fee-for-service.

Not all PPO plans are administered by Optum Care. Please look at the member's insurance card and/or portal to confirm whether they are enrolled in one of our PPO plans. Only insurance cards that include the Optum Care logo on the front or back of the card are administered by us. Also note the claims address on the back of the card.

Claims for members impaneled to Optum Care contracted PCPs are paid by Optum Care, and claims for members impaneled to Intermountain Healthcare® (IHC) PCPs are processed by UnitedHealthcare® (UHC). The member card will identify which of the two to send claims to.

PPO plans are currently offered in Southern Nevada only (Clark and Nye Counties).

Dual special needs plans (D-SNP)

This special needs plan (SNP) meets the needs of individuals enrolled in Medicare who also qualify for Medicaid (called dual eligible). This plan combines the benefits of Medicare and Medicaid.

D-SNP plans are currently offered in Clark and Washoe Counties only. Annually, all network providers are required to complete the D-SNP training and submit a signed attestation to network services (beginning January of each year).

Chronic special needs plans (C-SNP)

This SNP is for members who have one or more severe or disabling chronic conditions. We help members manage their condition as well as their overall health and well-being.

C-SNP plans are currently offered in Southern Nevada only (Clark and Nye Counties).

Institutional special needs plans

These SNPs are for members who reside in a contracted skilled nursing facility or assisted living facility and require an institutional level of care.

UnitedHealthcare Group MA

We offer these plans to employer groups for their retired Medicare-eligible employees. They have benefits similar to individual plans. The member's health care ID card has the employer group name and number on it.

Chapter 2: Contact information

How to contact us

Online

Optum Care offers an online provider portal for faster service to all contracted providers for their use to access important member and network information at their convenience 24 hours a day, seven days a week. Providers have secure access to member eligibility information, automated referrals and prior authorizations, claims status, and network updates.

The Optum Care Mountain West provider center (provider portal): providers.optumcaremw.com

Telephone

Optum Care provider services is also accessible by phone. Service advocates are available to answer provider questions Monday through Saturday, 8 a.m.–8 p.m. local time.

Optum Care customer service: 1-855-893-2297

Provider relations

Network management representative

Our preferred method of communication is to meet with you face to face. Our network managers are always ready to answer your questions, accommodate your needs, and share information.

To contact your network manager, email: nvcontractingdept@optum.com

Provider address changes and other practice updates

In order to maintain accurate provider directories and for reimbursement purposes, we ask that you report all changes of address, additions or terminations of providers to your practice, and other practice information to us in writing via email (nvcontractingdept@optum.com) or by contacting your network management representative as soon as possible.

The physician/provider change form is available online on the Optum Care Network of Nevada Optum Care Mountain West provider center at providers.optumcaremw.com

It may also be located, along with other clinical resources, at professionals.optumcare.com/resources-clinicians/nevada-clinician-resources.html

Updates and news regarding changes to policies, protocols and best practices can be found online at providers.optumcaremw.com

Utilization management

Optum Care utilization management
Seven days a week, 7:30 a.m.–5:00 p.m.
Phone: 1-702-240-8878
Fax: 1-702-688-5056

Advance notification

Optum Care requires that all providers provide notification of intent to hospitalize members in advance of admission or delivery of services such as a scheduled general surgery at a surgery center. This is in addition to seeking prior authorization for the procedure or physician's services.

Advance notifications can be made by calling **1-702-240-8878** or by fax to **1-702-804-3773**.

Hospital admissions notifications

Hospital admissions notifications must be made within 24 hours of the admission.

Please use this number ONLY for admits/discharges:
Admits/discharges phone: **1-702-240-8878**
Admits/discharges fax: **1-702-804-3773**

Urgent and routine prior authorization

The Optum Care Mountain West provider center provider portal is the expected method for submitting prior authorizations: **providers.optumcaremw.com**

Prior authorizations can also be managed via phone: **1-855-893-2297** (option 2 for prior authorizations, then select NEW to reach Optum Care PA).

RX prior authorization for UnitedHealthcare and Anthem® patients:

Phone: 1-800-711-4555
Fax: 1-800-527-0531
Online: **providers.optumcaremw.com**

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:

For UHC members:
Phone: **1-800-773-2710**

For Anthem members:
Online: **anthem.com/account-login**

Complex case management

Phone: **1-702-733-3700**

IPA/network outpatient care management

Phone: **1-702-240-8934**

Special needs plans (D-SNP/C-SNP) care management

Phone: **1-702-243-4639**

Resource coordination center (RCC)

The Optum Care RCC manages Optum Care Network of Nevada patient population during care transitions when they are most vulnerable. We open doors to providing clinical expertise to our patients through our community programs, valuable resources and our clinical team.

Specialty, facility and ancillary contact information

Durable medical equipment

Northern Nevada

Preferred Homecare DME
Phone: **1-480-446-9010**

Bennett DME
Phone: **1-775-329-0799**

Durable medical equipment

Southern Nevada

Southwest Medical Associates: pharmacy and home medical equipment

Phone: **1-702-796-1016**
Medical equipment fax: **1-702-242-7703**
Pharmacy fax: **1-702-796-0818**

- Walkers
- Commodes (bedside & 3:1)
- IV infusion supplies and medication*
- Diabetic supplies* (insulin pump needs PA)
- O2 conserving devices
- Crutches and canes
- Ostomy supplies
- Wheelchairs* (custom/electric/transport), cushions
- Scooters*
- Lymphedema pumps
- Lift chairs
- Bili lights
- Enteral feeding equipment (pump & pole)*
- Specialty injectables

Preferred Homecare DME

Phone: **1-702-951-6900**
Pharmacy fax: **1-702-951-6904**

- Hoyer lifts*
- Bariatric beds for home use
- Oxygen concentration
- Continuous passive motion machine*
- Wheelchairs (standard/lightweight/ heavy duty/reclining)
- Mattress*
- TENS
- Tracheostomy supplies
- BIPAP and CPAP machines & apnea monitors*
- Nebulizers
- Suction pumps
- Ventilators
- Hospital beds *bariatric require prior auth*
- Traction unit
- Trapeze bar
- Percussion

Home health care
(includes nursing, PT/OT/ST, social work, aide)

Northern Nevada

Kindred at Home
Phone: **1-775-858-1900**
Fax: **1-775-585-1908**

Preferred Homecare
Phone: **1-775-825-8644**
Fax: **1-775-825-7244**

Quality Health Care Corporation (Eden)
Phone: **1-775-828-1000**
Fax: **1-775-828-1029**

Southern Nevada

Southwest Medical home health
Phone: **1-702-383-0887**

Always Better Care-for River Cities (Laughlin, Bullhead, etc.)
Phone: **1-702-298-0555**
Fax: **1-702-298-0577**

Hospice care

Southwest Medical hospice care
Phone: **1-702-671-1111**

*Requires a prior authorization from Optum Care UM department

Infusion and injectable medications

Northern Nevada

Option Care
Phone: **1-775-828-8200**

Southern Nevada

Southwest Medical Associates – pharmacy and home medical equipment

Phone: **1-702-796-1016**
RX fax: **1-722-796-0818**

Kidney resource services

Phone: **1-866-561-7518**

Laboratory

Quest Diagnostics
Phone: **1-702-733-3700**
Online: **questdiagnostics.com**

Mental health

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

Optum Behavioral Solutions
Phone: **1-800-579-5222**
Online: **liveandworkwell.com**

Northern Nevada:

Nevada Behavioral Health Services:
Phone: **1-775-382-8001**

Southern Nevada:

Nevada Behavioral Health Services:
Phone: **1-702-857-8800**

Nephrology

Nevada Kidney Disease & Hypertension Centers (NKDHC) is Optum Care's preferred nephrology group. Please ensure that NKDHC is utilized for all nephrology hospital consults and follow-up care for Optum Care members.

NKDHC inpatient consult
Phone: **1-702-732-2438**

For dialysis, the preferred provider group is Fresenius.
Fresenius
Phone: **1-800-881-5101**

Non-emergency transportation

Northern and Southern Nevada

For UHC and Anthem members:

- Number of rides vary by plan
- Not available for retiree or PPO
- 48 hours advance notice is required

For UHC Members
ModivCare

For facilities (7 a.m.–7 p.m.)
Reservations: **1-888-589-6163**
Fax: **1-888-589-6164**

For facilities (after hours)
Reservations: **1-866-913-1888**

For Anthem Members
ModivCare
Reservations (call Anthem): **1-844-469-1759**

Palliative care

Optum Care palliative care
Phone: **1-702-954-7505**

Prosthetics and orthotics – S. Nevada

Advanced Prosthetics & Orthotics
Phone: **1-702-256-5265**
Fax: **1-702-256-5265**

Hangar Clinic
Phone: **1-702-366-9681**

Mobility Prosthetics and Orthotic Services
Phone: **1-702-800-6520**
Fax: **1-702-800-6492**

Precision Orthotics & Prosthetics (POP)
Phone: **1-702-243-7671**
Fax: **1-702-259-7671**

Hearing/hearing aids

Hearing benefits are available for Optum Care Medicare Advantage plan members through UnitedHealthcare Hearing. UnitedHealthcare Hearing will connect members with in-network providers for evaluations. Participating providers include ENTs, audiologists, and hearing aid dispensers. All hearing aid recommendations are sent to UnitedHealthcare Hearing. UnitedHealthcare Hearing handles all eligibility, billing and out-of-pocket collections for eligible hearing services. They provide authorizations for hearing aid purchases and the provider places the order with the manufacturer. Hearing aid fittings and follow-up appointments will be provided by the hearing provider.

UnitedHealthcare Hearing
Phone: **1-855-523-9355**

In-network specialty groups

In an ongoing effort to provide our patients with the highest level of service, Optum Care has selected high quality providers within specialty groups based on quality, performance metrics, geographic location and availability of clinical services. Our specialty providers can be found online at **providers.optumcaremw.com**

Additional specialists and facilities

For information on additional Optum Care specialists and facilities, please contact our service center.

Optum Care service center
Phone: **1-855-893-2297**

Language and hearing impaired assistance

Optum Care 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 Care, 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.

It is the provider's responsibility under Title III of the Americans with Disabilities Act to promptly make accommodations for the hearing impaired when requested and to cover the cost of the interpreter when necessary in an effort to avoid a delay in care. Patients have the right to a certified medical interpreter or sign language interpreter to translate health information accurately. Providers cannot charge the patient for the costs of sign language interpreter services or auxiliary aids.

For more information, call Optum Care at **1-855-893-2297**. The Optum Care service center is open Monday through Saturday, 8 a.m.–8 p.m.

The TTY **711** and language lines are open 24 hours a day, seven days a week.

For technical difficulties/additional assistance, please contact Optum Care service center for Nevada: **1-855-893-2297.**

Provider portal and website

About the Optum Care Network of Nevada Mountain West provider center

The Optum Care Mountain West provider center is designed specifically for our contract providers. It offers offices access to patient authorization and claims information online, along with other value-added services.

The portal is the preferred method for PCP providers to submit referrals to specialists for their patients. Referring providers can track the status and receive notification pertaining to their referrals through the portal. Specialists will receive referrals through signing onto and viewing their portal account. Specialists are asked to provide updates to the referral such as status of scheduling, inability to reach the patient, and completion of care which are visible to the referring provider.

Prior authorizations are managed in the provider portal. Treating providers submit requests for prior authorizations for their patients through the portal, monitor status, receive approvals/denial. Approved prior authorizations in the portal are linked to the claims management system and, therefore, the claims process is simplified for the provider.

While the provider portal does not accept claims submission, providers can track claims status through the provider portal. Refer to procedures for claims submission for more information.

Secure email is also available on the provider portal and enables providers to communicate with our service center.

Please refer to the Mountain West Provider Center User Guide available on the provider portal for complete instructions on use of the portal.

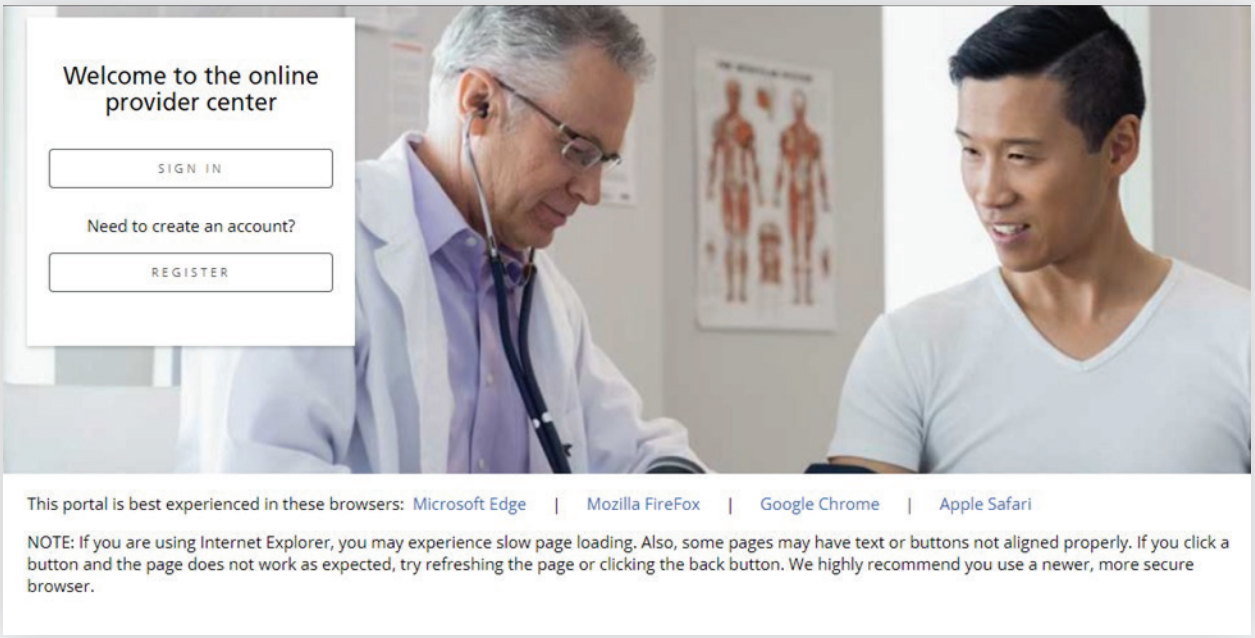
The Optum Care provider portal offers additional online resources such as clinical practice guidelines, provider reference materials, and tutorial video for new users.

To access the provider portal, visit **providers.optumcaremw.com**

Provider registration to the portal is required for first time users in order to access secure member information, manage referrals and prior authorizations and review claims. The provider can register through accessing the above web address and creating an account. Your account information will be emailed to you in about two business days. Additional users may be added to the account. For any assistance with this process, please contact Optum Care Network of Nevada at **providers.optumcaremw.com**

About the website

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



Optumcare.com for medical professionals

On our website, contracted and non-contracted practitioners and other health care professionals can learn more about what it means to be part of Optum Care. There you will find the philosophies that guide our approach to care, as well as valuable resources for Optum Care contracted providers including:

- Forms for prior authorization, electronic processing, referrals, disputes and provider updates
- Reference guides for referrals to various specialties, including a list of locations for laboratories and urgent care centers
- User guide for creating a provider portal account
- Coding tips and tools

Medical professionals can visit professionals.optumcare.com

Optumcare.com for patients

On our website, current and potential members of Optum Care can explore the various services Optum Care Network of Nevada offers. Features include:

- FAQs to address the most common questions from existing and potential members
- A provider lookup tool that allows patients to find primary care practitioners, specialists and facilities within Optum Care Network of Nevada
- Information about prior authorizations, laboratory and urgent care locations
- Important health and wellness related news and articles on topics such as diabetes, cancer screenings and cardiovascular disease
- A secured patient portal for authorization and claims information

Patients can visit optumcare.com/patient-login.html

Chapter 3: Health plan information

Patient enrollment and assignment

Primary care practitioner selection

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. A PCP is defined as a practitioner specializing in family practice, internal medicine, or general practice. Other providers may be included as primary care practitioners, such as nurse practitioners and practitioner assistants, as allowed by state mandates.

Prior to scheduling appointments, it is important to verify that you are the patient's assigned PCP on the patient eligibility screen found on the Optum Care portal. If you are not the assigned PCP, please have the patient contact the member service number on the back of their health plan ID card.

If a patient does not select a PCP, the health plan will select one on their behalf.

Changing PCP

Members may elect to change their PCP at any time. PCP changes must be initiated by the members by contacting their health plan. Changes are generally effective on the first day of the following month. Referrals to a specialist previously submitted by the patient's PCP will not be affected by the change in PCP.

UHC policy is that changes made prior to the 20th of the month will show up on the 1st of the next month. For changes made after the 20th, members and providers can expect to see the changes on the 1st of the month following the next month. Example: Member changes 1/23/20, changes will show on 3/1/20.

Please note, a change in a member's PCP may change the member's Medicare Advantage Plan and its associated network of providers. For instance, a member may be reassigned to a network other than Optum Care, such as Intermountain Health Care (IHC) or P3 Partners, and previous specialty providers may no longer be considered in-network. It is for this reason that all providers must verify a member's eligibility for the Optum Care Network of Nevada via the provider portal or by calling the phone number on the back of the member ID card at each date of service. This should be in addition to obtaining a copy of their current member ID card.

Our service center is available to assist patients in selecting providers: **1-855-839-2297.**

2022 health plan information

Northern Nevada

UnitedHealthcare AARP Medicare Advantage Plan 1 (HMO), Washoe and Lyon Counties
UnitedHealthcare AARP Medicare Advantage Plan 2 (HMO), Washoe and Lyon Counties
UnitedHealthcare Dual Complete (Dual SNP), Washoe County
Anthem MediBlue Plus (HMO), Washoe County

Southern Nevada

UnitedHealthcare AARP Medicare Advantage (HMO), Clark and Nye Counties
UnitedHealthcare AARP Medicare Advantage Premier (HMO), Clark and Nye Counties
UnitedHealthcare Medicare Advantage Focus (HMO), Clark and Nye Counties
UnitedHealthcare AARP Medicare Advantage Walgreens Plan 1 (HMO), Clark and Nye Counties
UnitedHealthcare Medicare Advantage Assist (HMO-CSNP), Clark and Nye Counties
UnitedHealthcare Medicare Advantage Choice (PPO), Clark and Nye Counties
UnitedHealthcare Medicare Advantage Patriot (PPO), Clark and Nye Counties
UnitedHealthcare Medicare Advantage Walgreens Plan 2 (PPO), Clark and Nye Counties
UnitedHealthcare Dual Complete (Dual SNP), Clark County
Anthem MediBlue Plus (HMO), Clark County

Please note that these plans are part of a shared network. UnitedHealthcare also offers Intermountain Healthcare (IHC), and Anthem offers P3. **Therefore, providers should verify member eligibility for each date of service.**

Health care identification cards

Our members receive health care identification (ID) cards that include important information necessary for **providers to** submit claims including payer ID. It is important to check the member's health care ID card at each visit and keep a copy of both sides for the member's records. Possession of a health care ID card is not proof of eligibility. Providers should **verify eligibility** and benefits prior to providing services. Verification of member eligibility can be done via the Optum Care provider portal: **providers.optumcaremw.com**

The two sample cards on the following page each serve as a reference to providers to aid in the identification of Optum Care Network of Nevada plans when patients present their membership identification cards at the time of their medical services.

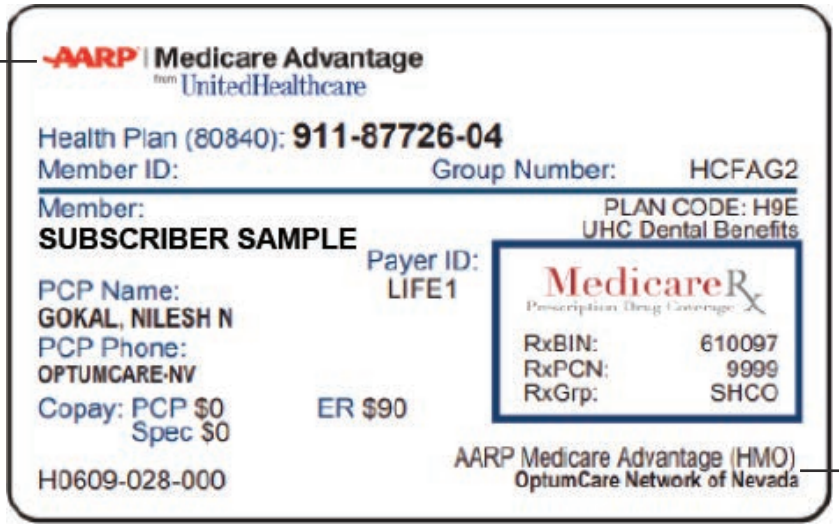
Sample Card 1

UnitedHealthcare Medicare Advantage plans

The first sample card shows that the member has a UnitedHealthcare Medicare Advantage plan. It is important to identify the logos that are on the card and indicated below. Most importantly, an Optum Care Nevada member can be easily identified by the presence of the Optum Care logo located in the bottom right corner of the card. **The absence of the Optum Care logo suggests that the member belongs to another network.**

Sample card front

Logos displayed here.



Plan name displayed here.

Sample card back

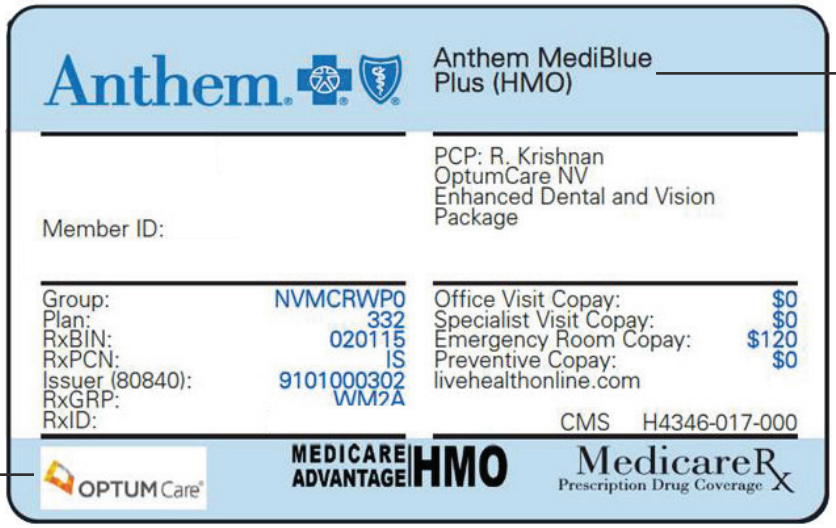
Network logo displayed here.

Sample Card 2

Anthem MediBlue Medicare Advantage plans

While the second type of member ID card has a different appearance, the same health plan is available. The name of the Anthem MediBlue plan that the member is enrolled in appears in the top right corner on the front of the card. Similar to the first card sample, the Optum Care logo is also visible and can be located at the bottom left corner of the front of the card. **The absence of the Optum Care logo suggests that the member belongs to another network.**

Sample card front



Plan name displayed here.

Network logo displayed here.

Sample card back

Patient eligibility and benefits

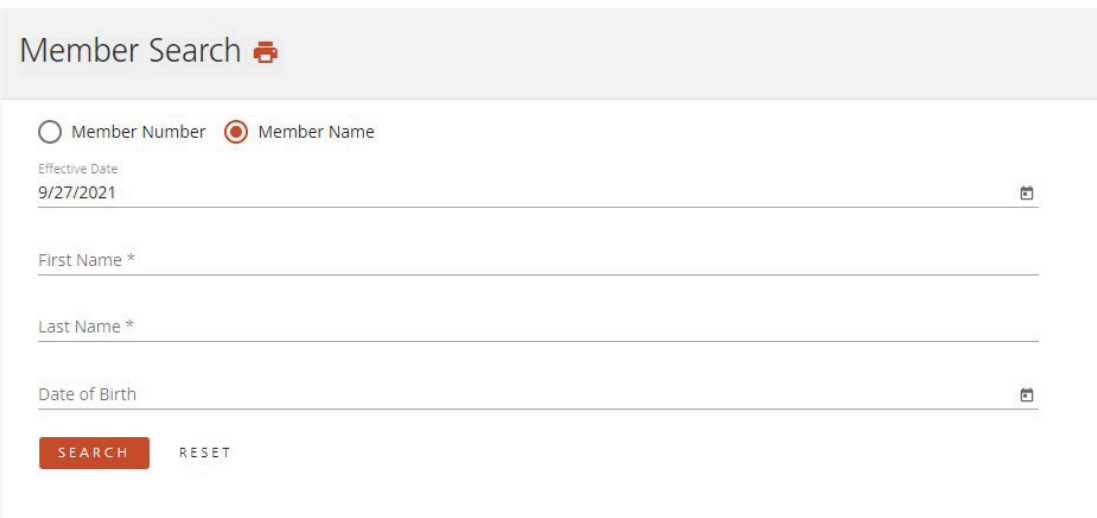
Checking your patient's eligibility and benefits prior to rendering services will allow you to verify the PCP assignment, **ensure the member is enrolled in the correct network,** collect copayments, and know when the patient has reached their maximum out-of-pocket limits, determine if a referral is required, and reduce denials for non-coverage.

Patient eligibility

To check eligibility and benefits, use either of the following methods:

- Go to the patient eligibility application on the Optum Care provider portal: providers.optumcaremw.com
- Call the phone number on the back of the member's health plan ID card

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



Chapter 4: Members' rights and responsibilities

Optum Care patients have certain rights and responsibilities, all of which are intended to uphold the quality of care and services they receive from you. These rights and responsibilities are outlined in the patient materials for Medicare Advantage benefit plans.

Members' rights:

- To be treated with respect and understand their need for privacy and dignity.
- To get help in a prompt, courteous, responsible and culturally competent manner.
- To be given information about their health care benefits.
- To be given information about any limitations and services not covered by the plan.
- To be told by their provider all of their medical information in words they understand.
- To talk with their provider about their care.
- To expect the health plan not to interfere with any contracted providers talking with them about their treatment choices.
- To have the health plan send them to another contracted provider if he/she does not agree to a treatment because of moral or religious grounds.
- To be given information about the list of contracted providers in their service area.
- To be told by their provider about any treatment they may get.
- To have their provider ask for their permission for all treatment, unless there is an emergency and they cannot sign a consent form and their health is in serious danger.
- To refuse treatment, including any trial treatment, and be told of the possible outcome of their choice.
- To choose an advance directive to pick the kind of care they wish to get if they become unable to express their wishes.
- To select, without interference, a primary care provider of their choice from the health plan's list of contracted providers.
- To make suggestions about the member rights and responsibilities policy.
- To file a complaint about the health plan.
- To file a complaint about the care they have received and to get a timely response.
- To file a grievance if they are not satisfied with their health plan's decision about their complaint.
- To get "timely access" to the records and information that pertains to them.

Members' responsibilities:

- To know and confirm their benefits before getting treatment.
- To show their member ID card before getting services.
- To protect their member ID card from being used by another person.
- To verify that the provider they get services from is part of the health plan network.
- To keep scheduled appointments.
- To pay any copayments/coinsurance at the time they get treatment.
- To ask questions and understand the care they are getting.
- To follow the advice of their provider and be aware of the possible outcomes if they do not.
- To tell us their opinions, concerns and complaints.
- To give information when asked to the health plan and contracted providers that would help improve their health status.
- To use emergency rooms services only for an injury or illness that they might think may be a serious threat to their life or health.
- To follow the treatment plan agreed upon by them and their provider.
- To give all the health plan staff respect and courtesy.
- To tell the health plan of any change in address.

Inform patients of advance directives

The federal Patient Self-Determination Act (PSDA) gives individuals the legal right to make choices about their medical care in advance of incapacitating illness or injury through an advance directive. Under the federal act, physicians and providers including hospitals, skilled nursing facilities, hospices, home health agencies and others must provide written information to patients on state law regarding advance treatment directive, the patient's rights to accept or refuse treatment, and their own policies regarding advance directives. To comply with this requirement, we also inform patients of state laws on advance directives through our patients' benefit material. We encourage these discussions with our patients.

Chapter 5: Provider responsibilities and standards

Primary care physician responsibilities

As a PCP, you are responsible to provide medically necessary primary care services. You are the coordinator of our members' total health care needs. You are responsible for seeing all members on your panel who need assistance, even if the member has never been in for an office visit. Some benefit plans require PCPs to submit electronic referrals for the member to see another network physician. See section on referrals later in this manual for detailed information on referral requirements.

Non-discrimination

Do not discriminate against any patient on quality of service or accessibility of services. You must keep policies and procedures to show your compliance. This includes discrimination based on:

- Type of health insurance
- Race
- Ethnicity
- National origin
- Religion
- Sex
- Age
- Disability
- Sexual orientation
- Claims experience
- Medical history
- Genetic information
- Type of payment

Cooperation with quality improvement and patient safety activities

You must follow our quality improvement and patient safety activities and programs.
These include:

- Quick access to medical records when requested
- Timely responses to queries and/or completion of improvement action plans during quality of care investigations
- Participation in quality audits, including site visits and medical record standards reviews, and Healthcare Effectiveness Data and Information Set (HEDIS®) record review
- Allowing use of practitioner and care provider performance data
- Notifying us when you become aware of a patient safety issue or concern

Demographic changes

Physician/health care professional verification outreach

We are committed to providing our members with the most accurate and up-to-date information about our network.

Your office may receive a call from us asking to verify your data currently on file in our provider database. This information is confidential and updated immediately in our database.

Provide official notice

Notify us, at the address in your agreement, within 10 calendar days if any of these situations occur:

- Material changes to, cancellation or termination of liability insurance.
- Bankruptcy or insolvency.
- Any indictment, arrest or conviction for a felony or any criminal charge related to your practice or profession.
- Any suspension, exclusion, debarment or other sanction from a state or federally funding health care program.
- Loss, suspension, restriction, condition, limitation, or qualification of your license to practice. For physicians, any loss, suspension, restriction, condition, limitation or qualification or staff privileges at any licensed hospital, nursing home, or other facility.
- Relocation or closure of your practice, and, if applicable, transfer of member records to another physician/facility.
- External sanctions or corrective actions levied against you by a government entity.

Provide timely notice of demographic changes

As a PCP, you are responsible for monitoring your office capacity based on member assignments and for notifying us if you have reached your maximum capacity. Please contact us immediately if your group panel status needs to change.

We may notify you in writing of changes in our panel status including closures based on state and/or federal requirements, current market dynamics and patient quality indicators.

We have developed specific definition for open, closed, or existing only practices to promote consistency throughout the participating network care provider related to acceptance of new or transferring members. Follow these definitions:

OP = Open panel. This will result for any member to be empaneled to the provider.

EO = Existing only panel. This will result in the current membership assigned to the provider and no new membership will be assigned.

CL = Closed panel. This will result in a provider's panel being closed and all membership will need to be reassigned. Typically, we do not use this panel because that means nobody can be empaneled to the provider, but their name comes up in the directory.

Notification of changes must be proactive

Every quarter, you, or an entity delegated to handle credentialing activities on behalf of us (a "delegate"), are expected to review, update, and attest to the care provider information available to our members. If you or the delegate cannot attest to the information, you must submit corrections to the Optum Care Network of Nevada, network and contracting department at **nvcontractingdept@optum.com**, or to our provider services center. You or the delegate must tell us of changes to the information at least 30 calendar days before the change is effective. This includes adding new information and removing outdated information, as well as updating the information listed in the following paragraph. Delegates are responsible for notifying us of these changes for all of the participating providers credentialed by the delegate. If you or a delegate fails to (1) update records or (2) give 30 days prior notice of changes or (3) attest to the information, you or the participating care providers credentialed by the delegate may be subject to penalties. Penalties may include a delay of processing claims or the denial of claims payment until the records are reviewed and attested to or updated.

You and the delegates are required to update all care provider information, such as:

- Patient acceptance status
- Address(es) of practice location(s)
- Office phone number(s)
- Email address(es)
- Care provider groups affiliation
- Facility affiliation
- Specialty
- License(s)
- Tax identification number
- NPI(s)
- Language spoken/written by staff
- Ages/genders served
- Office hours

If a health care provider leaves your practice, notify us immediately. This gives us time to notify impacted members.

The preferred method to submit such changes and updates is via the physician/provider change form available online. When you submit demographic updates, list only those addresses where a member may make an appointment and see the care provider. On-call and substitute care providers who are not regularly available to provide covered services at an office or practice location should not be listed at that address.

Physician/provider change form

To change panel status (open/closed/existing only)

If you wish to change your panel status (i.e., open to new patients, open to existing patients only, or closed), the request must be made in writing 30 days in advance. Changes to panel status apply to all patients for all products under Optum Care. We may notify you in writing of changes in our panel status including closures based on state and/or federal requirements, current market dynamics, and patient quality indicators.

We may notify you in writing of changes in your panel status including closures based on state and/or federal requirements, current market dynamics and patient quality indicators.

To change an existing TIN or to add a physician or health care provider

To submit a change, please complete and email the physician/provider change form to the appropriate email address listed on the form.

The physician/provider change form is available on the Optum Care Mountain West provider center provider portal at: **providers.optumcaremw.com** or by visiting **professionals.optumcare.com.**

For more information concerning provider changes, you can email the network and contracting department at **nvcontractdept@optum.com.**

Administrative terminations for inactivity

Up-to-date directories are a critical element of providing our members with the information they need to take care of their health. To offer more exact and up-to-date directories, we:

- Administratively terminate agreements for care providers who have not submitted claims for one year on the basis that they are not actively treating Optum Care patients and have voluntarily ceased participation in our network.
- Inactivate any TIN under which there have been no claims submitted for one year on the basis that they are not in active use. Because other TINs associated with a particular agreement have been active, this is not a termination of the agreement with the provider. Providers may contact Optum Care to reactivate an inactivated TIN.

When care providers tell us of practitioners leaving a practice, we make multiple attempts to get documentation of that change.

We administratively terminate a care provider if:

- We get oral notice that a practitioner is no longer with a practice, and
- We make three attempts to obtain documentation confirming the practitioner's departure, but do not receive the requested documentation, and
- The practitioner has not submitted claims under that practice's TIN(s) for six months prior to our receipt of oral notice the practitioner left the practice, or the effective date of departure provided to us, whichever is sooner.

Member dismissals initiated by a PCP (Medicare Advantage)

We recognize there are certain instances a PCP may choose to terminate a patient relationship. While we will not interfere with the PCP's decision, we will:

- Remind the PCP of their obligation to terminate the relationship in accordance with applicable requirements,
- Help ensure that the PCP provides us a reason for making the decision, and
- Require documentation that they have communicated this decision to the member.

Each dismissal should be carefully considered based on the facts and the circumstances specific to the member.

In addition to the requirements listed in the information required from the PCP section, PCPs who wish to terminate their relationship with a Medicare Advantage member (dismiss) and have a member reassigned must:

- Comply with all applicable legal and regulatory requirements;
- Send a certified letter to the member (evidence that the letter was mailed is acceptable even if a letter comes back as "undeliverable as addressed");
- Provide continuity of care as required by applicable laws and regulations for no less than 30 days from the member's receipt of the dismissal letter; and
- Provide us written notice.

To initiate this process, the PCP is directed to contact their assigned Optum Care of Nevada network manager or contact the department directly at: **nvcontractingdept@optum.com**

Required information from the PCP

For member reassignment, we require the following information from the PCP:

- PCP's reason for reassignment or termination
- Member's name, date of birth, address, and member ID
- PCP's name, NPI, and TINs
- Copy of certified letter the PCP sent to the member notifying them of the termination

We use good faith efforts to reassign the member to another PCP within 90 days of receipt of request. Changes will not be applied retroactively.

Filing of a lawsuit by a member

Lawsuits against a care provider

We do not automatically move the member to another medical group/IPA because of a lawsuit.

We consider transfer if:

- The complaint is about problems with quality of care or inappropriate behavior AND the care provider requests removal from their care.
- The transfer would not affect the member's current treatment.
  - The treating care provider must confirm this.
  - The treating care provider must cooperate in the transfer of medical records and information to the new care provider.
- The member wants another care provider who is part of the same medical group/IPA but located in a different office.

Lawsuits against a medical group/IPA

We do not deny the member access to care providers within a medical group/IPA because of a lawsuit. We consider a transfer if the member's complaint is about problems with the general practices and procedures of the medical group/IPA. **Note: If you receive notification of a member's plan to sue, please notify your care provider advocate.**

Continuity of patient care following termination of your participation

If your participation agreement terminates for any reason, you will be required to assist in the transition of patient care. This includes providing services for a reasonable time at our contracted rate during that continuation period, per your participation agreement and any applicable laws. Our customer service team is available to help you and our members with transition. We will notify affected patients at least 30 calendar days prior to the effective date of termination on your participation agreement, or as required under applicable laws.

Medicare opt-out

We follow, and require our care providers to follow, Medicare requirements for physicians and other practitioners who opt out of Medicare. If you opt out of Medicare, you may not accept federal reimbursement. Care providers who opt out of Medicare (and those not participating in Medicare) are not allowed to bill Medicare or its MA benefit plans during their opt-out period for two years from the date of official opt-out. For our MA membership, we and our delegated entities do not contract with, or pay claims to, care providers who have opted out of Medicare.

Exception to Medicare opt-out policy: In an emergency or urgent care situation, if you have opted out of Medicare, you may treat a MA beneficiary and bill for treatment. In this situation, you may not charge the member more than what a non-participating care provider is allowed to charge. You must submit a claim to us on the member's behalf. We pay Medicare covered items or services furnished in emergency or urgent situations.

Provider privileges

In order to help our patients get access to appropriate care and to help minimize out-of-pocket costs for patients, providers must have privileges at applicable participating facilities or arrangements with a participating practitioner to admit and provide facility services to patients. This includes, but is not limited to, full admitting hospital privileges, ambulatory surgery center privileges, and/or dialysis center privileges.

Member communication (CMS approval required)

Member communications require CMS approval. This includes:

- Anything with the Optum Care and/or plan name or logo
- Correspondence that describes benefits
- Marketing activities

Approval is not necessary for communication between care providers and patients that discuss:

- Their medical condition
- Treatment plan and/or options
- Information about managing their medical care

Once CMS approves, we send the letter to the member.

In addition to making sure the letter is approved by the governing regulatory body, we direct the letter to the correct audience. For example, we may need to distinguish a mailing to MA plan individual members versus Medicare group retiree members, as their benefits are distinctly different.

Part C reporting requirements

MA organizations are subject to additional reporting requirements. We may request data from our contracted care providers. This data is due by 11:59 p.m. Pacific time on our established reporting deadline.

Some measures are reported annually, while others are reported quarterly or semi-annually.
This includes, but is not limited to:

- Grievances
- Organization determinations/reconsiderations including source data for all determinations and re-openings
- Special needs plans care management (if applicable)
- Mid-year network changes
- Payments to care providers

Additional Medicare Advantage requirements

As an MA organization, UnitedHealthcare and its network care providers agree to meet all laws and regulations applicable to recipients of federal funds.

If you participate in the network for our MA products, you must comply with the following additional requirements for services you provide to our MA members.

- You may not discriminate against members in any way based on health status.
- You must allow members direct access to screening mammography and influenza vaccination services.
- You may not impose cost-sharing on members for the influenza vaccine or pneumococcal vaccine or certain other preventive services.
- You must provide female members with direct access to a women's health specialist for routine and preventive health care services.
- You must make sure your hours of operations are convenient to members.
- You must make sure medically necessary services are available to members 24 hours a day, seven days a week.
- Primary care providers must have backups for absences.
- You must adhere to CMS marketing regulations and guidelines. This includes, but is not limited to, the requirements to remain neutral and objective when assisting with enrollment decisions, which should always result in a plan selection in the Medicare beneficiary's best interest. CMS marketing guidance also requires that providers must not make phone calls or direct, urge, or attempt to persuade Medicare beneficiaries to enroll or dis-enroll in a specific plan based on the care provider's financial or any other interest. You may only make available or distribute benefit plan marketing materials to members in accordance with CMS requirements.
- You must provide services to members in a culturally competent manner taking into account limited English proficiency or reading skills, hearing or visual impairment, and diverse cultural and ethnic backgrounds.
- You must cooperate with our procedures to tell members of health care needs that require follow-up and provide necessary training to members in self-care.
- You must document in a prominent part of the member's medical record whether they have executed an advance directive.
- You must provide covered health services in a manner consistent with professionally recognized standards of health care.
- You must make sure any payment and incentive arrangements with subcontracted are specified in a written agreement, that such arrangements do not encourage reductions in medically necessary services, and that any physician incentive plans comply with applicable CMS standards.
- You must comply with all applicable federal and Medicare laws, regulations, and CMS instructions, including, but not limited to: (a) federal laws and regulations designed to prevent or ameliorate fraud, waste, and abuse, including, but not limited to, applicable provisions of federal criminal law, the False Claims Act (31 U.S.C. §3729 et seq.), and the Anti-Kickback Statute (§1128B of the Social Security Act); and (b) HIPAA administrative simplification rules at 45 CFR Parts 160, 162, and 164.

- The payments you receive from us or on behalf of us are, in whole or in part, from federal funds, and you are therefore subject to certain laws applicable to individuals and entities receiving federal funds.
- You must cooperate with our processes to disclose to CMS all information necessary for CMS to administer and evaluate the MA program and disclose all information determined by CMS to be necessary to assist members in making an informed choice about Medicare coverage.
- You must comply with our processes for notifying members of your agreement terminations.
- You must submit all risk adjustment data as defined in 42 CFR 422.310(a), and other MA program-related information as we may request, to us within the time frames specified and in a form that meets MA program requirements. By submitting data to us, you represent to us, and upon our request you shall certify in writing, that the data is accurate, complete, and truthful, based on your best knowledge, information, and belief.
- You must comply with our MA medical policies, policy guidelines, coverage summaries, quality improvement programs, and medical management procedures.
- You must cooperate with us in fulfilling our responsibility to disclose to CMS quality, performance, and other indicators as specified by CMS.
- You must cooperate with our procedures for handling grievances, appeals and expedited appeals. This includes, but is not limited to, providing requested medical records within two hours for expedited appeals and 24 hours for standard appeals, including weekends and holidays.
- We may request copies of medical records from you in connection with our utilization management/care management, quality assurance and improvement processes, claims payment and other administrative obligations, including reviewing your compliance with the terms and provisions in your agreement with us, and with appropriate billing practice. If we request medical records, you will provide copies of those records free of charge unless your participation agreement provides otherwise.
- In addition, you must provide access to any medical, financial or administrative records related to the services you provide to our members within 14 calendar days of our request or sooner for cases involving alleged fraud and abuse, a member grievance/appeal, or a regulatory or accreditation agency requirement, unless your participation agreement states otherwise. These records must be maintained and protected for 7 years or longer if required by applicable statutes or regulations. For example, for Medicare Advantage benefit plans, you must maintain and protect the confidentiality of the records for at least 10 years or longer if there is a government inquiry/investigation. You must provide access to medical records, even after termination of an agreement for service provided during the period in which the agreement was in place.
- All encounter data submitted to Optum Care Network of Nevada is subject to federal audit. We have the right to perform routine medical record chart audits on any or all of the medical group's/IPA's participating care providers at such time or times as we may reasonably elect to determine completeness and accuracy of encounter data ICD and CPT coding. The medical group/IPA shall be notified in writing of audit results pertaining to coding accuracy. As outlined in your participation agreement, the medical group/IPA may be subject to financial consequences if it or another submitting entity fails to submit or meet the encounter data element requirements. In addition, the medical group/IPA may be required to perform a complete medical record chart audit of its participating practitioners with notice from Optum Care Nevada.
- In addition, you must comply with the Medicare Advantage Regulatory Requirements Appendix (MARRA).

Medical records standards

In an effort to promote the optimal health of each patient through complete and accurate medical record documentation, Optum Care has a standard set of guidelines for patient 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, and 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.

Tobacco/alcohol/substance use

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, tobacco, and substance 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 diagnosis

Working diagnoses are consistent with findings.

Risk factors

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

Plan/treatment

Treatment plans are consistent with diagnosis.

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 records, 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 the PCP for an unresolved problem might lead to a request for consultations with a specialty physician.

Continuity of care

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.

Consultations, 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.

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 the 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's 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.

Corrective action plan (CAP)

1. Optum Care reviews results of each audit or study and identifies deficiencies as noted in Optum Care policies and procedures.
2. Optum Care requests CAPs to be submitted addressing deficiencies according to established policy or as otherwise directed by Optum Care. The CAP must be submitted to Optum Care within thirty (30) calendar days of written notification by Optum Care of the audit results.
3. Optum Care will provide advance written notice to contracted providers affected by a CAP, including a description of the identified deficiencies, the rationale for the corrective action, and the name and telephone number of the person authorized to respond to provider concerns regarding Optum Care's corrective action.
4. Failure to submit CAPs may result in one of the following activities, depending on the seriousness of the deficiency: (a) provider is frozen to new member enrollment; (b) request for cure under contract compliant; (c) contract non-renewal; or (d) contract termination.
5. Optum Care contracted providers can appeal the results of any oversight activity or specialized study or audit.

Optum Care Network of Nevada

Access standards for clinical services

The following information delineates the access standards for availability of services to members including primary care, specialty care, emergency services, waiting times for appointments, and proximity to specialties and hospitals to primary care. Performances against the established standards are measured continually by the provider services department.

Primary care physician	
Type of visit	**Time frame**
Emergency	Immediate disposition of member to appropriate care setting
Urgent	First available appointment within twenty-four (24) hours
Urgent, requiring authorization	First available within ninety-six (96) hours
Routine, non-urgent, and preventive health services	Appointment available within ten (10) days of the date of the referral/request
Follow-up exam	As directed by physician
Specialist	
Type of visit	**Time frame**
Specialist/ancillary consultation-outpatient	
Emergency	Immediate disposition of member to appropriate care setting
Expedited	Appointment is available within forty-eight (48) hours
At risk	Appointment is available within ten (10) days
Routine	Appointment is available within fourteen (14) days
Specialist consultation-inpatient	
Consultation referral before 12:00 noon	Same day
Consultation referral after 12:00 noon	Next day
Follow-up exam	As directed by physician

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

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

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

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

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

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

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

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

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

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

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

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

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

Access standards for behavioral health services

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

A. Appointment standards:

Behavioral health	
Type of visit	**Time frame**
Life-threatening emergency	Immediately
Non-life-threatening emergency	Six (6) hours
Urgent behavioral health needs	Within forty-eight (48) hours
Urgent behavioral health visit, requiring authorization	Within forty-eight (48) hours
Initial routine (non-urgent) visit with a behavioral health care provider	Within ten (10) business days of request
Non-urgent with a non-physician behavioral health provider	Within ten (10) business days of request
Follow-up routine (non-urgent)	Within ten (10) business days of request
Follow-up care after hospitalization for mental illness	Within seven (7) business days of request (initial visit)
Follow-up care after hospitalization for mental illness	Within thirty (30) business days of request (second visit)

B. After-hours access for behavioral health care:

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

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

After-hours care

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

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

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

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

Substitute coverage

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

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

Preventive care recommendations

Preventive care recommendations for men and women ages 50 and older

Immunizations	
Flu, annual	Recommended
Hepatitis A	For individuals with risk factors; for individuals seeking protection
Hepatitis B	For individuals with risk factors; for individuals seeking protection
Pneumococcal (pneumonia)	Recommended for individuals 65 and older; and individuals under 65 with risk factors
Td booster (tetanus, diphtheria)	Recommended once every 10 years
Varicella	Recommended for adults without evidence of immunity; should receive 2 shots
Zoster (shingles)	Recommended for all adults 60 and older
Screenings/counseling/services	
AAA (abdominal aortic aneurysm)	For men ages 65–75 who have ever smoked; one-time screening for AAA by ultrasonography
Alcohol misuse	Behavioral counseling
Aspirin	Visit to discuss potential benefit of use
Blood pressure, depression, height, weight, BMI, vision and hearing	At well visit, annually
Breast cancer	Recommended mammogram every 1–2 years for women ages 50–74
Breast cancer chemoprevention	Covered for women at high risk for breast cancer and low risk for adverse effect from chemoprevention
Cervical cancer	At least every 3 years if cervix present; after age 65. Pap tests can be discontinued if previous tests have been normal.
Colorectal cancer	Recommended for adults ages 50–75
Depression	For all adults
Diabetes	Recommended type 2 diabetes screening for individuals with sustained blood pressure greater than 125/80 mm Hg

Screenings/counseling/services (continued)	
Domestic violence and abuse	Screening and counseling for interpersonal domestic violence
Gonorrhea	Recommended for all sexually active women who are at increased risk of infection
HIV	For all adults at increased risk for HIV infection
HPV	Recommended for all sexually active women 65 and younger
Lipid disorder	Screening periodically
Obesity	Screening, counseling, and behavioral interventions
Osteoporosis	Recommended routine screening for women 65 and older; routine screening for women under age 64 if at increased risk
Prostate cancer	Prostate-specific antigen (PSA) test and digital rectal exam
Sexually transmitted infections	Behavioral counseling as needed
Syphilis	Recommended for individuals at increased risk for infection
Tobacco use and cessation	Screening for tobacco use and cessation intervention

Heart health

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

Other topics to discuss with patients

Nutrition

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

Sexual health

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

Substance abuse

- Stop smoking. Limit alcohol consumption. Avoid alcohol or drug use while driving.

Dental health

- Floss and brush with fluoride toothpaste daily. Seek dental care regularly.

Other topics

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

Provider credentialing and re-credentialing

Optum Care Nevada requires providers to be credentialed with two credentialing entities: 1) Sierra Credentialing, and 2) Mountain West Credentialing. Optum Care Nevada's network management department receives and manages all provider applications throughout the credentialing process for both entities. All new credentialing applications and inquiries should be directed to **nvcontractingdept@optum.com**.

Sierra Credentialing processes provider credentialing applications for UnitedHealthcare (UHC) lines of business including all of the UHC Medicare Advantage products. Please refer to Sierra Credentialing policies. For Mountain View Credentialing, the following applies.

Optum Care is dedicated to providing our members with access to effective health care and, as such, Mountain West Credentialing credentials practitioners and other health care professionals who seek to participate in our network and get listed in our provider directory. Recredentialing of providers is completed at least every 36 months thereafter in order to maintain and improve the quality of care and services delivered to our members. Our credentialing standards are more extensive than (though, fully compliant with) the National Committee for

Quality Assurance (NCQA) and Centers for Medicare and Medicaid Services (CMS) requirements.
Mountain West Credentialing is the delegated entity to credential providers for the Anthem Mediblue lines of business. See page 18 for a list of the current Anthem Mediblue Medicare Advantage plans.

	Optum Care Network of Nevada	County	All credentialing applications are to be initiated through nvcontractingdept@optum.com	
			Sierra Credentialing	Optum Mountain West Credentialing
Southern Nevada	UnitedHealthcare AARP Medicare Advantage (HMO)	Clark, Nye	X	
	UnitedHealthcare AARP Medicare Advantage Premier (HMO)	Clark, Nye	X	
	UnitedHealthcare Medicare Focus (HMO)	Clark, Nye	X	
	UnitedHealthcare Medicare Advantage Assist (HMO C-SNP)	Clark, Nye	X	
	UnitedHealthcare AARP Medicare Advantage Walgreens (HMO)	Clark, Nye	X	
	UnitedHealthcare AARP Medicare Advantage Choice (PPO)	Clark, Nye	X	
	UnitedHealthcare AARP Medicare Advantage Patriot (PPO)	Clark, Nye	X	
	UnitedHealthcare AARP Medicare Advantage Walgreens Plan 2 (PPO)	Clark, Nye	X	
	UnitedHealthcare Dual Complete (Dual SNP)	Clark	X	
	Anthem MediBlue Plus (HMO)	Clark, Nye		X
Northern Nevada	UnitedHealthcare AARP Medicare Advantage Plan 1 (HMO)	Washoe, Lyon	X	
	UnitedHealthcare AARP Medicare Advantage Plan 2 (HMO)	Washoe, Lyon	X	
	UnitedHealthcare Dual Complete (Dual SNP)	Washoe	X	
	Anthem MediBlue Plus (HMO)	Washoe		X

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 practitioners and other health care professionals. The CAQH process is available to practitioners 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 practitioners and other health care professionals to make updates online.

To communicate interest in becoming credentialed with Optum Care Network of Nevada, potential providers should submit formal interest letters and W-9 forms to the following email address for consideration: **nvcontractingdept@optum.com.**

Initial credentialing

Initial credentialing process takes approximately 60 to 90 days to complete, from receipt of the completed credentialing application to committee approval. Once received, the credentialing process will begin. The credentialing time frame 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 (i.e., required documents are not attached, fields on application are incomplete, etc.), this will also delay the processing of the application. The credentialing department has a streamlined verification process that enables short turnaround times.

Re-credentialing

Re-credentialing occurs every three years. Eight months prior to the three-year credentialing anniversary the provider will receive a request to log into CAQH and complete the online application, or if provider has already done so, then verify that the attestation is current and up to date. CAQH requires that the attestation process be completed every 120 days. The CAQH website is **proview.caqh.org.** If you need your CAQH provider ID number or assistance with the re-attestation process, please contact the credentialing department or CAQH provider help desk at **1-888-599-1771.**

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

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 Care patients. It is fraudulent practice to bill under one physician when services are actually provided by another physician.

Optum Care Nevada 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 the provider update form and submit it via email to **nvcontractingdept@optum.com.**

Rights related to the credentialing process

Practitioners and other health care providers applying for Optum Care 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 **Optum Care Mountain West credentialing** application by emailing: **mtnwest_credentialing@optum.com** or by contacting your Optum Care Nevada network manager.
To check the status of your Sierra credentialing application, send via email to: **nvsierracred@sierrahealth.com.**

Provider's right to access records

We may request copies of medical records from you in connection with our utilization management/care management, quality assurance and improvement processes, claims payment and other administration obligations, including reviewing your compliance with terms and provisions of your agreement with us, and with appropriate billing practice. If we request medical records, you will provide copies of those records free of charge unless your participation agreement provides otherwise.

In addition, you must provide access to any medical, financial or administrative records related to the services you provide to your patients within 14 calendar days of our request or sooner for cases involving alleged fraud and abuse, a patient grievance/appeal, or a regulatory or accreditation agency requirement, unless your participation agreement states otherwise. These records must be maintained and protected for confidentiality for 10 years or longer if required by applicable statutes or regulations. For example, for the Medicare Advantage plans, you must maintain and protect the confidentiality of the records for at least 10 years or longer if there is a government inquiry/investigation. You must provide access to medical records, even after termination of an agreement, for services provided during the period in which the agreement was in place.

Complaints and grievances

We acknowledge that patient disputes may arise with the health plan or its contracting/participating providers, especially related to coverage issues. Optum Care respects the rights of its patients to express dissatisfaction regarding quality of care/services and to appeal any denied claim/service. All patients receive instructions on how to file a complaint/grievance in their combined evidences of coverage and disclosure form, evidence of coverage or certificate of coverage, as applicable.

Network providers are required to comply with the following requirements when there is a patient grievance or appeal:

- Assist the patient with locating and completing the appeals and grievance form upon request from the patient. This form is located at **optumcare.com/patient-login.html.**
- Or direct the member to call the customer service number located on the back of their insurance card.
- Respond to Optum Care or UnitedHealthcare's (UHC) requests for information relevant to the patient's appeal or grievance within the designated time frame. You must supply records as requested within 2 hours for expedited appeals and 24 hours for standard appeals. This includes, but is not limited to, weekends and holidays.
- Comply with all final determinations made by UHC requesting patient appeals and grievances.
- Cooperate with UHC and the external independent medical review organization including, but not limited to, promptly forwarding to the external review organization copies of all medical records and information relevant to the disputed health care service in your possession, as well as any newly discovered relevant medical records or information in the participating medical group's/IPA's possession that is requested by external review organizations.
- Provide UHC with proof of effectuation within the stipulated time frames on reversals of adverse determinations. Providers must supply proof of effectuation on overturned appeals to UHC and Optum Care (for expedited, within 2 hours of overturn notice; and for standard, within 24 hours of overturn notices). This applies to all calendar days (no exceptions or delays allowed for weekends or holidays).

Provider dispute resolution process

See chapter 8 of this manual.

Medicare compliance expectations and training

The Centers for Medicare & Medicaid Services (CMS) requires Medicare Advantage (MA) organizations and Part D plan sponsors to annually communicate specific compliance and fraud, waste and abuse (FWA) requirements to their "first tier, downstream, and related entities" (FDRs). FDRs include contracted physicians, health care professionals, facilities and ancillary providers, as well as delegates, contractors, and related parties. As a delegate that performs administrative or health care services, CMS and other federal or state regulators require that you and your employees meet certain FWA and general compliance requirements. FDRs are expected to have an effective compliance program, which includes training and education to address FWA and compliance knowledge.

Optum Care Network of Nevada's expectation remains that FDRs and their employees are sufficiently trained to identify, prevent and report incidents of non-compliance and FWA. This includes temporary workers and volunteers, the CEO, senior administrators or managers, and subdelegates who are involved in or responsible for the administration or delivery of UnitedHealthcare MA or other Medicare Advantage plan sponsor benefits or services delegated to Optum Care Network of Nevada.

We have general compliance training and FWA resources available at **unitedhealthgroup.com.** The required education, training, and screening requirements include the following:

Standards of conduct awareness

What you need to do:

- Provide a copy of your own code of conduct, or the UnitedHealth Group's (UHG's) Code of Conduct at **unitedhealthgroup.com** > About > Ethics & Integrity > UnitedHealth Group's Code of Conduct. Provide the materials annually and within 90 days of hire for new employees.
- Maintain records of distribution standards (i.e., in an email, website portal or contract) for 10 years. We, or CMS, may request documentation to verify compliance.

Fraud, waste, and abuse and general compliance training

What you need to do:

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

Exclusion checks

Prior to hiring or contracting with employees, you must review federal (HHS-OIG and GSA) and state exclusion lists, as applicable. This includes the hiring of temporary workers, volunteers, the CEO, senior administrators or managers, and subdelegates who are involved in or are responsible for the administration or delivery of UnitedHealthcare MA or other Medicare Advantage plan sponsor benefits or services delegated to Optum Care Network of Nevada.

What you need to do:

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

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

Review the exclusion lists every month and disclose to Optum Care Network of Nevada any exclusion or any other event that makes an individual ineligible to perform work directly or indirectly on federal health care programs.

Maintain a record of exclusion checks for 10 years. We, or CMS, may request documentation of the exclusion checks to verify they were completed.

Reporting misconduct

If you identify compliance issues and/or potential fraud, waste or abuse, please report it to us immediately so that we can investigate and respond appropriately. Please see the reporting misconduct section of the UnitedHealth Group code of conduct. Reports may be made anonymously, where permitted by law:

For UHC Medicare Advantage members:
You can report to UnitedHealthcare online on **uhc.com/fraud** or by calling **1-844-359-7736**

For Anthem/Amerigroup Medicare Advantage members by:
Calling the HelpLine at **1-877-725-2702;** visiting **anthemethicshelpline.com;** or by sending an email to **ethicsandcompliance@anthem.com**

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

Preclusion list policy

The Centers for Medicare and Medicaid Services (CMS) has a preclusion list effective for claims with dates of service on or after April 1, 2019. The preclusion list applies to both MA plans as well as Part D plans. The preclusion list is comprised of a list of prescribers and individuals or entities who:

- Are revoked from Medicare, are under an active reenrollment bar, and CMS has determined that the underlying conduct that led to the revocation is detrimental to the best interests of the Medicare program; or
- Have engaged in behavior for which CMS could have revoked the prescriber, individual or entity to the extent possible if they had been enrolled in Medicare and that the underlying conduct that would have led to the revocation is detrimental to the best interests of the Medicare program.
- Have been convicted of a felony under federal or state law within the previous 10 years and that CMS deems detrimental to the best interests of the Medicare program.

Care providers receive a letter from CMS notifying them of their placement on the preclusion list. They have the opportunity to appeal with CMS before the preclusion is effective. There is no opportunity to appeal with Optum Care Network of Nevada. CMS updates the preclusion list monthly and notifies MA and Part D plans of the claim rejection date, the date upon which we reject or deny a care provider's claims due to precluded status. Once the claim-rejection date is effective, a precluded care provider's claims will no longer be paid, pharmacy claims will be rejected, and the care provider will be terminated from the Optum Care Network of Nevada. Additionally, the precluded care provider must hold Medicare beneficiaries harmless from financial liability for services provided on or after the claim rejection.

Chapter 6: Medical management

Optum Care's preferred method of management of the medical needs of its members is through use of the Optum Care **Mountain West provider center** (provider portal).

Gaining access to the provider portal: New users

New users of the provider portal must individually register through the following website: providers.optumcaremw.com. While a practice or group may already have an account and users, when a new user is identified, he/she must also register in the portal to create their own user account **using their One Healthcare ID. Those who do not yet have a One Healthcare ID, there is an opportunity to create one through our portal sign-in page.** The registration for the portal may take a few days to process and the user should receive an email with a username and temporary password. The new user is encouraged to sign in at this time, establish a permanent password, and begin accessing the system.

For additional instructions on the use of the provider portal, users can view a tutorial **located under the provider resources section on the provider portal home page.**

Referrals

Optum Care Network of Nevada's plans focus on the coordination of care by the PCP.

Optum Care of Nevada requires that the referral process be followed when a primary care provider has determined that a patient should receive additional care or services from another provider, such as a specialist, ancillary provider, or facility.

There are some occasions when a provider other than the PCP, such as a specialist, will submit a referral for specialist or ancillary services in the network. A member needs a referral in order to receive services from any specialty provider who is not practicing under the same tax identification number (TIN) as their PCP.

If members see a specialist without a referral, the claim will be denied as not authorized. The receiving care provider is responsible for confirming that there is a referral. If there is not a referral, the care provider is liable for the charges; you cannot bill the member.

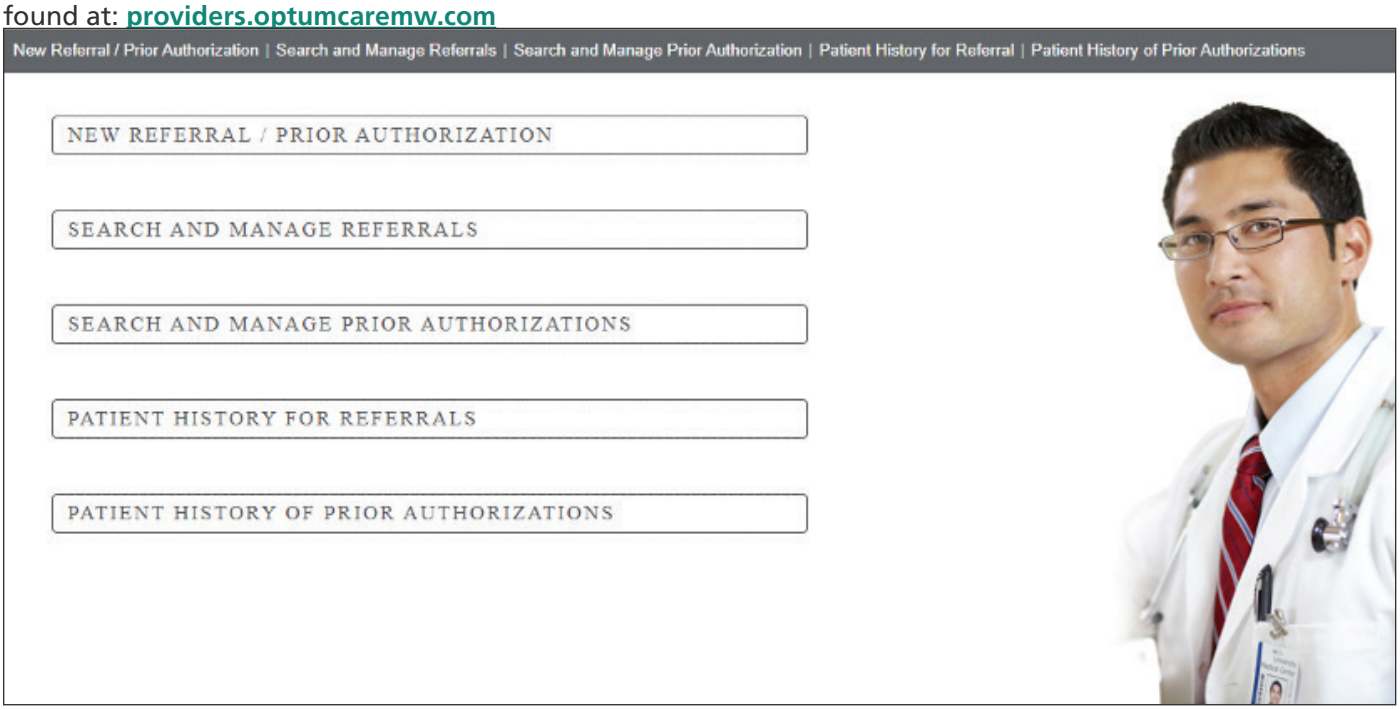
Providers should check the health ID card which may have language concerning required referrals for specialists.

Referrals differ from the prior authorization process (discussed later in this chapter) in that they are effective immediately and do not require approval from the health plan.

Referrals to out-of-network specialists, hospitals, providers, etc., require prior authorization prior to services being provided to the member. See prior authorization section below.

How to submit a referral

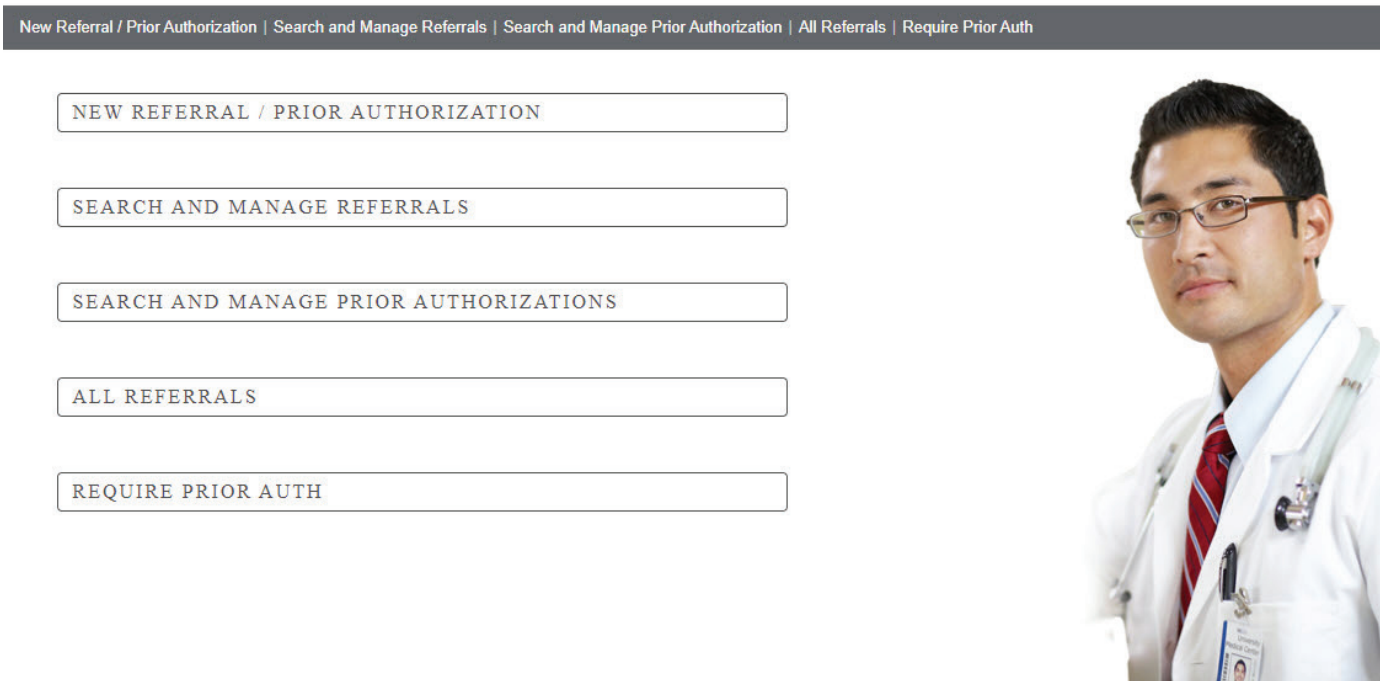
The PCP or specialist making the recommendation for additional services is responsible for making the referral. Optum Care Nevada's preferred method for the submission of referrals is via the secure online provider portal found at: **providers.optumcaremw.com**



The benefits of using the provider portal to manage all referrals include access to the online referral tool 24/7, automation of loading the referral to the claims system to ease claims processing, and availability of information concerning the status of the referral to members and family members online. After submitting a referral, providers can opt to fax the referral from the submission screen on the provider portal. The specialist/physician that the patient is referred to will receive a faxed copy of the referral if this feature is used in addition to the ability to manage the referral via the portal.

Managing referrals

Specialists can view and manage referrals via the Optum Care Mountain West provider center provider portal located at: **providers.optumcaremw.com**



It is important that all specialists log onto the portal on a daily or routine basis to manage their referrals. Providers must establish timely contact with patients to schedule services and to make updates to the status field on the referral. Frequent updates allow for communication with the referring PCP as well as the health plan.

Providers now have the ability to opt in to receive email notifications when they receive a referral through the portal as well as updates on the final outcome. To enable this feature, click “Change Profile” under the “My Account” section on the portal and follow the instructions.

Prior to seeing a member, the specialist or facility must check the status of the referral in the portal and confirm the member’s eligibility on the date of service. For planned/elective admissions and outpatient services rendered by a physician, facilities must verify that the servicing physician has a referral to see the member. If not, the facility claim may not be covered or the member may have a higher cost share. Referrals are for the specialist rendering the service or for the facility.

- Referrals are effective immediately;
- Referrals are viewable online within 48 hours;
- Referrals are generally good for a period of one year;
- Referrals do not have a maximum number of visits;
- Only the PCP or a PCP within the same tax ID number may submit referrals;
- For a change of specialist/facility, the referring PCP must make the change in the provider portal. Changes to referrals cannot be made by the receiving specialist or facility;

- If a referral is no longer valid, but the member requires additional care, the member or specialist must contact the member's PCP to request a new referral. The PCP then decides whether to issue an additional referral;
- If you need to refer a member to an out-of-network care provider because there are no network care providers in the area available, request prior authorization by submitting a prior authorization request for the provider needed.

Paper referrals will continue to be honored by the health plan and may be accepted by receiving specialists/facilities. If a patient shows for an appointment with a paper referral, the specialist may call the referral in to our provider services line where it will be manually loaded into the system or they can drop the claim to paper with an attached copy of the referral. Providers may contact the provider services center for more information.

Medicare Advantage services not requiring a referral

These services do not require a referral. However, they may require notification or authorization. For information on authorization requirements, refer to the provider portal at: **providers.optumcaremw.com**

- Any service provided by a network PCP;
- Any service provided by a network physician practicing under the same tax ID as the member's assigned PCP;
- Services from network OB/GYN specialists;
- Routine refractive eye exam (this falls under the vision plan if applicable);
- Network optometrists (this falls under the vision plan if applicable);
- Mental health/substance use services with network behavioral health clinicians;
- Services rendered in any emergency room, network urgent care center, network convenience care clinic or designated network online "virtual clinic visits";
- Services from a network pathologist, network radiologist or network anesthesia physician;
- Outpatient network lab, network X-ray, or network diagnostic services
  - Services billed by a network specialist require a referral;
- Network rehabilitative services with exception of manipulative treatment and vision therapy (physician services)
  - Services billed by a network specialist require a referral.

Prior authorizations

Prior (or pre-service) authorization is any case or service that Optum Care Nevada must approve, in whole or in part, in advance of the patient obtaining medical care or services. 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, in the most cost-effective manner, and follows evidence-based practices. 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.

Prior authorization is required for all out-of-network hospitalizations, surgeries, procedures, referrals, evaluations, services and treatments.

Prior authorization is NOT required for emergency care. However, notification of such services is expected within 24 hours. See notification section later in this chapter.

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

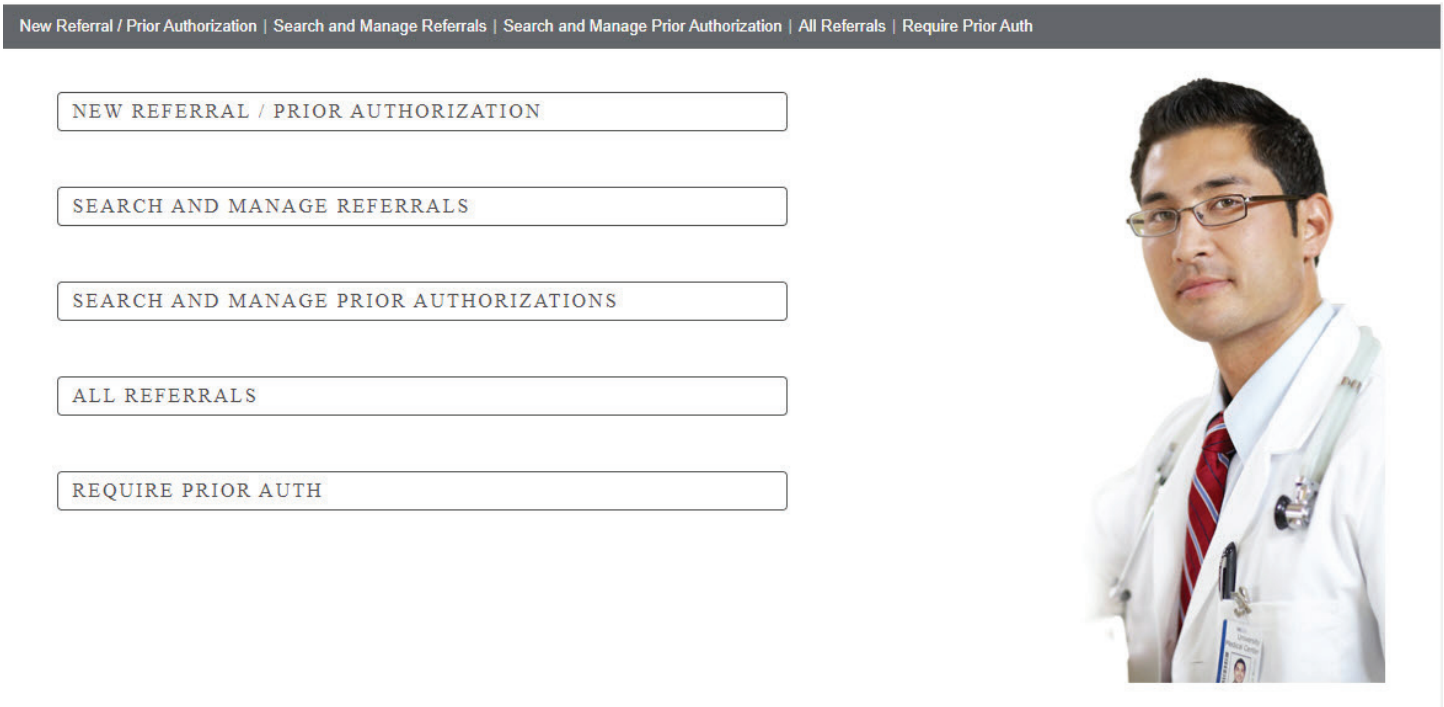
- Non-urgent (routine) pre-service decisions
  - As soon as medically indicated within a maximum of 14 calendar days after receipt of request
- Urgent (expedited) pre-service decisions
  - As soon as medically necessary within 72 hours after receipt of requests (includes weekends and federal holidays)

Optum Care Network of Nevada provided an overview of general referral and prior authorization information as a resource to contracted providers. To view the most current prior authorization list, go to Optum Care Mountain West Provider Center provider portal: **providers.optumcaremw.com**

How to submit a prior authorization:

To submit a request for prior authorization, the PCP, specialists, and/or auxiliary providers must utilize the provider portal: **providers.optumcaremw.com**

- This is a secure method for sharing information
- Requested and approved services upload to specialists, patient portals, customer services, and the claims processing system.



The benefits of using the online provider portal include:

- The prior authorization is automatically loaded to our claims system. When the claim comes in, it will be matched to the authorization and additional notations of authorization/referral numbers on claim are not necessary.
- It eases electronic filing of claims and timely payments.
- Patients and family members are able to see the status of their referrals when they log into the member portal.

While Optum Care's preferred method of submission and management of prior authorizations is electronic via the provider portal, providers may contact the following phone number if they have technical difficulties or special instructions/circumstances:

NV PA line: 1-855-893-2297 (option 2 for PA, then select NEW to reach Optum Care PA)

Provider reference material is available on the provider portal, including a video tutorial, on the management of both referrals and prior authorizations.

To download a copy of the Optum Care prior authorization request, visit **professionals.optumcare.com.**

Advance notification

Optum Care requires that physicians, health care providers, and ancillary care providers provide notification of intent to hospitalize members in advance of admission or delivery of services such as a scheduled general surgery at a surgery center. This is in addition to seeking prior authorization for the procedure or physician's services.

Advance notification is the first step in the process of making a coverage determination. It is also used for case and condition management programs. The information received about planned medical services helps support the pre-service clinical coverage review process, where applicable, and the care coordination process. It allows us to support our patients throughout their course of treatment, including pre-service planning and coordination of home care and other discharge plans.

Advance notification is required for services listed on the **advance notification/prior authorization list** located at **uhcprovider.com** under the advance notification and plan requirement resources section.

We require prior authorization for all MA benefit plans. Prior authorization requests allow us to verify if services are medically necessary and covered. After you notify us of a planned service listed on the advance notification/ prior authorization list, we tell you if a clinical coverage review is required, as part of our prior authorization process, and what additional information we need to proceed. We will notify you of our coverage decision within the time required by law. Just because we require notification for a service does not mean it is covered. We determine coverage by the member's benefit plan.

The pre-service clinical review process determines if the requested services are:

- Covered under the member's benefit plan;
- Clinically necessary and appropriate; and
- Performed at the most appropriate setting for the member.

It is very important that you follow all plan requirements so we can help you get claims paid. Missing requirements, such as advance notification, may result in claims being denied in whole or in part. If that's the case, the member cannot be billed for those denied services.

Advance notice should be submitted as far in advance as possible, but is required to be submitted at least 5 business days prior to the planned service date (unless otherwise specified with the advance notification/prior authorization list) with supporting clinical documentation, to allow enough time for coverage review. Advance notification for home health services and durable medical equipment is required within 48 hours after the start of service.

How to submit advance notification

Advance notifications can be made by calling **1-702-240-8878** or by fax to **1-702-804-3773.**

Hospital admission notifications

Facilities are responsible for admission notification for the following types of admissions:

- All planned/elective admissions for acute care
- All unplanned admissions for acute care
- All skilled nursing facility (SNF) admissions
- All post-acute care admissions
- All admissions following outpatient surgery
- All admissions following observation
- All admissions for observation

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

Admission notification by facility is required even if the physician supplied advance notification and a pre-service/ prior authorization 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 in the agreement with Optum Care.

Admission notification must contain the following details regarding the admission:

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

For emergency admissions when a patient is unstable and not capable of providing coverage information, the facility should notify Optum Care 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 notification-related reimbursement deductions.

Reimbursement reductions for failure to timely provide admission notifications

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

How to submit admission notification

The process for admitting notifications:

1. UHS facilities send an email with the admissions to the following address: optumurcommunication@sierrahealth.com
2. Other facilities must fax face sheets to the UR admit fax number **1-702-804-3773** or call **1-702-240-8878.**

Referral vs. prior authorization vs. advanced notification

The **referral** process, advance notification process, and prior authorization processes are separate processes. A referral is required in order for a member to see a specialist and is originated by the assigned PCP through the provider portal. While a referral is required by the health plan to see a specialist, it is not an authorization for payment for services. While a referral is considered a pre-approval to see a specialist, it does not require authorization from Optum Care Nevada. In simple terms, a referral can be considered as a warm hand-off from the PCP to the specialist to ensure communication of medical intent and patient history, appropriate care, and ease of access for the member. The health plan uses the referral process to ensure that this process is followed.

A **prior authorization** is payment approval sought by a physician or health care provider from the member's health plan for specific procedures, admissions, medical devices, medications, etc. The prior authorization process is a means of managing costs and the management of overall patient care based on evidence-based practices.

An **advanced notification** is notification to the health plan that an inpatient procedure or admission will occur and a period of 5 days is recommended prior to the service delivery. A prior authorization request is often submitted at the same time that the advance notification is done.

Care management

Optum Care's care management program provides high-touch care coordination within PCP offices, hospitals, SNF, and patients' homes. Through a variety of programs, the network assists patients throughout their health care journey. The care management program works 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. Our primary focus is to help the most complex patient through the acute care settings into the community and then provide collaboration with the post-acute network to develop ongoing care.

Key components of Optum Care's care management and care coordination programs

- Provides 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 follow up with PCP or appropriate specialist

- Support patients up to 30 days from referral/discharge, longer if necessary
- Develop individual intervention to address identified needs
- Assist with addressing social service needs through resourcing and referral, such as:
  - Meals on Wheels referral
  - Placement assistance
  - ALTCS and AHCCCS referrals
- Educate on the importance of:
  - Advanced directives
  - Personal health records for consistency communication among 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
- Telephone advice nurses work directly with patients who have health questions or difficulty navigating through the health care environment. They are available to members and providers 24 hours a day, seven days a week.

Care management contact information

Utilization management department
7 days a week, 7:30 a.m.–5:00 p.m.
Phone: **1-702-240-8878**
Fax: **1-702-688-5056**

Admit notification line:
Fax: **1-702-804-3773**

Resource coordination center and telephone advice nurse:
7 days a week, 24 hours a day
Phone: **1-702-877-8115** or **1-877-512-9339**

Complex care manager:
1-702-877-8115

IPA/network outpatient care management:
1-702-240-8934

Special Needs Plans (D-SNPand C-SNP) care management:
1-702-243-4639

Additional care management resources

Optum behavioral health:
1-800-579-5222

Nevada Behavioral Health (Statewide):
For direct referrals regarding behavioral health needs
1-702-857-8800

Optum NurseLine:
24-hour access hotline for patient to reach a nurse to answer questions regarding health concerns
1-702-877-8115 or **1-877-512-9339**

Optum Care Medical Network case management and disease management

Advanced illness/palliative care
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 chronic, irreversible disease and a limited life expectancy of 12 to 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 psychosocial 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 may include daily at-home monitoring; nursing assessment and support; and patient education. Immediate telephonic support is provided by a RN, if weight or symptoms change.

CAD – diabetes management program
A comprehensive program that includes educational 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 these programs by completing and submitting referrals through the Optum Care provider portal located at **providers.optumcaremw.com** or via Tiger Text, which is a HIPAA-compliant phone app.

The care management team can also be reached by phone at **1-702-240-8878** or by fax at **1-702-804-3773.**

Chapter 7: Quality

5-star measures

Several industry quality programs, including the Centers for Medicare and Medicaid Services (CMS) star rating, 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 four 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 **cms.gov.**

Net Promoter Score (NPS)

NPS measures the loyalty between a company and its consumer. The metric is tracked by organizations across all industries. It is an alternative to the traditional customer satisfaction survey and is claimed to be correlated to revenue growth. It has become "the" standard in measuring loyalty and commitment to a brand.

The NPS is based off of a single question:

How likely are you to recommend Optum Care or provider name/group to a friend or family member?

Patients are asked to rate their likelihood on an 11-point scale, where "0" is not at all likely and "10" is extremely likely. Scores of "9" and "10" suggests that customers or patients are considered promoters of the brand. The average of all individual patient scores for a provider or a provider group reflects their overall NPS rating. NPS scores are an important measure of customer satisfaction for Optum Care Network of Nevada and are used when evaluating providers for quality.

Health improvement

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

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

Optum Care uses standardized, objective and clinically valid criteria that are compatible with established principles of health care and flexible enough to allow for variations. This criterion 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 Care UM department to obtain UM policy or criteria used in making medical decisions.

Quality improvement

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 Care 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 the implementation of the UM program plan and 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 any time, 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 meeting 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 are 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 re-credentialing 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

Chapter 8: Our claims and billing procedures

Our claims process

Optum Care Nevada's preferred method of claim submission is electronic, known as the Electronic Data Interchange (EDI). EDI is the computer to computer transfer of data transactions and information between payers and providers. Electronic claims submission allows the provider to eliminate the hassle and expenses of printing, stuffing and mailing claims to the network. It substantially reduces the delivery, processing and payment time of claims. 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 Care for submitting claims electronically to the network. Providers are able to use any major clearinghouse.

Electronic data interchange (EDI)

For electronic claim submissions, use **Payer ID: LIFE1**.
Claim submissions should be in a HIPAA-compliant 837 I or P 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 a blueprint for the data that guides the data to make the transitions between different data trading partners as smooth as possible.

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 exchange between health care participants
  - Improves quality of health care delivery and its process
- Reduces cycle time
  - Enhanced information is available quicker
  - Ensures fast, reliable, accurate, secure and detailed information

Paper claims submissions

Optum Care prefers to receive claims electronically, but we do accept claims submitted on paper. If necessary, paper claims may be submitted to the following address:

Optum Care Claims
P.O. Box 30539
Salt Lake City, UT 84130

Prompt claims processing

We know that you want your claims to be processed promptly for the covered services you have provided our members. This is what you can do to help us process your claims timely and accurately:

1. Review the member's eligibility to ensure that you submit the claim to the correct payer. There are multiple options for checking eligibility:
   a. Online in the eligibility verification function on the Optum Care Mountain West Provider Center Provider portal: **providers.optumcaremw.com**
   b. View the member's health ID card;
   c. By calling provider services center or the customer service number on the back of the member's health insurance ID card.

   Eligibility and benefit information provided is not guarantee of payment or coverage in any specific amount. Actual reimbursement depends on various factors, including compliance with applicable administrative protocols; date(s) of services rendered, and benefit plan terms and conditions. For Medicare Advantage plans, reimbursement is also dependent on CMS guidance and claims processing requirements.
2. When applicable, notify us in accordance with the advance notification, admission notification and prior authorization sections of this guide.
3. Prepare complete (clean) and accurate claims.
4. Submit claims electronically for fast delivery and confirmation or receipt.

Submission forms

- Professional venders must submit on a CMS 1500
- Hospitals, ambulatory surgery centers, and facilities must submit on the CMS 1450

To order CMS 1500 and CMS 1450 (also known as UB-04) forms, contact the U.S. Government Printing Office at **1-202-512-0455,** or visit the Medicare website at: **cms.gov/medicare/billing/electronicbillingeditrans/16_1500.html**

Submission time frames

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

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

If you dispute a claim that was denied due to timely filing, you will be asked to show proof you filed your claim within your timely filing limits. Please see the provider dispute section of this manual for the necessary supporting documentation needed for proof of timely filing when filing a dispute.

Claims and encounter submissions

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. Your claim may be pended or not processed if you omit any of the following:

- Member's name
- Member's gender
- Member's date of birth
- Members ID number
- Member's group name
- Member's group number
- Rendering practitioner, health care professional, ancillary provider, or facility representative's name
- Rendering practitioner, health care professional, ancillary provider, or facility representative's name signature
- Address where service was rendered
- Physician, heath care professional, ancillary provider or facility "remit to" address
- Phone number of practitioner, health care professional, ancillary provider or facility performing the service (provide this information in a manner consistent with how that information is presented in your agreement with us)
- Practitioner, health care professional, ancillary provider, or facility NPI and/or federal TIN
- Referring practitioner's name and NPI, and TIN (if applicable)
- Date of service(s)
- Place of service(s)
- Number of services (day/units) rendered
- A description of the service rendered using valid CPT, ICD-10, HCPCS, and/or revenue codes, the number of days or units for each service line, the place of service code/bill type and the type of service code;
- 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 and associated NPI as applicable.
- Current National Drug Code (NDC) 11-digit number, NDC unit of measure (F2, GR, ML, UN, ME) and NDC units dispensed (must be greater than 0) for all claims submitted with drug codes. Enter the NDC information for the drug(s) administered in the 24D field of the CMS-1500 form, Field 43 of the UB-04 form, or the LIN03 and CTP04-05 segments of the HIPAA 837 professional or institutional electronic form.
- Method of administration (self or assisted) for hemophilia claims – notes the method of administration and submits with the claim form with applicable J-codes and hemophilia factor, to enable accurate reimbursement. Method of administration is either noted as self or assisted.

Incomplete claims or claims requiring medical records in order to make a determination of payer liability will be contested back to the provider via EOP with a descriptive reason code informing the provider what additional

information is needed. Medicare claims will be developed in accordance with CMS regulations. Any claims submitted with invalid codes or claims missing required billing elements will be mailed back to the provider with reason codes attached requesting a corrected claim. All payments and copayments are subject to the benefit information as defined by the patient's specific health plan. Claims payment is always dependent on patient eligibility status on the date of service as determined by the health plan.

For the proper payment and application of copayment, deductible and coinsurance, 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 reasons. You must submit a claim and/or encounter for your services, regardless of whether you have collected the copayment, deductible or coinsurance from the patient at the time of service. All claims are validated using clinical editing software to check for coding accuracy. For contract specific information, please refer to your contract.

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 the claim.

Electronic funds transfer (EFT)

Optum Care offers EFT/ERA solution through our preferred vendor, InstaMed. ERA/EFT is a convenient paperless and secure way to receive claim payments. Funds are deposited directly into your designated bank account and include the reassociation trace number, in accordance with CAQH CORE Phase III Operating Rules for HIPAA standard transactions.

Benefits of EFT include:

- Free integrated ERA/EFT including trace number linking the ERA and EFT.
- Quick registration, with only 8 to 10 business days before you receive your first payment.
- No disruption to your current workflow; there is an option to have ERAs routed to your existing clearinghouse.
- View payments at summary and detail level with intuitive reporting.
- Receive live InstaMed customer service support from 7:00 a.m. ET to 9:00 a.m. ET via phone, email and web.

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

Helpful billing and claims tips

Things to remember when billing and submitting claims:

- EDI submission is Optum Care Nevada'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 accordingly.
- Know the contract(s). Be sure all billing staff is familiar with current billing and contract information.
- To verify and view claims status, go to the Optum Care Mountain West Provider Center provider portal at: providers.optumcaremw.com or contact the Optum Care provider service center at **1-855-893-2297.**

Medicare risk adjustment

Optum Care encourages providers to ensure accuracy of all data and documentation pertaining to patient health information, including clinical documentation and diagnosis codes, and patient demographics. 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 (also called the risk adjustment factor or RAF). Optum Care uses the CMS hierarchal condition categories model to calculate annual patient risk or RAF score that represents the specific patient's disease burden.

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.

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

COB when Optum Care is not the primary payer

If a patient presents current proof of other primary insurance making Optum Care 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 Care is notified that the patient has other insurance.

Workers' compensation

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

Provider dispute resolution

Definition of a provider dispute

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

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

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

If the provider dispute concerns a claim or reimbursement of an overpayment of a claim from Optum Care 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.
- All required information must be included. Disputes that are missing information will be returned to the submitter.

To submit a provider dispute:

- Contact the Optum Care service center at **1-855-893-2291,** or
- Send an email to our claims team at **claimsdispute@optum.com,** or
- Download a copy of the Optum Care provider dispute resolution request, visit the resources section at the following website: **professionals.optumcare.com.**

Chapter 9: Glossary

Definitions and terminology

Admission notification: A notice to Optum Care that a patient has been admitted to any inpatient setting, including hospitals, skilled nursing facilities, home health, etc. The facility is required to report within 1 business day after actual admission date. For weekend and federal holiday admission, notification must be by 5 p.m. local time on the next business day.

Advance notification: The first step in the process of making a coverage determination and for referrals to case and condition management programs.

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

Ambulatory care: Health services provided on an outpatient basis. While many inpatients may be ambulatory, the term "ambulatory care" usually implies that the patient has come to a location other than their home to receive services and has departed the same day. Examples include chemotherapy and physical therapy.

Ambulatory surgical facility (ASC): A facility licensed by the state where it is located, equipped and operated mainly to provide for surgeries and obstetrical deliveries and allows patients to leave the facility the same day surgery or delivery occurs.

Ancillary provider services: Health services ordered by a care provider, including, but not limited to, laboratory services, radiology services, and physical therapy.

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 the 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 serviced regardless of the actual number or nature of services provided each person. This is a per-member-per-month (PMPM) 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 the 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.

Coinsurance: The member's share of the costs of a covered health care service, calculated as a percent (for example, 20 percent) of the allowed amount for the service. Members may pay coinsurance plus any deductibles owed.

Copayment: A fixed amount members may pay for a covered health care service, usually upon receiving the service.

Centers for Medicare & Medicaid Services (CMS): A federal agency within the U.S. Department of Health and Human Services.

Coordination of benefits (COB): Allows benefit plans that provide health and/or prescription coverage for a person with Medicare to determine their respective payment responsibilities (i.e., determine which insurance benefit plan has the primary payment responsibility and the extent to which the other benefit plans will contribute when an individual is covered by more than one benefit plan).

Covered services: Medically necessary services included in the member's benefit plan. Covered services change periodically and may be mandated by federal or state legislation.

C-SNP-chronic special needs plans: This special needs plan (SNP) is for members who have one or more severe or disabling chronic conditions. We help members manage their condition as well as their overall health and well-being.

Current procedural terminology (CPT) codes: American Medical Association (AMA)-approved standard coding for billing of procedural services performed.

Credentialing: The verification of applicable licenses, certifications, and experience to assure that provider status is extended only to professional, competent providers who continually meet the qualifications, standards, and requirements established by UnitedHealthcare and Optum Care.

Discharge planning: Process of screening eligible candidates for continuing care following treatment in an acute care facility, and assisting in planning, scheduling and arranging for that care.

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.

D-SNP-dual special needs plans: This SNP meets the needs of individuals enrolled in Medicare who also qualify for Medicaid (called dual eligible). This plan combines the benefits of Medicare and Medicaid.

Electronic funds transfer (EFT): The electronic exchange of funds between two or more organizations.

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): Digital versions of a normal patient medical record that providers store and access via computer rather than papers and manila folders.

Encounter: An interaction between a patient and health care providers, for the purpose of provider health care services or assessing the health status of a patient.

Explanation of payment (EOP): Document available to providers that provided details on claims that have been paid, denied, or adjusted.

Explanation of benefits (EOB): Statement or document from the health insurance company to covered individuals explaining what medical treatments/services were paid on their behalf.

Evidence of coverage (EOC): Document that describes in detail the health care benefits covered by the health plan.

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.

Fraud: Health care fraud is a crime that involves misrepresenting information, concealing information, or deceiving a person or entity to receive benefits, or to make a financial profit. (18 U.S.C.§1347).

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.

Health Insurance Portability and Accountability Act (HIPAA) of 1996: A federal legislation that provides data privacy and security provisions for safeguarding medical information.

Home health care or home health services: Medical care services provided in the home, often by a visiting nurse, usually for recovering patients, aged homebound patients, or patients with a chronic disease or disability.

Maximum out-of-pocket (MOOP): Out-of-pocket expenses are copays, deductibles and coinsurance. The health plan caps the out-of-pocket expenses, meaning when the patient reaches the maximum out-of-pocket costs, the health plan takes over and provides coverage for the rest of the year.

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

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

Net promotor score (NPS): A management tool that can be used to measure of the loyalty between a company and its consumer. It is an alternative to traditional customer satisfaction surveys. It is claimed to be correlated with revenue growth and is used by organizations across all industries. It has become "the" standard in measuring loyalty and commitment to a brand.

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

Nurse practitioner (NP): A registered nurse who has graduated from a program which prepares registered nurses for advanced or extended practice and who is certified as a nurse practitioner by the American Nursing Association.

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.

Preferred hospital: Refers to those contracted Optum Care hospitals that Optum Care has identified as Optum Care's primary admitting facilities.

Physician assistant (PA): A health care professional licensed to practice medicine with physician supervision. Physician assistants are trained in intensive education programs accredited by the Commission on Accreditation of Allied Health Education Programs.

Preferred provider organization (PPO): Health plan that offers members access to a network of contracted physicians and hospitals, but also allows them the flexibility to seek covered services from outside of the contracted network (out-of-network), at a higher cost.

Primary care provider (PCP): A physician such as a family practitioner, pediatrician, internist, general practitioner, or obstetrician, who serves as a gatekeeper for their assigned members' care. Other providers may be included as primary physicians such as nurse practitioners and physician assistants as allowed by state mandates.

Prior authorization: Approval to receive medical treatment or equipment. For example, surgeries, in home care, medical tests, medical equipment, etc.

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

Quality management program: The policies and procedures adopted by Optum Care or plan and designed to monitor and ensure the quality of covered services provided to Optum Care members.

Risk adjustment factor (RAF) score: Used by CMS and insurance companies to represent a patient's health status. RAF scores are used to predict the cost for a health care organization to care for a patient.

Referral: When a provider suggests a patient receive additional care from another provider such as a specialist or facility.

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

Secondary payer: A source of coverage that pays after the primary insurance benefit has been applied.

Service area: A geographic area serviced by an Optum Care contracted provider, as stated in the health care provider's agreement with us.

Skilled nursing facility (SNF): A Medicare-certified nursing facility that (a) provides skilled nursing services and, (b) is licensed and operated as required by applicable law.

Third-party administrator (TPA): An organization that provides or manages benefits, claims or other services, but it does not carry any insurance risk.

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 or documentation that is needed to process the claim for payment.

Utilization management (UM): The process of evaluating and determining the coverage for and the appropriateness of medical care services, as well as providing assistance to a clinician or patient in cooperation with other parties, to help ensure appropriate use of resources. UM includes prior authorization, concurrent review, retrospective review, discharge planning and case management.

Workers' compensation: Workers' compensation is a form of insurance providing wage replacement and medical benefits to employees injured in the course of employment in exchange for mandatory relinquishment of the employee's right to sue their employer for the tort of negligence.

OPTUM Care® | Network of Nevada