



# 2024 Optum Health Administrative Guide

Optum Care Network of Washington

# Quick Reference Guide

<b>Welcome</b>	Optum Care Network of Washington (OCN) is an organization that is delegated to perform certain functions on behalf of health plans. OCN has a local management team. This Quick Reference Guide provides an overview of key information you will need when caring for OCN members.
<b>Portal Access and Digital Solutions</b>	Website: <a href="https://partner.optum.com/washington/">partner.optum.com/washington/</a> Use our website to sign in to the Optum Care Provider Center, a tool that gives you access to eligibility, prior authorization, and claims information in real time. You'll also find our referral lookup tool, important forms and many other resources: <a href="https://onehealthport.com">onehealthport.com</a> <ul style="list-style-type: none"><li>• Check member eligibility status</li><li>• Complete prior authorization and referral management tasks for multiple health plans</li><li>• View individual claim submissions and submit claim inquiry</li><li>• Securely access health plan documents, policies and guides</li><li>• Attestation review and submission</li><li>• Secure messaging with OCN teams</li></ul>
<b>Forms and Resources</b>	<a href="#">Optum.com</a> > Business > Providers > Resources > <a href="#">Forms and resources</a>
<b>Submitting a Claim</b> <i>(see manual for additional health plan payer ID and addresses)</i>	For electronic submissions, use payer ID: LIFE1 <i>Claims should be submitted electronically.</i> Paper claims, though not preferred, can be mailed to: Optum Care Claims PO Box 30788 Salt Lake City, UT 84130-0788
<b>Electronic Funds Transfer</b>	Access Optum Pay at <a href="https://myservices.optumhealthpaymentservices.com">myservices.optumhealthpaymentservices.com</a> . <b>Enrollment:</b> Once you have submitted your online Optum Pay enrollment, it may take up to 10 business days for enrollment to be activated. Optum Pay Support: Contact <b>1-877-620-6194</b> , 8 a.m.–5 p.m. PT, Monday–Friday
<b>Hospital Admission Notifications</b>	Notify Optum Care Network of hospital admissions no later than 24 hours after admission and 24 hours post discharge. Notifications should be submitted electronically online. Submit by phone or fax if online not available. Online: <a href="https://onehealthport.com">onehealthport.com</a> Phone: <b>1-877-836-6806</b> Fax for inpatient notification and clinical submissions: <b>1-253-627-4708</b>
<b>Optum Care Service Center</b>	Eligibility, claims/authorization status, general billing questions, prior authorization intake Phone: <b>1-877-836-6806</b> , 8 a.m.–5 p.m. PT, Monday–Friday
<b>Prior Authorizations</b>	Prior authorization and admission notification are required for certain services based on the patient's benefit plan. Prior authorization requests should only be submitted electronically online unless online not available. Online: <a href="https://onehealthport.com">onehealthport.com</a> Phone: <b>1-877-836-6806</b> , 8 a.m.–5 p.m. PT, Monday–Friday Fax—New Auth (General): <b>1-855-402-1684</b> Fax—Part B New Auth: <b>1-855-402-1684</b> Fax—Clinical Submissions for New or Existing Auth: <b>1-855-402-1684</b>
<b>Credentialing and Health Care Professional Updates</b>	<b>Clinician request for credentialing:</b> Clinicians requesting participation with Optum Care Network should contact their local account manager or <a href="mailto:credentialing@optumpnw.com">credentialing@optumpnw.com</a> . Please ensure that your CAQH account is up to date to prevent delays in credentialing. Health care professional updates: To make NPI, TIN, or clinician demographic updates, contact the contracted health plans to complete and submit the appropriate form(s).
<b>Member Eligibility and Benefits</b>	<b>Member Eligibility:</b> Check member eligibility status at <a href="https://onehealthport.com">onehealthport.com</a> . <i>Disclaimer: Please check the health plan's website for the most up to date member eligibility information as the data provided at the provider portal is not a guarantee of payment or eligibility.</i> UHC members: <a href="https://uhcprovider.com/eligibility">uhcprovider.com/eligibility</a> Humana members: <a href="https://humana.com/provider">humana.com/provider</a> Premera members: <a href="https://premera.com/wa/provider/">premera.com/wa/provider/</a> Coordinated Care members: <a href="https://coordinatedcarehealth.com/providers">coordinatedcarehealth.com/providers</a> <b>Member Benefits:</b> Direct members to the appropriate contact for all benefit related questions UHC members: <b>1-800-866-1086</b> TTY 711 Humana members: <b>1-800-457-4708</b> TTY 711 Premera members: <b>1-888-850-8526</b> TTY 711 Coordinated Care members: <b>1-877-644-4613</b>
<b>Member Services</b>	<b>UHC Vision</b> Online: <a href="https://myuhcvision.com">myuhcvision.com</a> Phone: <b>1-866-644-3414</b> <b>Optum Physical Health (PT/OT/ST/Chiro)</b> Online: <a href="https://myoptumhealthphysicalhealth.com">myoptumhealthphysicalhealth.com</a> Phone: <b>1-800-573-4575</b> <b>Optum Behavioral Health or substance abuse</b> Phone: <b>1-800-985-2596</b> TTY 7 <b>Non-Emergency Transportation</b> Phone: <b>1-866-418-9812</b>

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## Purpose and use of this guide

The administrative guide contains important information about Optum Care Network of Washington (OCN), policies and procedures, claims submission and adjudication requirements. General recommendations are provided to support and enable participating clinicians and administrators to deliver effective care for members of Optum Care through contracts with AARP® Medicare Advantage H plans and plan benefit packages (PBP) listed below insured through UnitedHealthcare®, Humana, Premera and Coordinated Care in Washington.

Plan name and type	CMS contract	Group #	Type	Applied county/counties
AARP® Medicare Advantage	H3805-039	90907	HMO	Benton, Clackamas, Columbia, Jackson, Josephine, Lane, Linn, Marion, Multnomah, Polk, Washington, Yamhill
AARP® Medicare Advantage	H3805-039	90910		
AARP® Medicare Advantage	H1278-030	90744	PPO	Franklin, Kitsap, Lewis, Pierce, Skagit, Whatcom, Yakima
AARP® Medicare Advantage	H1278-030	90746		
AARP® Medicare Advantage	H2406-042	90797	PPO	Benton, Clackamas, Columbia, Jackson, Josephine, Lane, Linn, Marion, Multnomah, Polk, Washington, Yamhill
AARP® Medicare Advantage	H2406-073	90821		
AARP® Medicare Advantage	H2406-044	90799	PPO	Ada, Canyon
AARP® Medicare Advantage	H2406-070	90819	PPO	Benton, Clackamas, Columbia, Jackson, Josephine, Lane, Marion, Multnomah, Polk, Washington, Yamhill
AARP® Medicare Advantage	H2406-070	90818		
AARP® Medicare Advantage	H2406-112	90858	PPO	Bonner, Boundary, Idaho, Kootenai, Latah, Nez Perce, Shoshone
AARP® Medicare Advantage	H2406-112	92127		
AARP® Medicare Advantage Choice	H1278-028	90738	PPO	Spokane
AARP® Medicare Advantage Choice Plan 1	H1278-029	90740	PPO	Clark, Cowlitz, Island, King, Snohomish, Thurston
AARP® Medicare Advantage Choice Plan 1	H1278-029	90742		
AARP® Medicare Advantage Choice Plan 2	H1278-032	90750	PPO	Clark, Cowlitz, Island, King, Snohomish, Thurston
AARP® Medicare Advantage Patriot	H4604-019	90912	HMO POS	Ada, Adams, Bannock, Bingham, Blaine, Boise, Bonner, Bonneville, Boundary, Camas, Canyon, Cassia, Elmore, Gem, Gooding, Idaho, Jefferson, Jerome, Kootenai, Latah, Lincoln, Madison, Minidoka, Nez Perce, Owyhee, Payette, Shoshone, Twin Falls, Valley, Washington
AARP® Medicare Advantage Patriot	H3805-035	90156	HMO	Spokane
AARP® Medicare Advantage Patriot	H1278-031	90748	PPO	Clark, Cowlitz, Franklin, Island, King, Kitsap, Lewis, Pierce, Skagit, Snohomish, Thurston, Whatcom, Yakima
AARP® Medicare Advantage Plan 1	H3805-037	90902	HMO	Benton, Clark, Cowlitz, Franklin, Island, King, Kitsap, Lewis, Pierce, Skagit, Snohomish, Thurston, Walla Walla, Whatcom, Yakima
AARP® Medicare Advantage Plan 1	H3805-037	91656		
AARP® Medicare Advantage Plan 1	H3805-001	92117	HMO POS	Benton, Clackamas, Columbia, Jackson, Josephine, Lane, Linn, Marion, Multnomah, Polk, Washington, Yamhill
AARP® Medicare Advantage Plan 1	H3805-033	90153	HMO	Spokane
AARP® Medicare Advantage Plan 2	H4604-020	90913	HMO POS	Bonner, Boundary, Idaho, Kootenai, Latah, Nez Perce, Shoshone
AARP® Medicare Advantage Plan 2	H3805-017	90890	HMO POS	Clark, Cowlitz, Island, King, Kitsap, Lewis, Pierce, Skagit, Snohomish, Thurston, Whatcom
AARP® Medicare Advantage Plan 2	H3805-017	91651		
AARP® Medicare Advantage Plan 2	H3805-034	90155	HMO	Spokane
AARP® Medicare Advantage Plan 3	H3805-015	91647	HMO POS	Benton, Clark, Cowlitz, Franklin, Island, King, Kitsap, Lewis, Pierce, Skagit, Snohomish, Thurston, Walla Walla, Whatcom, Yakima
AARP® Medicare Advantage Plan 3	H3805-015	92118		
AARP® Medicare Walgreens	H3805-032	90894	HMO POS	Clark, King, Pierce, Snohomish, Thurston
Humana Gold Diabetes	H5619-154	076/832	HMO	Clark, Cowlitz
Humana Gold Plus	H1036-306	076/596	HMO	Clackamas, Columbia, Deschutes, Jefferson, Multnomah, Washington
Humana Gold Plus	H5619-133	076/545	HMO	Benton, Franklin, Walla Walla
Humana Gold Plus	H5619-134	076/530	HMO	Benton, Clark, Cowlitz, Franklin, Island, King, Kitsap, Pierce, Skagit, Snohomish, Spokane, Thurston, Walla Walla, Whatcom
Humana Gold Plus	H1036-153	076/662	HMO	Clackamas, Columbia, Multnomah, Washington
Humana Gold Plus	H2486-007	076/549	HMO	Clark
Humana Gold Plus	H5619-056	076/112	HMO	Clark, Cowlitz
Humana Gold Plus	H5619-059	076/114	HMO	Clark, Cowlitz, King, Skagit, Snohomish, Whatcom
Humana Gold Plus	H1036-219	076/762	HMO	Crook, Deschutes, Jefferson
	H2486-009	076/604		
	H2486-010	076/825		

Plan name and type	CMS contract	Group #	Type	Applied county/counties
Humana Gold Plus	H5619-057	076/113	HMO	King
Humana Gold Plus	H5619-155	076/833	HMO	King, Snohomish
Humana Gold Plus	H5619-100	076/156	HMO	Pierce
Humana Gold Plus	H5619-061	076/116	HMO	Pierce, Thurston
Humana Gold Plus	H5619-114	076/253	HMO	Skagit, Whatcom
Humana Gold Plus	H5619-143	076/570	HMO	Spokane
Humana Gold Plus	H5619-060	076/115		
Humana Gold Plus	H2486-006	076/550	HMO	Snohomish
Humana Gold Plus	H5619-063	076/118		
Humana Gold Plus	H5619-136	076/556	HMO DSNP	Clark, Cowlitz
Humana Gold Plus	H5619-136	076/561	HMO DSNP	Snohomish
Humana Gold Plus	H5619-136	076/562	HMO DSNP	Skagit, Whatcom
Humana Gold Plus	H5619-136	076/563	HMO DSNP	Benton, Columbia, Franklin, Garfield, Island, Jefferson, King, Kitsap, Lewis, Lincoln, Mason, Pierce, Skamania, Spokane, Thurston, Wahkiakum, Walla Walla
Medicaid State Health Reform			HMO	
Medicaid State Healthy Options Plan			HMO	
Medicaid State S-CHIP Plan			HMO	
Medicare Advantage	H4604-013	90911	HMO POS	Bonner, Boundary, Idaho, Kootenai, Latah, Nez Perce, Shoshone
Medicare Advantage - Carpenters Health & Security Trust Group	H3805-806	92146	HMO	Yakima, Benton, Clark, Cowlitz, Franklin, Island, King, Kitsap, Lewis, Pierce, Skagit, Snohomish, Thurston, Walla Walla, Whatcom
Medicare Advantage - Cement Masons	H3805-806	92149	HMO	Yakima, Benton, Clark, Cowlitz, Franklin, Island, King, Kitsap, Lewis, Pierce, Skagit, Snohomish, Thurston, Walla Walla, Whatcom
Medicare Advantage - City of Seattle	H3805-806	92210	HMO	Yakima, Benton, Clark, Cowlitz, Franklin, Island, King, Kitsap, Lewis, Pierce, Skagit, Snohomish, Thurston, Walla Walla, Whatcom
Medicare Advantage - Harrison Electrical	H3805-806	92133	HMO	Yakima, Benton, Clark, Cowlitz, Franklin, Island, King, Kitsap, Lewis, Pierce, Skagit, Snohomish, Thurston, Walla Walla, Whatcom
Medicare Advantage - Machinist H&W Trust	H3805-806	92169	HMO	Yakima, Benton, Clark, Cowlitz, Franklin, Island, King, Kitsap, Lewis, Pierce, Skagit, Snohomish, Thurston, Walla Walla, Whatcom
Medicare Advantage - Pacific Coast Shipyards	H3805-806	92176	HMO	Yakima, Benton, Clark, Cowlitz, Franklin, Island, King, Kitsap, Lewis, Pierce, Skagit, Snohomish, Thurston, Walla Walla, Whatcom
Medicare Advantage - Retirees Welfare Trust	H3805-806	92190	HMO	Yakima, Benton, Clark, Cowlitz, Franklin, Island, King, Kitsap, Lewis, Pierce, Skagit, Snohomish, Thurston, Walla Walla, Whatcom
Medicare Advantage - UFCW Local 555	H3805-806	92204	HMO	Yakima, Benton, Clark, Cowlitz, Franklin, Island, King, Kitsap, Lewis, Pierce, Skagit, Snohomish, Thurston, Walla Walla, Whatcom
Premera EOC Classic Plan	H7245-002	2024PR0002	HMO	Cowlitz, Island, King, Kitsap, Lewis, Pierce, San Juan, Skagit, Snohomish, Spokane, Thurston, Walla Walla, Whatcom
Premera EOC Plan	H7245-001	024PR0001	HMO	Cowlitz, Island, King, Kitsap, Lewis, Pierce, San Juan, Skagit, Snohomish, Spokane, Thurston, Walla Walla, Whatcom
Premera EOC Total Health	H7245-005	2024PR0005	HMO	Spokane, Stevens, Walla Walla
Coordinated Care				Adams, Asotin, Benton, Chelan, Clallam, Clark, Columbia, Cowlitz, Douglas, Ferry, Franklin, Garfield, Grant, Grays Harbor, Island, Jefferson, King, Kitsap, Kittitas, Klickitat, Lewis, Lincoln, Mason, Okanogan, Pacific, Pend Oreille, Pierce, San Juan, Skagit, Skamania, Snohomish, Spokane, Stevens, Thurston, Wahkiakum, Walla Walla, Whatcom, Whitman, Yakima

**Delegation by plan**

Please refer to the *Delegation by Plan* in the Appendix.

This manual is effective Jan. 1, 2024, for all providers participating in Optum Care Network of Washington (OCN). It is effective for all care providers who participate in our network during 2024. This manual is subject to change. We frequently update content in our effort to support our health care providers.

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.

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

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

## Terms and definitions used in this guide

- “Member” or “customer” refers to a person eligible and enrolled to receive coverage from a payer for covered services as defined or referenced in your agreement
- “You”, “your” or “provider” refers to any health care provider subject to this guide and includes physicians, health care professionals, facilities and ancillary providers, except when indicated
  - All items are applicable to all types of health care providers subject to this guide
- “Your agreement”, “provider agreement”, or “agreement” refers to your participation agreement with us.
- “Us”, “we” or “our” refers to Optum Care Network of Washington (OCN) on behalf of itself and its other affiliates for those products and services subject to this guide
- Any reference to “ID card” includes both a physical and digital card

## Delegation defined

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

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



## Optum Care Network (OCN)

Optum Care Network of Washington (OCN) operates as an association with a local management team administering certain health plan functions in compliance with its delegation. OCN partners with local clinician groups to improve quality of care, clinical outcomes and member satisfaction through collaboration with the care delivery system. Optum Care Network is a service organization focused on helping independent physician practices, as well as large medical groups and hospital systems, succeed at value-based care in a way that is easier, faster and more cost-effective. We do this by providing seamless data technology that puts actionable data at the fingertips of health care professionals; streamlined whole-person care to help address the needs of patients with complex conditions; and a dedicated Optum Practice Engagement Manager who brings the expertise, training and support needed to succeed at value-based care.

## Service area

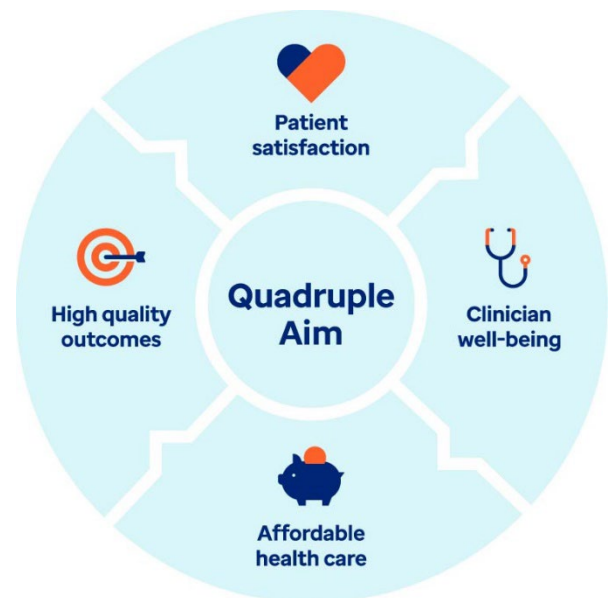
Optum Care Network of Washington serves the entire state of Washington.

## Strong values focused on the Quadruple Aim

The Quadruple Aim is a strategic framework, made up of 4 core pillars, which guides our clinical priorities and efforts towards a more sustainable health care system.

- High quality outcomes
- Satisfied patients
- Affordable health care
- Clinician well-being

As we aspire to enable healthier lives and to help make the health system work better for everyone, our focus on the Quadruple Aim — improved outcomes, outstanding patient and provider experiences, and a lower total cost of care — will help guide us in our delivery of coordinated, patient-centered care.





## A message from Dr. Imelda Dacones, *President*

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

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

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

This provider manual offers valuable information about the Optum Care Network of Washington and how to work effectively with us. We hope it will be a user-friendly reference guide and educational resource for you and your staff. We strive to continually improve and provide the best service and useful information to you. Please do not hesitate to reach out if you have questions regarding this manual.

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

As your partner and support, we, OCN, are here to ensure a seamless experience for you, your staff, and our patients and enrollees.

Together, we will help people live their best lives.

With gratitude,  
Imelda Dacones, MD FACP  
*President*, Optum Care Network of Washington (OCN)



## How to contact OCN

You may contact OCN through the following methods:

- **Provider portal:** The portal is a secure, online, customized experience that assists providers in caring for OCN patients. It is a one-stop shop offering claims insights, prior authorization submission and status, and population health performance data. These tools can help providers improve patient care and lower costs. Log in at [onehealthport.com](https://onehealthport.com).
- **Optum Care Service Center:** Our service advocates are available to answer questions on topics such as health care professional search, claims, eligibility and more
  - Phone: **1-877-836-6806**, 8 a.m.-5 p.m. PT, Monday-Friday
- Network relations and contracting: [OCNWACContracting@optum.com](mailto:OCNWACContracting@optum.com)
- Mailing address for general information:  
Optum Care Network Administration  
904 7th Ave, 2nd Floor, Admin Office  
Seattle, WA 98104
- Each practice in our network is supported by a dedicated practice engagement manager (PEM) who is your go-to resource. To acquire contact information for your PEM, contact our team at [engagementteam@optumpnw.com](mailto:engagementteam@optumpnw.com).

## Network engagement

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

- Primary OCN relationship owner with clinic
  - Partners with clinic leadership to strive for optimal performance in quality, accurate coding and documentation, patient experience, and affordability to improve long-term clinical outcomes while lowering the total cost of care
  - Leads and schedules meetings with the clinic
  - Ensures clinic has tools and data needed for success in patient care delivery
  - Communicates Quality Incentive Program (QIP) elements and achievements
- Population health performance
  - Provides point of care tool delivery, training, and submission tracking
  - Provides performance and incentive reporting
  - Supports MA marketing and growth coordination
  - Supports care management service coordination
  - Provides clinics with information on new and existing wraparound services
- Training/education
  - Assesses practice training needs
  - Coordinates Primary Care Provider (PCP), staff, and clinic administrator education on accurate coding and documentation, quality, and affordability

## Portal access

### Summary

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

The OCPC provides access to the following:

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

### User access

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

- Navigate to the OCPC website via [onehealthport.com](https://onehealthport.com) using OHP user ID and single sign-on and choose Optum logo
- Navigate to the OCPC website [onehealthport.com](https://onehealthport.com)
  - Complete the fields under the *Provider Registration – New User* section
  - The request will then be reviewed by an OCN system administrator
  - Once account registration is approved, an email will be sent to the provider with log in information and instructions
  - Log in to OCPC and finalize setup

## Language and hearing-impaired assistance

Optum Care wants to ensure 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 who 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 health care professional'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, to avoid a delay in care. Patients have the right to a certified medical interpreter or sign language interpreter to translate health information accurately. Health care professionals cannot charge the patient for the costs of sign language interpreter services or auxiliary aids.

- For more information, call Optum Care Service Center at **1-877-836-6806**, 8 a.m.–5 p.m. PT, Monday-Friday
- The TTY 711 and language lines are open 24 hours a day, 7 days a week
- For technical difficulties and additional assistance, please contact Optum Care Service Center: **1-877-836-6806**, 8 a.m.–5 p.m. PT, Monday-Friday

## 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 health care professional. See section on referrals later in this guide for detailed information on referral requirements.

## Non-discrimination

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

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

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

## 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 health care professional performance data
- Notifying us when you become aware of a patient safety issue or concern

## Medicare compliance expectations and training

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

FDRs are expected to have an effective compliance program which includes training and education to address FWA and compliance knowledge. OCN’s expectation remains that FDRs and their employees are sufficiently trained to identify, prevent, and report incidents of non-compliance and FWA. This includes temporary workers and volunteers, the CEO, senior administrators or managers, and sub-delegates who are involved in or responsible for the administration or delivery of MA or Part D benefits or services.

We have general compliance training and FWA resources available at [unitedhealthgroup.com](https://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](https://unitedhealthgroup.com) > About > Ethics & Integrity > UnitedHealth Group’s Code of Conduct. Provide the materials annually and within 90 days of hire for new employees.
- Maintain records of distribution standards (i.e., in an email, website portal or contract) for 10 years. We, our plan sponsors, or CMS, may request documentation to verify compliance.

### Fraud, waste and abuse and general compliance training – what you need to do

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

### Exclusion checks

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

### Exclusion checks – 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/](https://oig.hhs.gov/)
  - General Services Administration (GSA) System for Award Management at [sam.gov/sam](https://sam.gov/sam)
- Review the exclusion lists every month and disclose to OCN any exclusion or any other event that makes an individual ineligible to perform work directly or indirectly on federal health care programs. Maintain a record of exclusion checks for 10 years. We, our plan sponsors, or CMS, may request documentation of the exclusion checks to verify they were completed.

## Preclusion list policy

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

- Are revoked from Medicare, are under an active reenrollment bar, and CMS has determined that the underlying conduct that led to the revocation is detrimental to the best interests of the Medicare program; or
- Have engaged in behavior for which CMS could have revoked the prescriber, individual or entity to the extent possible if they had been enrolled in Medicare and that the underlying conduct that would have led to the revocation is detrimental to the best interests of the Medicare program.
- Have been convicted of a felony under federal or state law within the previous 10 years and that CMS deems detrimental to the best interests of the Medicare program.
- Care providers receive a letter from CMS notifying them of their placement on the preclusion list. They have the opportunity to appeal with CMS before the preclusion is effective. There is no opportunity to appeal with Optum Care Network or the plan sponsor. CMS updates the preclusion list monthly and notifies MA and Part D plans of the claim rejection date, the date upon which we 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. Additionally, the precluded care provider must hold Medicare beneficiaries harmless from financial liability for services provided on or after the claim rejection.

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

For more information on the preclusion list, visit [cms.gov](https://www.cms.gov).

## Reporting misconduct

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

- UHC members report at [uhc.com/fraud](https://uhc.com/fraud) or by calling **1-844-359-7736**
- Humana members report at [ethicshelpline.com](https://ethicshelpline.com) or by calling **1-877-584-3539**
- Premera members report by email to [SIUReferrals@premera.com](mailto:SIUReferrals@premera.com) or by calling **1-888-844-8985**
- Coordinated care members report at [coordinatedcarehealth.com/providers/resources/report-fraud](https://coordinatedcarehealth.com/providers/resources/report-fraud) or by calling **1-866-685-8664**

## Privacy

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

Other regulations to follow include, but are not limited to:

- The Cures Act
- Information Blocking Rules
- Telephone Consumer Protection Action 47 USC Section 227

## Guide updates

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

## Provider demographic change notice requirements

Notify us at the address in your agreement within 3 business 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 funded health care program
- Loss, suspension, restriction, condition, limitation or qualification of your license to practice. For health care professionals, any loss, suspension, restriction, condition, limitation or qualification of 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 health care professional/facility
- External sanctions or corrective actions levied against you by a government entity

## Notification of changes must be proactive

Every quarter, you, or an entity delegated to handle credentialing activities and are expected to review, update and attest to the care provider information available to our members. 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 the participating care 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)
- Office phone number(s)
- Email address(es)
- Care provider groups affiliation
- Facility affiliation
- Specialty
- License(s)
- Tax identification number
- NPI(s)
- CAQH
- Languages 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. 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. Please submit all changes on an OCN roster to your practice engagement manager.

## To change an existing TIN, add a health care professional or update your practice or facility information

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

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

## Termination of participation

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



## Change in ownership/control

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

## Closing your practice

Closing your practice due to retirement or business considerations is a complex undertaking. The process can be very different for primary care providers and specialists. OCN would like to support you in locating resources for your transition and understanding actions required. Please contact Network Relations and Contracting for assistance planning these logistics. The table below provides a start in preparing for such a change.

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

## 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 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 to reactivate an inactivated TIN.

When care providers tell us of practitioners leaving a practice, we make multiple attempts to document the change.

We administratively terminate a care provider once the following actions are taken:

- We get oral notice that a practitioner is no longer with a practice
- We make 3 attempts to obtain documentation confirming the practitioner's departure but do not receive the requested documentation
- The practitioner has not submitted claims under that practice's TIN(s) for 6 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)

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

## Patient assignment and reassignment

OCN manages patients assigned to primary care providers (PCPs) for Humana Medicare Advantage HMO, AARP Medicare Advantage HMO through UnitedHealthcare (UHC MA), UHC Medicaid, Premera Medicare Advantage HMO and Coordinated Care. Patients are assigned to a Primary Care Provider through one of the following processes:

- The patient chooses a PCP at the time of enrollment
- The health plan assigns a PCP after enrollment if the patient has not designated a PCP

Practices should make every attempt to engage patients assigned to them and establish care.

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

- Humana:
  - Patients may call Humana customer service number on the back of their ID card to request a different PCP, or
  - Patients may complete a PCP change form and fax to Humana
- UHC Medicare Advantage:
  - Patients may call the UHC customer service number on the back of their ID card to request a different PCP
- UHC Medicaid:
  - Patients may call the UHC customer service number on the back of their ID card to request a different PCP, or
  - Patients may complete a **PCP change form** and submit by UHC as directed on the form
- Premera Medicare Advantage:
  - Patients may call the Premera customer service number on the back of their ID card to request a different PCP
- Coordinated Care:
  - Patients may call the Coordinated Care customer service number on the back of their ID card to request a different PCP

## Threats or filing of legal action by a member

### Threats or filing of legal action against a care provider

We do not automatically move the member to another medical group/IPA because threats or filing of a lawsuit or other similar grievance or complaint.

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, which must be confirmed by the treating care provider
- The member wants another care provider who is part of the same medical group/IPA but located in a different office

If a transfer is affected, the treating care provider must cooperate in the transfer of medical records and information to the new care provider.

### Threats or filing of legal action against a medical group/IPA

We do not deny the member access to care providers within a medical group/IPA because of threat or filing of a lawsuit or other similar grievance or complaint. 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.

## 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 2 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 communications

Member communications require CMS approval. This includes:

- Anything with the Optum 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. PT 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 a first-tier entity to a MA organization, OCN 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, 7 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. Make available all plan materials, services, and information, including those produced or distributed by contracted providers, in accessible format as referenced in Section 504 of the Rehabilitation Act of 1973. Provide required materials on a standing basis in an accessible format upon receiving a request for the materials or when otherwise learning of the enrollee's need for an accessible format (42 C.F.R §§ 422.2267(a)(3) and 423.2267(a)(3)).
- 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. 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 2 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.

# Provider Responsibility

- 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 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.
- In addition, you must comply with the Medicare Advantage Regulatory Requirements Appendix (MARRA)

## Health equity in MA and cultural competency

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

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

## Medical records standards

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

- **Patient identification:** Each page in the record will contain the patient name and/or patient ID number
- **Personal/biographical data:** Each record will have the patient's address, employer, home and work phone numbers, marital status, date of birth, emergency contact, and phone number
- **Patient language:** Each patient's health record will 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.
- **Working diagnoses:** Working diagnoses are consistent with findings
- **Problem list:** Significant illnesses and medical conditions will be identified on the problem list. If the patient has no known medical illnesses 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 3 or more times):** Past medical history will be easily identified, including serious accidents, operations, and illnesses. It is recommended to include sexual activity and mental health status, if applicable. For children and adolescents (18 years or younger), past medical history will be noted as above and will include childhood illnesses, immunizations, and prenatal care and births, if applicable.
- **Smoking/ETOH/substance abuse:** Medical records for patients who are 14 years of age and older must contain a notation that the patient has been asked about depression, violence, alcohol, substance and cigarette use, and counseled, as necessary.
- **History and physical:** Appropriate subjective and objective information will be obtained for the presenting complaints.
- **Appropriate use of lab and other studies:** Laboratory and other studies ordered will be noted, as appropriate.
- **Risk factors:** Possible risk factors for the patient relevant to the particular treatment will be noted.
- **Plan/treatment:** Treatment plans are consistent with diagnoses.
- **Return visit:** Progress notes will have a notation concerning follow-up care, calls, or visits. A specific time to return for an appointment will be noted in weeks, months, or as needed.
- **Follow-up:** Encounter forms or notes will have a notation, when indicated, regarding follow-up care, calls, or visits. Missed appointments will be noted in the medical record, including outreach efforts. Unresolved problems from previous office visits will be addressed in subsequent visits. Follow-up of referrals with any lab or test results should be maintained as well.
- **Appropriate use of consultants:** Review for under- and over-utilization will be noted. For example, repeated visits with a PCP for an unresolved problem might lead to a request for consultations with a specialty physician.
- **Continuity of care:** For example, if a consultation is requested, a note from the consultant, after the visit, must be documented in the record. If the visit does not occur (e.g., failed visit by the patient) the failure to visit should be documented as well.
- **Consultants/X-rays/lab and imaging report initials:** Consultations, lab and X-ray reports filed in the chart will have the primary care physician's initials and date signifying review. Consultation and abnormal results will have an explicit notation in the record of follow-up plans. Recommendation that date report/results received will be noted.
- **Medication documentation:** Current medication is documented, including complete dosage information, dates, and refill information.
- **Immunization record:** For adult immunization, physicians will follow the guidelines from the United States Preventive Services Task Force. For pediatric records, there will be a completed immunization record or a notation that "immunizations are up-to-date."
- **Preventive services:** There will be evidence that preventive screenings and services are offered. A suggested checklist may be provided to each office for use and inclusion in the medical record.
- **Addendum to record:** Any adult patient who inspects their 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 (such as patient name, ID number, etc.) will be limited to 250 words per alleged incomplete or incorrect item and will clearly indicate, in writing, that the patient wished the addendum to be a part of the record. The physician will attach the addendum to the record and will include the addendum whenever the physician makes a disclosure of the alleged incomplete or incorrect portion of the record to any third party. The receipt of information in an addendum that contains defamatory or otherwise unlawful language, and the inclusion of this information in the record, will not, in and of itself, subject the physician to liability in any civil, criminal, administrative, or other proceeding.



## Appointment wait standards

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

- (A) Urgently needed services or emergency—immediately;
- (B) Services that are not emergency or urgently needed, but the enrollee requires medical attention—within 10 business days; and
- (C) Routine and preventive care—within 30 business days

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

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

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

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

## 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. Review the most current directory of our network practitioners and health professionals at our website.

Access the provider lookup tool to find the current directory of our network practitioners and health professionals:

[professionals.optumcare.com](https://professionals.optumcare.com)

## After-hours access for behavioral health care

All behavioral health providers are required to have an automated answering system 24 hours a day, 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.

## Appointment access criteria

### PCP and specialty access standards

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

### Appointment access standards behavioral health

Access type	Standard
Access to non-urgent appointment with health care professional for routine care	Within 10 business days of request
Non-urgent appointments with a non-physician behavioral health care provider	Within 10 business days of request
Access to urgent care	Within 48 hours of request
Access to non-life-threatening emergency care	Within 6 hours of request
Access to life-threatening emergency care	Immediately
Access to follow-up care after hospitalizations for mental illness	Within 7 business days of request (initial visit); within 30 business days of request (second visit)

### Appointment access standards exceptions

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

## Preventive care recommendations for men and women ages 50 and older

Immunizations	Standard
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 (chicken pox)	Recommended for adults without evidence of immunity; should receive 2 shots
Zoster (shingles)	Recommended for all adults 50 and older

Screenings/counseling/services	Standard
AAA (abdominal aortic aneurysm)	For men ages 65 to 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 wellness visit, annually
Breast cancer	Recommended mammogram every 1 to 2 years for women ages 50 to 74
Breast cancer chemoprevention	Covered for women at high risk for breast cancer and low risk for adverse effects from chemo prevention
Cervical cancer	At least every 3 years if cervix present. After age 65, pap tests may be discontinued if previous test results normal
Colorectal cancer	Recommended for adults 45 to 75
Depression	For all adults
Diabetes	Recommend Type 2 diabetes screening for individuals who are overweight, obese, have sustained blood pressure greater than 135/80 mm Hg, or diagnosed HTN
Domestic violence and abuse	Screening and counseling for interpersonal and domestic violence
Gonorrhea	Recommended for all sexually active women who are at increased risk for infection
HIV	For all adults at increased risk for HIV infection
HPV	Recommended for all sexually active women 65 and younger
Lipid disorder	Screening periodically
Obesity	Screening, counseling, and behavioral interventions
Osteoporosis	Recommend routine screening for women 65 and older; routine screening for women under age 64 if at increased risk
Prostate cancer	Men 55–69 should have a discussion with their PCP to determine if screening is appropriate for them
Sexually transmitted infections	Medical intervention and behavioral counseling as needed
Syphilis	Recommended for individuals at increased risk for infection
Tobacco use and cessation	Screening for tobacco use and cessation intervention

### Heart health

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

## Other topics to discuss with patients

- Overall physical and emotional health\*
  - Compared to one year ago, how would you rate your physical health in general now?
  - Compared to one year ago, how would you rate your emotional problems in general now? *This includes feeling anxious, depressed or annoyed.*
- Fall risk prevention\*
  - Have you fallen or do you think that you are at risk of falling?
  - Do you have problems with your balance or walking?
- Urinary incontinence\*
  - Have you experienced any leaking of urine?
  - Do you have concerns about bladder control?
- Exercise\*
  - For heart health, adults should exercise regularly, at least 30 minutes a day on most days. This can help lower the risks of heart disease, brittle bones, obesity and diabetes.
  - Patients should talk to a doctor before starting a new intense exercise.
  - Food
    - Eat a healthy diet. Limit fat and calories. Eat fruits, vegetables, beans and whole grains every day.
    - The best calcium intake is around 1,500 mg/day for post-menopausal women not on estrogen therapy.
    - Vitamin D is important for bone and muscle development, roles and safety.
- Sexual health
  - Sexually transmitted infection (STI)/HIV prevention, practice safer sex (use condoms) or abstinence.
- Substance use disorders
  - Stop smoking. Limit alcohol consumption. Stay away from alcohol or drug use while driving.
- Dental health
  - Floss and brush with fluoride toothpaste daily. Seek dental care regularly.
- Other topics
  - Possible risks and benefits of hormone replacement therapy (HRT) for post-menopausal women
  - Risk of prostate cancer and benefits of screening in men to determine what is best for you
  - The dangers of drug interactions
  - Glaucoma eye exam by an eye care professional for adults age 65 and older

\* Patients are asked in the Health Outcomes Survey (HOS) if these 4 topics were discussed. Reference the Health Outcomes Survey information of the Quality section of this guide for more information.

## Service standards

### Care coordination

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

The PCP is responsible for providing or overseeing comprehensive healthcare services for members. The PCP is the manager and medical home of a member's total health care needs. This includes:

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

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

### Office availability and wait times

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

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

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

## Verification of eligibility

When a patient visits their health care professional, the patient's eligibility should be verified at each visit before rendering covered services to ensure timely and appropriate claims payment for patients who are eligible with health care coverage. The health care professional should verify eligibility with the patient's health plan no more than 48 hours prior to providing covered services and again on the date of service. Eligibility may be accessed at [onehealthport.com](https://onehealthport.com).

The patient's member ID card and verification of eligibility with the patient's health plan is not a guarantee of coverage. The health care professional should maintain a copy of the eligibility verification in the patient's file in case of retroactivity or eligibility disputes for payment purposes. In the event such activity or dispute occurs, the health care professional may be required to provide proof of the eligibility verification transaction to receive payment for covered services rendered.

Disclaimer: Please check the health plan's website for the most up to date member eligibility information as the data provided above is not a guarantee of payment or eligibility. For members with coverage in a UHC Medicare Advantage Health plan and where the member has selected a health care professional within OCN you can access UHC's member eligibility tool to verify member eligibility and benefits and to view the member's ID card.

Online with provider portal: [onehealthport.com](https://onehealthport.com)

Online with health plan:

- UHC members: [uhcprovider.com/eligibility](https://uhcprovider.com/eligibility)
- Humana members: [humana.com/provider](https://humana.com/provider)
- Premera members: [premera.com/wa/provider/](https://premera.com/wa/provider/)
- Coordinated Care members\*: [coordinatedcarehealth.com/providers](https://coordinatedcarehealth.com/providers)

*\* Providers can accept verification of enrollment in Coordinated Care from the Recipient Eligibility Verification System (REVS) system in lieu of the ID card. Check online through our secure provider portal or use our IVR System.*

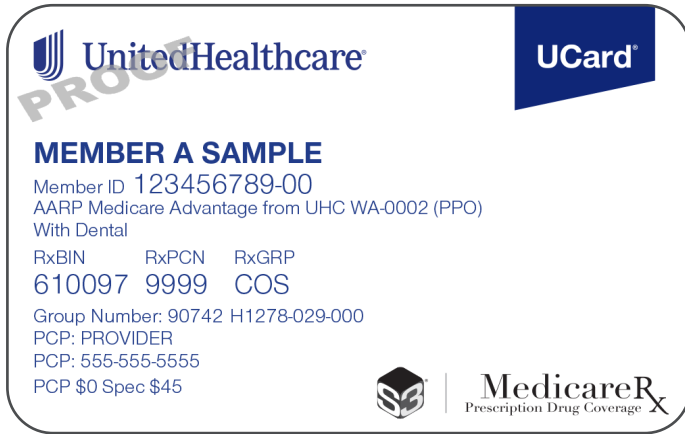
## Example ID cards

The Medicare Advantage ID card will include the payer ID LIFE1, the Optum Care Network claims address and health care professional services phone number.

## Participating plans and sample of their member ID cards

The cards represent the plans Optum manages under UHC Medicare Advantage, Humana, Premera and Coordinated Care. (You can confirm the plan is managed by Optum by identifying the UHC Medicare assigned H number on the bottom left-hand corner of the card.)

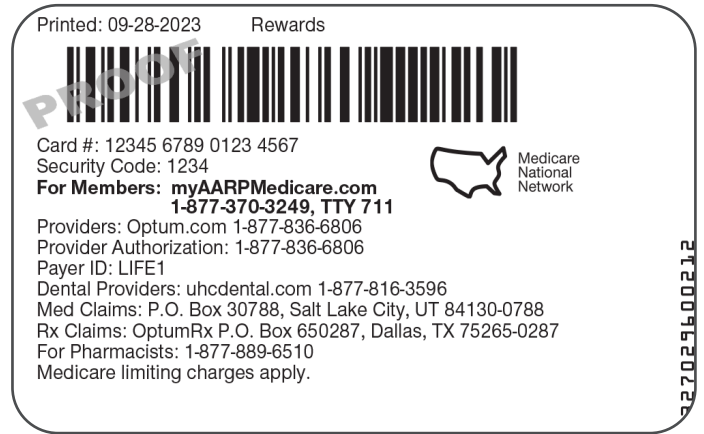
These member ID cards are samples for illustration only; actual information varies depending on payer, plan and other requirements.




**UnitedHealthcare** UCard

**MEMBER A SAMPLE**  
 Member ID 123456789-00  
 AARP Medicare Advantage from UHC WA-0002 (PPO)  
 With Dental  
 RxBIN RxPCN RxGRP  
 610097 9999 COS  
 Group Number: 90742 H1278-029-000  
 PCP: PROVIDER  
 PCP: 555-555-5555  
 PCP \$0 Spec \$45

MedicareRx  
 Prescription Drug Coverage



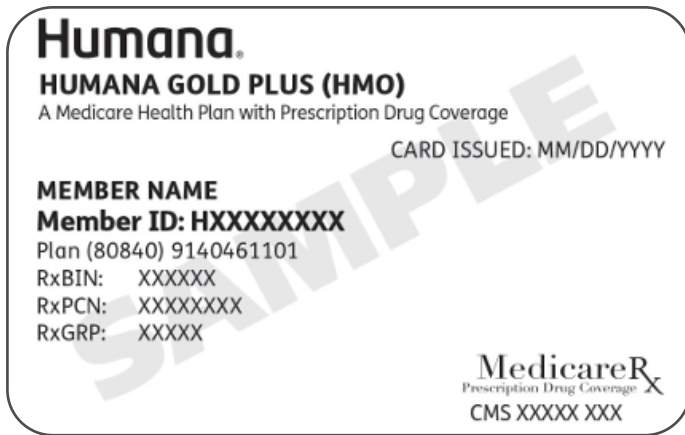
Printed: 09-28-2023 Rewards



Card #: 12345 6789 0123 4567  
 Security Code: 1234  
**For Members: myAARP Medicare.com**  
**1-877-370-3249, TTY 711**  
 Providers: Optum.com 1-877-836-6806  
 Provider Authorization: 1-877-836-6806  
 Payer ID: LIFE1  
 Dental Providers: uhcdental.com 1-877-816-3596  
 Med Claims: P.O. Box 30788, Salt Lake City, UT 84130-0788  
 Rx Claims: OptumRx P.O. Box 650287, Dallas, TX 75265-0287  
 For Pharmacists: 1-877-889-6510  
 Medicare limiting charges apply.

Medicare National Network

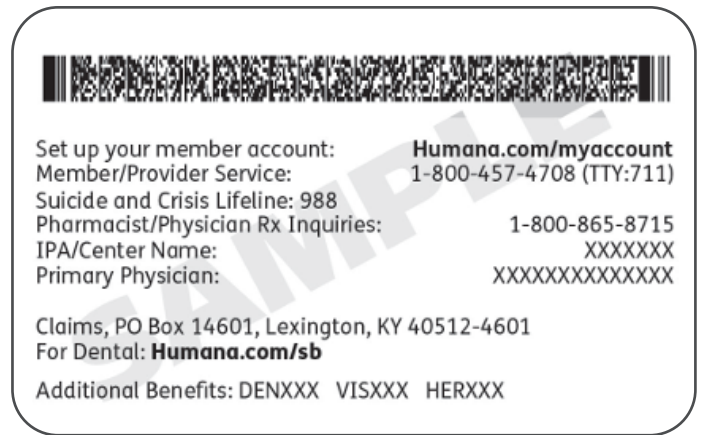

222009600212



**Humana**  
**HUMANA GOLD PLUS (HMO)**  
 A Medicare Health Plan with Prescription Drug Coverage  
 CARD ISSUED: MM/DD/YYYY

**MEMBER NAME**  
**Member ID: HXXXXXXXXX**  
 Plan (80840) 9140461101  
 RxBIN: XXXXXX  
 RxPCN: XXXXXXXX  
 RxGRP: XXXXX


MedicareRx  
 Prescription Drug Coverage  
 CMS XXXXX XXX

Set up your member account: **Humana.com/myaccount**  
 Member/Provider Service: 1-800-457-4708 (TTY:711)  
 Suicide and Crisis Lifeline: 988  
 Pharmacist/Physician Rx Inquiries: 1-800-865-8715  
 IPA/Center Name: XXXXXXXX  
 Primary Physician: XXXXXXXXXXXXXXXX

Claims, PO Box 14601, Lexington, KY 40512-4601  
 For Dental: **Humana.com/sb**  
 Additional Benefits: DENXXX VISXXX HERXXX



**PREMERA** 

**BLUE CROSS**  
An Independent Licensee of the Blue Cross Blue Shield Association

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**Member** **Medical Network Individual Signature**

**SAMPLE CARD**

Prefix Identification # Suffix  
**ABC 123456789 01**

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Group # **1234567** **Rx Plan M4**

Rx Group # **BCWAPDP**  
**BIN# 610014**

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**BCBS 430**

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**INDIVIDUAL PLAN**  
OFFICE VISIT COPAY \$40  
PCP COPAY \$5 / EMERGENCY ROOM \$150  
RETAIL RX \$5/\$40/50%  
MAIL-ORDER RX \$15/\$120/50%

	IN NETWORK	OUT OF NETWORK
DEDUCTIBLE INDIVIDUAL	\$1,000	\$1,000
DEDUCTIBLE FAMILY	\$3,000	\$3,000
OUT OF POCKET INDIVIDUAL MAX	\$4,000	\$4,000
OUT OF POCKET FAMILY MAX	\$10,000	\$10,000

**PREMERA** 

**BLUE CROSS**  
An Independent Licensee of the Blue Cross Blue Shield Association

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Visit [www.premera.com](http://www.premera.com) for coverage details, on-line services and health-related information.

Customer Service 1-800-607-0546  
TTY for the deaf and hard of hearing 711  
Outside of U.S. call Toll Free 1-855-390-6514  
BlueCard Provider Locator 1-800-810 BLUE (2583)  
Provider BlueCard Eligibility 1-800-676 BLUE (2583)  
Pharmacy Locator/Mail Order Rx 1-800-391-9701  
24-Hour NurseLine 1-800-784-9265

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**PROVIDERS:** Please submit all claims with ID number, prefix and group number to the local Blue Cross Blue Shield Plan. This card is not a guarantee that the member's coverage is currently in effect. Providers may call BlueCard Eligibility to verify membership and coverage.


**MEMBER/PROVIDER:** Send paper claims and correspondence to:  
**Premera Blue Cross of WA**  
P.O. Box 21702  
Eagan, MN 55121


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**MEMBERS:** Please show this card when you receive services. See your benefit booklet for covered services. If you have questions, call Customer Service or write us at the address on this card.  
**PROVIDERS/MEMBERS:** Pre-Approval (prior authorization) may be required for some services/drugs. Providers: Check benefits at web address above or call Customer Service prior to providing services.

**This member only has emergent care benefits outside the state of Washington.**

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 EXPRESS SCRIPTS® Pharmacy Benefits Manager

 **coordinated care.**



RXBIN: 004336  
RXPCN: MCAIDADV  
RXGRP: RX5435

NAME:  
MEDICAID ID#:  
MEMBER ID#:  
DOB:

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If you have an emergency, call 911 or go to the nearest emergency room (ER).  
Emergency services by a provider not in the plan's network will be covered without prior authorization. [CoordinatedCareHealth.com](http://CoordinatedCareHealth.com)

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**IMPORTANT TELEPHONE NUMBERS**

**Members:**  
Member Services: 1-877-644-4613  
TDD/TTY: 1-866-862-9380  
24/7 Nurse Advice Line: 1-877-644-4613

**Providers:**  
Provider Services & IVR Eligibility Inquiry: 1-877-644-4613  
Prior Auth: [CoordinatedCareHealth.com](http://CoordinatedCareHealth.com) or 1-877-644-4613  
Pharmacy: 1-800-311-0591

Coordinated Care  
1145 Broadway, Suite 300  
Tacoma, WA 98402

EDI/EFT/ERA please visit  
Provider Resources at  
[www.CoordinatedCareHealth.com](http://www.CoordinatedCareHealth.com)

**Medical and Behavioral Health Claims:**  
Coordinated Care  
Attn: Claims  
PO Box 4030  
Farmington, MO 63640-4197

# Claims

OCN is delegated to adjudicate and pay claims for selected health plans (see Delegation by Plan in the Appendix). Health care professionals and facilities are responsible for verifying patient eligibility, benefits and obtaining referrals/authorizations, if applicable, prior to services being rendered. Please refer to the table below:

Plan name and type	CMS contract	Group #	Type	Applied county/counties
AARP® Medicare Advantage	H3805-039 H3805-039	90907 90910	HMO	Benton, Clackamas, Columbia, Jackson, Josephine, Lane, Linn, Marion, Multnomah, Polk, Washington, Yamhill
AARP® Medicare Advantage	H1278-030 H1278-030	90744 90746	PPO	Franklin, Kitsap, Lewis, Pierce, Skagit, Whatcom, Yakima
AARP® Medicare Advantage	H2406-042 H2406-073	90797 90821	PPO	Benton, Clackamas, Columbia, Jackson, Josephine, Lane, Linn, Marion, Multnomah, Polk, Washington, Yamhill
AARP® Medicare Advantage	H2406-044	90799	PPO	Ada, Canyon
AARP® Medicare Advantage	H2406-070 H2406-070	90819 90818	PPO	Benton, Clackamas, Columbia, Jackson, Josephine, Lane, Marion, Multnomah, Polk, Washington, Yamhill
AARP® Medicare Advantage	H2406-112 H2406-112	90858 92127	PPO	Bonner, Boundary, Idaho, Kootenai, Latah, Nez Perce, Shoshone
AARP® Medicare Advantage Choice	H1278-028	90738	PPO	Spokane
AARP® Medicare Advantage Choice Plan 1	H1278-029 H1278-029	90740 90742	PPO	Clark, Cowlitz, Island, King, Snohomish, Thurston
AARP® Medicare Advantage Choice Plan 2	H1278-032	90750	PPO	Clark, Cowlitz, Island, King, Snohomish, Thurston
AARP® Medicare Advantage Patriot	H4604-019	90912	HMO POS	Ada, Adams, Bannock, Bingham, Blaine, Boise, Bonner, Bonneville, Boundary, Camas, Canyon, Cassia, Elmore, Gem, Gooding, Idaho, Jefferson, Jerome, Kootenai, Latah, Lincoln, Madison, Minidoka, Nez Perce, Owyhee, Payette, Shoshone, Twin Falls, Valley, Washington
AARP® Medicare Advantage Patriot	H3805-035	90156	HMO	Spokane
AARP® Medicare Advantage Patriot	H1278-031	90748	PPO	Clark, Cowlitz, Franklin, Island, King, Kitsap, Lewis, Pierce, Skagit, Snohomish, Thurston, Whatcom, Yakima
AARP® Medicare Advantage Plan 1	H3805-037 H3805-037	90902 91656	HMO	Benton, Clark, Cowlitz, Franklin, Island, King, Kitsap, Lewis, Pierce, Skagit, Snohomish, Thurston, Walla Walla, Whatcom, Yakima
AARP® Medicare Advantage Plan 1	H3805-001	92117	HMO POS	Benton, Clackamas, Columbia, Jackson, Josephine, Lane, Linn, Marion, Multnomah, Polk, Washington, Yamhill
AARP® Medicare Advantage Plan 1	H3805-033	90153	HMO	Spokane
AARP® Medicare Advantage Plan 2	H4604-020	90913	HMO POS	Bonner, Boundary, Idaho, Kootenai, Latah, Nez Perce, Shoshone
AARP® Medicare Advantage Plan 2	H3805-017 H3805-017	90890 91651	HMO POS	Clark, Cowlitz, Island, King, Kitsap, Lewis, Pierce, Skagit, Snohomish, Thurston, Whatcom
AARP® Medicare Advantage Plan 2	H3805-034	90155	HMO	Spokane
AARP® Medicare Advantage Plan 3	H3805-015 H3805-015	91647 92118	HMO POS	Benton, Clark, Cowlitz, Franklin, Island, King, Kitsap, Lewis, Pierce, Skagit, Snohomish, Thurston, Walla Walla, Whatcom, Yakima
AARP® Medicare Walgreens	H3805-032	90894	HMO POS	Clark, King, Pierce, Snohomish, Thurston
Humana Gold Diabetes	H5619-154	076/832	HMO	Clark, Cowlitz
Humana Gold Plus	H1036-306	076/596	HMO	Clackamas, Columbia, Deschutes, Jefferson, Multnomah, Washington
Humana Gold Plus	H5619-133	076/545	HMO	Benton, Franklin, Walla Walla
Humana Gold Plus	H5619-134	076/530	HMO	Benton, Clark, Cowlitz, Franklin, Island, King, Kitsap, Pierce, Skagit, Snohomish, Spokane, Thurston, Walla Walla, Whatcom
Humana Gold Plus	H1036-153	076/662	HMO	Clackamas, Columbia, Multnomah, Washington
Humana Gold Plus	H2486-007	076/549	HMO	Clark
Humana Gold Plus	H5619-056	076/112	HMO	Clark, Cowlitz
Humana Gold Plus	H5619-059	076/114	HMO	Clark, Cowlitz, King, Skagit, Snohomish, Whatcom
Humana Gold Plus	H1036-219 H2486-009 H2486-010	076/762 076/604 076/825	HMO	Crook, Deschutes, Jefferson

Plan name and type	CMS contract	Group #	Type	Applied county/counties
Humana Gold Plus	H5619-057	076/113	HMO	King
Humana Gold Plus	H5619-155	076/833	HMO	King, Snohomish
Humana Gold Plus	H5619-100	076/156	HMO	Pierce
Humana Gold Plus	H5619-061	076/116	HMO	Pierce, Thurston
Humana Gold Plus	H5619-114	076/253	HMO	Skagit, Whatcom
Humana Gold Plus	H5619-143	076/570	HMO	Spokane
Humana Gold Plus	H5619-060	076/115		
Humana Gold Plus	H2486-006	076/550	HMO	Snohomish
Humana Gold Plus	H5619-063	076/118		
Humana Gold Plus	H5619-136	076/556	HMO DSNP	Clark, Cowlitz
Humana Gold Plus	H5619-136	076/561	HMO DSNP	Snohomish
Humana Gold Plus	H5619-136	076/562	HMO DSNP	Skagit, Whatcom
Humana Gold Plus	H5619-136	076/563	HMO DSNP	Benton, Columbia, Franklin, Garfield, Island, Jefferson, King, Kitsap, Lewis, Lincoln, Mason, Pierce, Skamania, Spokane, Thurston, Wahkiakum, Walla Walla
Medicaid State Health Reform			HMO	
Medicaid State Healthy Options Plan			HMO	
Medicaid State S-CHIP Plan			HMO	
Medicare Advantage	H4604-013	90911	HMO POS	Bonner, Boundary, Idaho, Kootenai, Latah, Nez Perce, Shoshone
Medicare Advantage - Carpenters Health & Security Trust Group	H3805-806	92146	HMO	Yakima, Benton, Clark, Cowlitz, Franklin, Island, King, Kitsap, Lewis, Pierce, Skagit, Snohomish, Thurston, Walla Walla, Whatcom
Medicare Advantage - Cement Masons	H3805-806	92149	HMO	Yakima, Benton, Clark, Cowlitz, Franklin, Island, King, Kitsap, Lewis, Pierce, Skagit, Snohomish, Thurston, Walla Walla, Whatcom
Medicare Advantage - City of Seattle	H3805-806	92210	HMO	Yakima, Benton, Clark, Cowlitz, Franklin, Island, King, Kitsap, Lewis, Pierce, Skagit, Snohomish, Thurston, Walla Walla, Whatcom
Medicare Advantage - Harrison Electrical	H3805-806	92133	HMO	Yakima, Benton, Clark, Cowlitz, Franklin, Island, King, Kitsap, Lewis, Pierce, Skagit, Snohomish, Thurston, Walla Walla, Whatcom
Medicare Advantage - Machinist H&W Trust	H3805-806	92169	HMO	Yakima, Benton, Clark, Cowlitz, Franklin, Island, King, Kitsap, Lewis, Pierce, Skagit, Snohomish, Thurston, Walla Walla, Whatcom
Medicare Advantage - Pacific Coast Shipyards	H3805-806	92176	HMO	Yakima, Benton, Clark, Cowlitz, Franklin, Island, King, Kitsap, Lewis, Pierce, Skagit, Snohomish, Thurston, Walla Walla, Whatcom
Medicare Advantage - Retirees Welfare Trust	H3805-806	92190	HMO	Yakima, Benton, Clark, Cowlitz, Franklin, Island, King, Kitsap, Lewis, Pierce, Skagit, Snohomish, Thurston, Walla Walla, Whatcom
Medicare Advantage - UFCW Local 555	H3805-806	92204	HMO	Yakima, Benton, Clark, Cowlitz, Franklin, Island, King, Kitsap, Lewis, Pierce, Skagit, Snohomish, Thurston, Walla Walla, Whatcom
Premera EOC Classic Plan	H7245-002	2024PR0002	HMO	Cowlitz, Island, King, Kitsap, Lewis, Pierce, San Juan, Skagit, Snohomish, Spokane, Thurston, Walla Walla, Whatcom
Premera EOC Plan	H7245-001	024PR0001	HMO	Cowlitz, Island, King, Kitsap, Lewis, Pierce, San Juan, Skagit, Snohomish, Spokane, Thurston, Walla Walla, Whatcom
Premera EOC Total Health	H7245-005	2024PR0005	HMO	Spokane, Stevens, Walla Walla

## Claims submission

Please refer to the information below for claims submission information by health plan.

Plan name and type	OCN electronic claims	OCN paper claims
UnitedHealthcare Medicare Advantage (HMO and PPO)	Claims should be submitted electronically to <b>LIFE1</b> . OCN Electronic Claims Payor ID#: LIFE1 Clearinghouse: Optum360	Paper claims, though not preferred, can be mailed to: OCN Paper Claims Optum Care Network Claims PO Box 30788 Salt Lake City, UT 84130-0788
Humana Gold Plus (HMO)	Claims should be submitted electronically to <b>LIFE1</b> . OCN Electronic Claims Payor ID#: LIFE1 Clearinghouse: Optum360	Paper claims, though not preferred, can be mailed to: OCN Paper Claims Optum Care Network Claims PO Box 30788 Salt Lake City, UT 84130-0788
Humana (PPO)	Claims should be submitted electronically to <b>61101</b> . Humana Electronic Claims Payor ID#: 61101 Clearinghouse: Availity	Paper claims, though not preferred, can be mailed to: Humana Paper Claims PO Box 14601 Lexington, KY 40512
Premiera Blue Cross (HMO)	Claims should be submitted electronically to <b>LIFE1</b> . OCN Electronic Claims Payor ID#: LIFE1 Clearinghouse: Optum360	Paper claims, though not preferred, can be mailed to: OCN Paper Claims Optum Care Network Claims PO Box 30788 Salt Lake City, UT 84130-0788
UnitedHealthcare Dual Complete (DSNP)	Claims should be submitted electronically to <b>95959</b> . UHC Electronic Claims Payor ID#: 95959	Paper claims, though not preferred, can be mailed to: UHC Paper Claims See back of member ID card for mailing address
Humana Gold Plus (DSNP)	Claims should be submitted electronically to <b>LIFE1</b> . OCN Electronic Claims Payor ID#: LIFE1 Clearinghouse: Optum360	Paper claims, though not preferred, can be mailed to: OCN Paper Claims Optum Care Network Claims PO Box 30788 Salt Lake City, UT 84130-0788
UnitedHealthcare Medicaid Advantage (Apple Health)	Claims should be submitted electronically to <b>LIFE1</b> . OCN Electronic Claims Payor ID#: LIFE1 Clearinghouse: Optum360	Paper claims, though not preferred, can be mailed to: OCN Paper Claims Optum Care Network Claims PO Box 30788 Salt Lake City, UT 84130-0788

Please do not submit duplicate claims unless you haven't received payment or an explanation of payment within 45 days of submission.

## Reimbursement

Reimbursement for services is defined in your practice/facility participation agreement. However, your reimbursement is affected not only by the terms of your Agreement, but also the following:

- Patient's eligibility at the time of the service
- Whether services provided are covered benefits under the patient's health plan
- Whether services are medically necessary as required by the patient's health plan
- Whether services were without prior approval/authorization if authorization is required
- Patient copayments, coinsurance, deductibles and other cost-share amounts due from the patient and coordination of benefits with third-party payors as applicable
- Adjustments of payments based on coding edits described above

All services must comply with all federal laws, rules and regulations applicable to individuals or entities receiving federal funds, including without limitation Title VI of the Civil Rights Act of 1964, Age Discrimination Act of 1975, Americans with Disability Act and Rehabilitation Act of 1973. Please refer to your Provider/Facility Agreement for additional terms.

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

## Electronic funds transfer (EFT)

Optum Care processes payments through the Optum Financial online tool, Optum Pay. Health care professionals enrolled in Optum Pay will receive electronic payments. Health care professionals not enrolled in Optum Pay will receive payments in the form of a paper check or virtual card payment (VCP) mailed to the address on file with Optum Care until Optum Pay enrollment has been activated. Access Optum Pay at [myservices.optumhealthpaymentservices.com](https://myservices.optumhealthpaymentservices.com).

## About Optum Pay

- Secure, easy access to claims payment data
- Data download options drive efficiencies
- Flexible administrative management options

## Optum Pay enrollment

Enroll online in Optum Pay automated clearing house (ACH) to receive electronic payments. Access Optum Pay enrollment at [myservices.optumhealthpaymentservices.com](https://myservices.optumhealthpaymentservices.com). The following information is required to complete your enrollment:

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

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

Note: To receive electronic remittance advice (ERA), i.e. 835, through a clearinghouse, please contact Payment Services Support for more information at **1-888-477-0256**, 6 a.m.–6 p.m. PT, Monday–Friday.

## Optum Pay support

If you have questions regarding your Optum Pay account, please contact **1-877-620-6194**, 8 a.m.–5 p.m. PT, Monday–Friday.

## Charging members

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

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

## Clinical claims review

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

## Claims status

The fastest and most efficient way to check a claim's status for contracted health care professional is to utilize the provider portal at [onehealthport.com](https://onehealthport.com). Care providers may view detailed claims information associated with their tax ID number. Most claim inquiries can be researched at [onehealthport.com](https://onehealthport.com).

You can also call to check a claim status at **1-877-836-6806**, 8 a.m.–5 p.m. PT, Monday-Friday.

## Timely filing requirements

Timely filing requirements are determined by the provider-contracted timely filing provisions. We may deny claims not filed within the timely filing limits. If you dispute a claim that was denied due to timely filing, you must submit proof that you filed the claim within the timely filing limits. Timely filing limits vary based on provider contract.

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

If you do not submit clean claims within these time frames, we reserve the right to deny payment for the claim(s). Claim(s) that are denied for untimely filing may not be billed to a member.

We have claims processing procedures to help ensure timely claims payment to care providers. We are committed to paying claims for which we are financially responsible within the time frames required by state and federal law.

## Claim receipt verification

- For verification of receipt of paper claim by OCN within 15 working days of receipt, you may access [onehealthport.com](https://onehealthport.com). Please contact your OCN Practice Engagement Manager (PEM) representative for information about access to this website.
- You may verify the receipt of your electronic claims by contacting your clearinghouse directly.



## Provider dispute resolution process

### Dispute resolution process for contracted providers

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

Examples of types of disputes:

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

Each provider dispute must contain the following information:

- Member demographic information
- Provider's name, TIN, and contact information
- If the provider dispute concerns a claim or reimbursement of an overpayment of a claim from Optum Care the following must be provided:
  - Clear identification of the disputed item, such as the claim(s) number, medical records, and invoices if applicable
  - Date of service
  - Clear description of the dispute

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

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

Helpful provider dispute submission tips:

- Provider dispute forms must be completed in full and included with the dispute.
- All required information must be included; disputes that are missing information will be returned to the submitter.

To submit a provider dispute:

- Contact OCN by email at [ocndisputewa@optum.com](mailto:ocndisputewa@optum.com)
- Contact the Optum Care service center at **1-877-836-6806**, Monday–Friday, 8 a.m.–5 p.m., PST
- Download a copy of the Optum Care provider dispute resolution request form: at [optum.com/business/hcp-resources/page.hub.provider-dispute-resolution-form-washington.html](https://optum.com/business/hcp-resources/page.hub.provider-dispute-resolution-form-washington.html)

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

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

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



## Provider escalation process

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

## Past due payments

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

## Dispute resolution process for non-contracted providers

- Definition of Non-Contracted Provider Dispute: A non-contracted provider dispute is a non-contracted provider's written notice to OCN challenging, appealing, or requesting reconsideration of a claim (or a bundled OCN of substantially similar claims that are individually numbered) that has been denied, adjusted, or contested or disputing a request for reimbursement of an overpayment of a claim. Each non-contracted provider dispute must be submitted on a completed Provider Dispute Resolution Form and:
  - If the non-contracted provider dispute concerns a claim or a request for reimbursement of an overpayment of a claim from OCN to provider the following must be provided: A clear identification of the disputed item, the date of service, and a clear explanation of the basis upon which the provider believes the payment amount, request for additional information, contest, denial, request for reimbursement for the overpayment of a claim, or other action is incorrect.
  - If the non-contracted provider dispute involves an enrollee: The name and identification number(s) of the enrollee or enrollees, a clear explanation of the disputed item including the date of service, provider's position on the dispute, and an enrollee's written authorization for provider to represent said enrollees.
- Dispute Resolution Process: The dispute resolution process for non-contracted providers is the same as the process for contracted providers detailed previously in this guide.

## Overpayment recovery process: Payment Resolution Services (PRS)

Payment Resolution Services is a recovery team within Optum tasked to pursue overpayment recovery efforts for unsatisfied overpayment balances within 150 days of the initial requests for refund. These efforts may be in the form of phone calls or letter correspondence on behalf of Optum to reach overpayment recovery resolution.

Upon overpayment identification, Optum adjusts services on the original claim and generates letter correspondence to the provider explaining the request for overpayment refund. Should no refund or overpayment dispute be received from the provider within 150 days, PRS retains management of all future overpayment recovery for the identified services.

- Submitting overpayment recovery: Submit payment directly to PRS
  - Phone: **615-472-9204**
  - To pay online: Provide required information located on the letter including PRS account number and date of services to [payprs.com](https://payprs.com)
  - To pay by check or money order: Mail to address located on letter

## Misrouted claims

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

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

### 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.

## Coordination of benefits (COB): Medicaid

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

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

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

HCA enrolls some fee-for-service Medicaid members who have other primary health insurance.

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

- Affected members will have 3 ID cards: a ProviderOne card, a primary insurance card and a UnitedHealthcare Community Plan card
- You must verify eligibility: Please verify member COB with UnitedHealthcare, not ProviderOne
- If OCN is billed as a secondary payer, OCN will not require prior authorization. However, if the member's primary health insurance does not cover the service, you must follow OCN requirements.
- When COB payment is equal to or more than the allowable rate, the primary insurance has no patient responsibility, and the claim is paid in full, OCN requires no additional payment
- When COB payment is equal to or less than allowable rate with a patient responsibility from the primary insurance, OCN reimburses the patient responsibility up to the allowable rate
- When the COB payment is less than primary's allowable rate for services performed, OCN pays for the difference between the primary payment and the OCN allowable rate
- Claims received with pediatric preventive, private duty nursing procedure codes and ABA procedure codes follow OCN Pay & Chase policy
- OCN may bill or adjust claims with COB within 30 months of the initial process date

## Payment Integrity

Optum Payment Integrity services ensures that the right payment is made to the right person at the right time. For detailed information regarding Payment Integrity services, please refer to the *2024 Claims Provider Guide* found at [Optum.com](https://www.optum.com) > Business > Providers > Resources > [Forms and resources](#).

## Claims Editing System (CES)

Optum® CES uses logic to check each claim for errors, omissions and questionable coding relationships by testing the data against an expansive database containing industry rules, regulations and policies governing health care claims. Services identified to be out of required coding compliance will be administratively denied. If desired, options are available for submission of payment dispute.

## Coordination of benefits

Coordination of benefits is the process Optum utilizes to identify members with other group health insurance (i.e. Medicare) primarily responsible for paying a claim. This process determines which plan will pay first for covered medical services or prescription drugs and what the second plan will pay after the first plan has paid.

## Data Mining

Data Mining is an analytic program using intelligence to identify aberrant payments due to various root causes. Services identified as overpayment will be administratively denied.

## Payment Integrity review

Payment Integrity review is a PI Operations program designed to detect, prevent and recover funds for services deemed ineligible for payment due to policy and coding non-compliance. The program is comprised of 3 types of reviews:

- Post payment review
- Pre-payment review
- Health care professional education

## Optum Prepayment Review System (OPRS)

OPRS is a predictive analytic tool for professional and institutional medical claims. The OPRS review identifies aberrant behavior requiring additional review prior to payment. Post-adjudication, pre-pay claims will be reviewed by OPRS coding review nurse team. OPRS returns a process recommendation for each service line. One of 4 recommendations will be applied:

- Allow
- Deny
- Pend (for medical records)
- Hold (48 hour hold for additional internal review)

## OptumInsight

OptumInsight, a vendor partner to the Optum Care Payment Integrity program, provides pre and post-pay reviews on Diagnosis Related Group (DRG) Coding and Compliance™, Outpatient Facility™, Itemized Bill Review™, Short Stay Hospital Bill Validation™ and Hospital Bill Audit™.

## Payment Resolution Services (PRS)

Payment Resolution Services is an Optum recovery team to pursue overpayment recovery efforts for unsatisfied overpayment balances within 150 days of Optum Care's initial requests for refund. These efforts may be in the form of phone calls or letter correspondence on behalf of Optum Care to reach overpayment recovery resolution.

## Advanced Communication System (ACE)

The Advanced Communication System is an EDI capability that identifies potential billing errors within a claim and allows care providers the opportunity to review and repair the claim before it is processed.

### ACE program overview

ACE Edits are sent within 24 hours of a claim submission, so problematic claims may be reviewed in a matter of hours instead of formerly resulting claims denials days later.

- ACE edits are designed to identify the specific error that triggered the edit.
- A message on the 277CA clearinghouse rejection report will explain why the claim was flagged and provide direction on how to update and resubmit the claim, or if any future action needs to be taken. An informational banner is exhibited on all claims receiving ACE edits. The intent of the banner is to provide resources for further information on ACE edits and the associated policies at a claim level – see example to the right.

### ACE edit types

- **Return edit:** Sent when the claim in question is likely to result in a denial, reduce potential medical record requests or reduce potential future overpayment requests if it continues into the Optum Care claims processing system. This edit is found at the line level of the claim.
- **Rejection edit:** Sent when the claim is automatically returned and needs immediate attention. If no action is taken to correct the claim, it will not enter the Optum Care claims processing system. This edit is found at the line level of the claim.
- **Documentation edit:** Will notify you when a claim requires additional information. Supporting documentation can be submitted through the Provider Portal. This edit is found at the line level of the claim.
- **Information edit:** Message notifies you of key information in the claim submission process or about upcoming events that require your attention. Informational Edits are found at the line level of the claim and do not impact the specific claim.

## Z-Code assigned molecular tests

Effective **June 30, 2024**, Optum will require health care providers to include the appropriate DEX™ Z-Code™ for molecular diagnostic test services when submitting Medicare Advantage claims. The DEX Z-Code is required in addition to the CPT® code, and this requirement applies to both facility and professional claims.

### DEX Z-Code registration

If you haven't already obtained a DEX Z-Code for your test, please register by visiting [dexcodes.com](https://dexcodes.com) to prepare for this upcoming change and help ensure there's no disruption in your payment.

### What to expect after you complete your registration

- The initial review for Z-Code assignment takes approximately 2 weeks from test submission
- The Z-Code can be submitted on claims once you have received email notification that the test has been assigned a recommended CPT® code and the assessment is complete
  - This typically occurs within 60 days from Z-Code assignment
- You will be notified by email if additional documentation is required dependent on test complexity
- For further guidance on the timeline for the registration of your tests, refer to [DEX Diagnostics Exchange Test Registration](#)

### Why this is important

- Providing the Z-Code on a claim, with the appropriate CPT® code, will clearly identify the test being performed and eliminate some of the administrative burden you may encounter surrounding billing for these services. This requirement applies to both facility and professional claims.
- Claims for molecular pathology services will be denied if the DEX Z-Code information is missing, invalid or does not match the service represented by the CPT® code reported on the claim. Claims denied for missing or invalid information may be resubmitted with the required information.

For additional information regarding the technical assessment, please refer to the [frequently asked questions](#). If you have questions about this new Optum claim requirement, please contact [opshelp@optum.com](mailto:opshelp@optum.com).

## Utilization management

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

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

## Referrals/prior authorizations

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

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

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

## Prior authorizations

Prior authorization requirements can be accessed at [onehealthport.com](https://onehealthport.com) or by calling OCN at **1-877-836-6806**, 8 a.m.-5 p.m. PT, Monday-Friday. Additionally, Medicare Advantage prior authorization requirements can be found on the Provider Portal at [UHCprovider.com](https://UHCprovider.com).

## Prior authorization requirements

Servicing provider	OCN contracted/plan contracted (Provider is contracted with OCN or the health plan)	Non-contracted/non-par (Provider is not contracted with OCN or the health plan)
<b>UnitedHealthcare (Medicare PPO/HMO and Medicaid)</b>	Follow UHC PA Guidelines UHC PA List Applies	All services provided by non-contracted providers require prior authorization (except for emergencies, urgently needed services when the network is not available, and dialysis).
<b>Premera</b>	Follow Premera PA Guidelines Premera PA List Applies	
<b>Humana</b>	Follow Humana PA Guidelines Humana PA list applies	

*Please note: Not all plans have out-of-network benefits.*

## Requesting prior authorization

To submit a prior authorization notification, log in to [onehealthport.com](https://onehealthport.com). If online is not available, call **1-877-836-6806**, 8 a.m.-5 p.m. PT, Monday-Friday, or fax your notification to:

- New Authorization (General): **1-855-402-1684**
- Part B New Authorization: **1-855-402-1684**
- Clinicals Submission for Authorization: **1-855-402-1684**

## Submitting a prior authorization request online for Medicare Advantage members who have an OCN network PCP

Log in to [onehealthport.com](https://onehealthport.com) to start a new request and select submit. For urgent requests call: **1-877-836-6806**. Urgent requests will be addressed within 72 hours of online submission. An urgent request is defined as a request for a patient that meets one or more of the following conditions:

- Imminent, serious threat to his/her health
- Potential loss of life, limb or other major bodily function(s)
- The timeframe for routine decisions could be detrimental to the patient

### Prior authorization provider notification process

When a prior authorization request is approved, OCN will notify the provider and enrollee so the provider may proceed with the service delivery.

When an adverse determination is made, OCN will notify both the provider and enrollee with a formal written notification that includes member appeal rights and next steps. The provider may also log in to [onehealthport.com](https://onehealthport.com) and access the referrals and prior authorizations to view the status of a prior authorization request.

### Prior authorization time frames

The department strives to process each request as expeditiously as an enrollee's condition requires. According to CMS regulations for organizational determinations, the determination must be rendered within the following time frames:

Type of request	Turn-around time
Expedited or urgent pre-service requests	72 hours
Standard or non-urgent pre-service requests	14 calendar days
Part B Drug Expedited or urgent pre-service requests	24 hours
Part B Drug Standard or non-urgent pre-service requests	72 hours

### Prior authorization status

A health care professional may log in to [onehealthport.com](https://onehealthport.com) and access referrals and prior authorizations to view the status of a prior authorization request or by call **1-877-836-6806**.

### Out of network services

All out-of-network hospitalizations, surgeries, procedures, referrals, evaluations, services and treatment require prior authorization. All out-of-network providers require prior authorization for any service rendered. Please refer to the Prior Authorization Grid at [Optum.com](https://Optum.com) > Business > Providers > Resources > [Forms and resources](#).

### Utilization management annual criteria notification

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

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

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

All providers have the opportunity to discuss any utilization management denial decision with an OCN Medical Director.

## Home health prior authorization

Prior authorization (PA) is required for all home health services after the initial start of care (SOC) and subsequent visits through day 14 during the 60-day certification period. Notification of admission to services is required (48-72 hours – verify by market).

- New home health care prior authorization: **1-877-836-6806**

**Note:** Start of Care (initial visit) does not require prior authorization. You can perform a comprehensive evaluation during the initial visit and are required to provide notification only to Optum Care. After day 14 of episode within first certification period, prior authorization is required. If you do not obtain authorization before services are rendered when required, claims may be denied.

### Home health prior authorization will be required for:

- Initial certification period on day 15-60
- Continuation of care
- Resumption of care (ROC)
- Additional visits
- Recertification for all subsequent 60-day episodes

## Medicare home health HCPCS: G Codes

To request home health visits, the home health agency must use one of the Medicare appropriate HCPCS codes to represent each visit by each home health care discipline. S Codes will be denied/rejected for incorrect coding. Please refer to the below resources which include a link to the CMS manual on appropriate coding.

HCPCS Code	Description
G0299	Direct skilled nursing services of a registered nurse (RN) in the home health or hospice setting, each 15 minutes
G0300	G0300 Direct skilled nursing services of a license practical nurse (LPN) in the home health or hospice setting, each 15 minutes
G0151	G0151 Services performed by a qualified physical therapist in the home health or hospice setting, each 15 minutes
G0152	G0152 Services performed by a qualified occupational therapist in the home health or hospice setting, each 15 minutes
G0152	G0153 Services performed by a qualified speech-language pathologist in the home health or hospice setting, each 15 minutes
G0155	G0155 Services of clinical social worker in home health or hospice settings, each 15 minutes
G0156	G0156 Services of home health/hospice aide in home health or hospice settings, each 15 minutes
G0157	Services performed by a qualified physical therapist assistant in the home health or hospice setting, each 15 minutes
G0158	Services performed by a qualified occupational therapist assistant in the home health or hospice setting, each 15 minutes
G0159	Services performed by a qualified physical therapist, in the home health setting, in the establishment or delivery of a safe and effective physical therapy maintenance program, each 15 minutes

## Understanding Optum home health approval with the G codes

All home health cases need to be submitted with the appropriate G code for discipline. Each G code will be equivalent to 1 visit. Although the G code is to be used and stated as 15 minutes, billing should be done where one unit corresponds to one visit in its entirety.

**Example:** G0299 X 9. This means Optum has approved 9 skilled nursing visits.

## Home health denials: Peer-to-peer requirement

Peer-to-peer can only occur with ordering physician and Optum Medical Director.



## Criteria used for home health medical necessity reviews

Optum uses Medicare criteria to facilitate medical necessity reviews for home health.

- Medicare Manual for Home Health requirements: [Medicare Benefit Policy Manual Chapter 7 Home Health Services](#)

## Medicare home health conditions coverage

The following criteria for initial and subsequent home health visits will be reviewed and member must meet all 3 conditions with a Medicare certified agency for initial and subsequent home health visits:

- Member is homebound. This means needs assistance of another person or of a supportive device. Leaving home requires a considerable and taxing effort
  - There is a normal inability to leave the home.
- A physician's order
  - A physician or a recognized non-physicist health care professional, had a face-to-face meeting with the member prior to certifying the individuals need for home care.
- Member requires skilled nursing care on an intermittent basis, or skilled physical/occupational therapy, and speech therapy.

## How to request a home health prior authorization

Please submit for prior authorization 7 days prior to your first visit after Start of Care in order to ensure time for medical necessity review of the authorization. To submit a home health prior authorization notification, log in to [onehealthport.com](#). If online is not available, call **1-877-836-6806**, 8 a.m.-5 p.m. PT, Monday-Friday, or fax your notification to:

- New Authorization (Home Health): **1-855-402-1684** (PA fax cover sheet and all documentation)

## Initial authorization process

Regardless of the method of submission, you will be required to submit the following information upon review:

- Ordering Provider demographic information, TAX ID, NPI and office contact name, phone, and fax number
- Servicing Provider (Home Health Agency) demographic information, TAX ID, NPI and office contact name, phone, and fax number.
- Member demographic information
- Attestation to member meeting Centers for Medicare & Medicaid Services (CMS) criteria for home health eligibility
- Home Health Discipline (SN, PT, OT, SP, AIDE) and number of visits requested (Using G codes)
- Member primary diagnosis and secondary diagnosis's
- CMS-485 form/signed plan of care by ordering physician (or verbal start of care order is accepted)
- Start of Care OASIS will be required within 7 days of initial authorization to support the authorization request
- Initial therapy evaluation within 7 days of the initial authorization request
- Face-to-face encounter

## Recertification: Completing request process

All recertifications require prior authorization for the 60-day increment and can be submitted using the same methods as listed above. Regardless of method of submission, you will be required to submit clinical documentation to support medical necessity criteria. This documentation includes:

- 485 form and/or start of care OASIS (if not already submitted)
- Home Health Discipline (SN, PT, OT, SP, AIDE) and number of visits requested (Using G codes)
- Last 2 visit notes per discipline involved
- Any other relevant clinical documentation

## Additional discipline visit vs. add new discipline for certification period

If there is any modification to member's care plan the home health agency is required to submit prior authorization for additional visits or add-on discipline prior to requested service date. The home health agency must submit the following documents: documentation of Physician's order (verbal order accepted), clinical documentation as applicable to support request RN/LPN notes, Physical Therapy notes, Occupational Therapy notes, Speech Therapy notes, Home Health Aid notes and Medical Social Worker notes.



## Compliance: Notice of Medicare Non-Coverage (NOMNC) – preparation and delivery

- Home Health agency must prepare and deliver the NOMNC
- Use the most current Medicare NOMNC (CMS-10123) form
- NOMNC must be delivered at least 2 calendar days before Medicare covered services end or the second to last day of service if care is not being provided daily
  - Note: Optum Prior Authorization Department can provide the current NOMNC form.
- Provider can type or write in the required fields:
  - The patient's name
  - The Medicare patient number
- The type of coverage (SNF, Home Health, CORF, or Hospice)
- The effective date (last day of coverage), which is always the last day beneficiaries will receive coverage for their services

If you have questions, please call Optum Care Service Center at **1-877-836-6806**.

## Additional resources

- [Medicare Claims Processing Manual: Chapter 10- Home Health Agency Billing](#)
- [Benefit Policy Manual, Chapter 7 Home Health Services](#)

## Referrals

Medicare Advantage members who have selected an OCN PCP will need to coordinate services with their network PCP for specialists, ancillary care providers, facilities and hospitals. The PCP will be the member's first and foremost source of care. They can best refer the member to other network health care professionals or specialists when additional care is needed.

## Specialty care

We have a large network that includes skilled medical professionals in almost every specialty. The specialists we contract with are carefully chosen and will work closely with you to provide the patient with what is needed.

## Hospital admission notification requirements

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 post-acute care admissions:
  - Skilled nursing facility (SNF)
  - Long-term acute care (LTAC)
  - Acute inpatient rehab (AIR)
- All admissions following outpatient surgery
- All admissions following observation stay
- 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 on the next business day.

Admission notification by the facility is required even if the health care professional supplied advance notification and a pre-service coverage approval is on file.

Receipt of an admission notification does not guarantee or authorize payment. Payment of covered services is contingent on coverage within an individual patient's benefit plan, the facility's eligibility for payment, any claim processing requirements and the facility's participation agreement with Optum.

Admission notifications must contain the following details regarding the admission:

- Patient name and health care ID number
- Facility name and National Provider Identifier (NPI) or Tax Identification Number (TIN)
- Admitting/attending health care professional 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 via phone or fax within 24 hours (or the next business day, for weekend or federal holiday admissions) from the time the information is known and communicate the extenuating circumstances. We will not apply any notification-related reimbursement deductions.

## Reimbursement reductions for failure to timely provide admission notification

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

## How to submit admission notifications

To notify OCN of hospital admissions no later than 24 hours after admission and 24 hours post discharge, log in to [onehealthport.com](https://onehealthport.com).

If online is not available, notifications can be submitted:

- Phone: **1-877-836-6806**
- Fax: **1-253-627-4708**

## Submit clinical information for hospital admissions

- Online: [onehealthport.com](https://onehealthport.com)
- Fax: **1-253-627-4708**

## Referral vs. prior authorization vs. advanced notification

The **referral** process, advance notification process and prior authorization processes are separate processes.

A referral is required 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 OCN. 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 health care professional 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 the advance notification is done.

## Prior authorization and hospital admission peer-to-peer process

The peer-to-peer process may be initiated before an adverse determination has been communicated to the member. The OCN nurse or coordinator will contact the ordering physician to make them aware that the request may be denied. If the ordering physician has additional clinical information that may help the request meet medical necessity criteria, the ordering physician is encouraged to contact the OCN medical director to provide such information. The peer-to-peer conversation gives the treating provider the opportunity to discuss the OCN determination before an actual denial has occurred and before the initiation of the appeals process.

Please call **1-877-836-6806** for a peer-to-peer discussion during the hours of 8 a.m.-5 p.m. PT, Monday-Friday.

The opportunity to discuss the determination is provided with the OCN medical director making the initial determination or a covering Optum Care medical director if the original OCN medical director is not available. If the peer-to-peer discussion does not result in the authorization of the request, OCN informs the provider and enrollee of their appeal rights during the notification.

**NOTE:** The peer-to-peer conversation may occur after the date/time provided during the notification call, however, once the adverse determination has been issued to the member, the initial adverse determination cannot be changed. If the peer-to-peer discussion does not result in the authorization of the request, OCN informs the provider of the appeal rights.

For Prior authorization only, Part B, Expedited and aged cases day 10 and greater are eligible for a peer-to-peer post decision discussion. A determination change is not available due compliance on case turnaround times. For a final determination change OCN informs the provider of the appeal rights.

## Health improvement

**Optum Care 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 is not based upon the likelihood or the perceived likelihood that the individual will support or tend to support the denial of benefit.

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. These criteria are based on reasonable medical evidence and acceptable medical standards of practice (i.e. applicable health plan benefits and coverage documents, national and local coverage determinations, CMS guidelines and Milliman Care Guidelines), 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 public or a health care professional, 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 to make a criteria request.

Health care professionals may contact the Optum Care UM department to obtain UM policy or criteria used in making medical decisions.

## Optum Care Management programs

Optum Care Management programs ensure members receive appropriate, timely and quality care to address individual health care needs. These programs work in collaboration with the member, the family/support system, providers, and key stakeholders to coordinate discharge, health care services, community resources and referrals to the appropriate next level of care.

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

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

Care Management has oversight of the following programs:

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

For additional information, please contact Network Relations and Contracting.

## Care Management request process

To refer members to Optum Medical Management programs, submit a completed Care Management Referral form (see appendix).

## Care Management services

Transitional care management

- Dedicated RN case manager
- Telephonic support
- Health goal development
- Coordinate access to community resources and services
- Disease management education and medication review
- Post-discharge 30-day follow-up from inpatient or skilled nursing facility

Complex and high-risk case management

- Dedicated RN case manager
- Telephonic support
- Patient centered plan of care
- Longitudinal management/coordination of care for medical issues
- Health goal development
- Coordinate access to community resources and services
- Disease management education and medication review

## Disease management

### Diabetes management

- Dedicated RN case manager
- Telephonic support
- Patient centered plan of care
- Coordination with PCP and specialist
- Coordinate access to community resources and services
- Evaluate and manage health risk factors
- Disease education (diet, medication management, complications, exercise and self-management techniques)

### Chronic obstructive pulmonary disease (COPD) management:

- Dedicated RN case manager
- Telephonic support
- COPD treatment assessment
- Patient centered plan of care
- Medication administration coaching
- Coordination with PCP and specialist
- Self-monitoring and interventions follow-up

### Congestive heart failure (CHF) management:

- Dedicated RN case manager
- Telephonic support
- CHF treatment assessment
- Patient centered plan of care
- Medication administration coaching
- Coordination with PCP and specialist
- Self-monitoring and interventions follow-up

## Social work support

- Supports all clinical programs as well as stand-alone referrals
- Coordination of community resources to address social determinants of health
- Provide education with advance directives and living will documents
- Support members through the emotional adjustments to life changes
- Support with financial resources, housing, transportation, placement and meal assistance

## Behavioral health

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

## Mobile Urgent Care Visit

DispatchHealth is a mobile acute care service that offers same day appointments for patients with the goal of preventing unnecessary visits to the emergency room and reducing avoidable hospital admissions and readmissions. Consider DispatchHealth for patients with an acute, not immediately life-threatening medical need who:

- Are unwilling or unable to come in
- Have difficulty with transportation
- May not come in otherwise

Contact:

- Snohomish County Direct Line: **1-425-372-5441** Pierce County
- Direct Line: **1-253-666-9459**
- For more information: [dispatchhealth.com](https://dispatchhealth.com)

## Additional resources

- Optum behavioral health
  - For direct referrals regarding behavioral health needs. Call behavioral health number on the back of member's card
- Optum nurse line
  - A 24-hour access hotline for member to reach a nurse to answer questions regarding health concerns. Members can call the number on the back of their insurance card.

# Credentialing and Recredentialing

## Credentialing

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

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

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

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

Health plan/Carrier	Providers credentialed
Coordinated Care	Medical, physical rehabilitation and behavioral health providers
First Choice Health	Medical, physical rehabilitation and behavioral health providers
Humana	Medical, physical rehabilitation and behavioral health providers
Premera	Medical, physical rehabilitation and behavioral health providers
UnitedHealthcare	Medical providers

Providers requesting participation with Optum Care Network should contact their local account manager. Please ensure that your provider CAQH account is up to date to prevent delays in credentialing.

CAQH Provider Support Website: [proview.caqh.org/PR](https://proview.caqh.org/PR)



## Initial credentialing

The initial credentialing process is from receipt of completed credentialing application to committee approval. 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 (e.g., required documents are not attached, fields on application not filled in, etc.), this will also delay the processing of the application.

## Providers joining your practice

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

## Types of providers credentialed

OCN credentials the following provider types:

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

## Providers adding location(s)

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

## Types of facilities credentialed

- Ambulatory surgery center
- Behavioral health (facility)
- Birthing center
- Chemical dependency treatment center
- Home health
- Home infusion therapy
- Hospital
- Independent diagnostic testing facility
- Laboratory
- Radiology\*
- Skilled nursing facility
- Urgent care center

\* Excluding therapeutic/interventional radiologists who credential individually

## Sub-delegation of credentialing

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

## Credentialing corrective action

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

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

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

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

## Rights related to the credentialing process

Practitioners and other health care providers applying for Optum Network have the following rights regarding the credentialing process:

- To review the information submitted to support your credentialing application
- To correct erroneous information
- To be informed of the status of your credentialing or re-credentialing application upon request

You may review the status of your Optum credentialing application by contacting your Optum practice engagement manager.

## Professional liability insurance coverage requirements

To complete credentialing requirements, each health care provider must provide evidence of professional malpractice coverage in minimum amounts of \$1 million per occurrence and \$3 million aggregate or amount required by state law.

## Recredentialing

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

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

Please note: In the event a contracted provider or group is adding a provider, the credentialing process must be completed, and there must be a fully executed contract in place prior to the practitioner seeing Optum Care patients. It is fraudulent practice to bill under one provider when services are provided by another provider and/or provider extender.

To ensure accurate records and provider directories, please report all demographic changes directly to your assigned network liaison.

## Facility recredentialing

Recredentialing occurs at least every 36 months. Prior to the 3-year credentialing anniversary, facilities will be notified that recredentialing is due and be sent a recredentialing application to complete. Non-response or failure to return a completed recredentialing application(s) and supporting documentation may be considered a voluntary termination of participation, unless otherwise determined by the Credentialing Chair and/or Credentialing Committee.

All facility locations must complete the credentialing process. Until the additional location has successfully completed the credentialing process, authorizations and claims payment will be delayed.

## Population health

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

These are the 4 guiding principles of OCN's population health programs:

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

## Quality and risk adjustment

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

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

What does this mean for your practice?

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

## Risk Adjustment Factor

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

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

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

## Ongoing education

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

## Opportunities and services

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

## What does this mean for your practice?

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

## Provider attestations

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

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

## 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 objectives

The committee shall oversee the following functions:

- Review and adoption of QI Program and related policies and procedures
- Review and adoption of UM Program, UM Work Plan and related policies and procedures
- Review and adoption of Complex Care Management (CCM) Program and related policies and procedures
- Review and approve practice protocols and guidelines related to the use of non-physician practitioners such as nurse practitioners
- Review and adoption of UM Criteria and Clinical Guidelines
- Oversight of clinical care and services to include but not be limited to:
  - Complex Case Management
  - Patient Safety reviews (such as Medication Reconciliation)
  - Utilization Management
  - Delegated and subdelegated functions
- Conduct an annual evaluation of the UM and QI programs to assess accomplishments and barriers and to establish goals for the next year's program
- 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

## 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

The CDQI (clinical documentation and quality improvement) department oversees risk adjustment and quality-based activities. This department provides education, training and feedback on provider performance against risk and quality standards and initiatives. CDQI oversees and manages the applications and tools that are designed to assist in closing gaps in care and ensure complete and accurate coding. These tools are deployed to the provider offices and designed to be used by the provider and/or support staff. These tools will:

- Provide guidance for specific tests and procedures based on a patient's health history and previous diagnoses.
- Enable providers to close both risk and quality-based gaps in care, at the point of care while improving diagnosis capture and reporting.
- Support submission of quality performance measures such as HEDIS-Stars.

## CMS quality measure overview

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

- Consumer Assessment of Healthcare Providers and Systems (CAHPS) or patient satisfaction data
- Health Care Effectiveness Data and Information Set (HEDIS) or medical record and claims data
- Health Outcomes Survey (HOS) or patient health outcomes data
- 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](https://www.cms.gov).

## **CPT® Category II codes**

Use to help achieve better outcomes for your patients and your practice.

CPT® Category II codes make it easier for you to share data quickly and efficiently with Optum. When you add them for certain preventive care services and test results, we can get a more complete picture of our plan members' health—and help you address care opportunities tied to Healthcare Effectiveness Data and Information Set (HEDIS®) quality measures.

### **Using CPT® Category II codes may also offer these benefits:**

- Fewer medical record requests: When you add CPT® Category II codes, we won't have to request charts from your office to confirm care you've already completed
- Enhanced performance: With better information, we can work with you to help identify opportunities to improve patient care. This may lead to better performance on HEDIS® measures for your practice
- Improved health outcomes: With more precise data, we can refer plan members to our programs that may be appropriate for their health situation to help support your plan of care
- Less mail for members: With more complete information, we can avoid sending reminders to patients to get screenings they may have already completed

## List of CPT Category II codes to report

The following chart shows which measures are tracked and which codes to use for each measure. For a complete list of CPT® Category II codes, please access [ama-assn.org](https://www.ama-assn.org) > Practice Management > CPT® (Current Procedural Terminology) > [Need Coding Resources](#)

Measure	CPT Category II code descriptor	Code
Advanced Care Planning – formerly COACP	Advance care planning discussed and documented—advance care plan or surrogate decision-maker documented in medical record (DEM) (GER, Pall Cr)	1123F
	Advance care planning discussed and documented in medical record—patient didn't wish to or was unable to name a surrogate decision maker or provide an advance care plan (DEM) (GER, Pall Cr)	1124F
	Advance care plan or similar legal document in medical record	1157F
	Advance care planning discussion documented in the medical record	1158F
Care of Older Adults –Pain Assessment	Pain severity quantified; pain present	1125F
	Pain severity quantified; no pain present	1126F
Care of Older Adults – Medication Review	Medication List documented in medical record	1159F
	Review of all medications by a prescribing practitioner or clinical pharmacist (e.g. prescriptions, OTCs, herbal therapies and supplements) documented in the medical record	1160F
Care of Older Adults - Functional Assessment	Functional status assessed	1170F
Eye Exam for Patients with Diabetes (EED) –formerly CDC EYE	Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed; with evidence of retinopathy	2022F
	Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed; without evidence of retinopathy	2023F
	7 standard field stereoscopic retinal photos with interpretation by an ophthalmologist or optometrist documented and reviewed; with evidence of retinopathy	2024F
	7 standard field stereoscopic retinal photos with interpretation by an ophthalmologist or optometrist documented and reviewed; without evidence of retinopathy	2025F
	Eye imaging validated to match diagnosis from 7 standard field stereoscopic retinal photos results documented and reviewed; with evidence of retinopathy (DM)	2026F
	Eye imaging validated to match diagnosis from 7 standard field stereoscopic retinal photos results documented and reviewed; without evidence of retinopathy	2033F
	Diabetic eye exam without evidence of retinopathy in prior year	3072F
Hemoglobin A1c Control for Patients with Diabetes (HBD) –formerly CDCA1C9, CDCA1C8	HbA1c level < 7.0%	3044F
	HbA1 c level > 9.0%	3046F
Diabetes Monitoring for People with Diabetes and Schizophrenia (SMD)	HbA1c level ≥ 7.0% & < 8.0%	3051F
	HbA1 c level ≥ 8.0% & ≤ 9.0%	3052F
Blood Pressure Control for Patients with Diabetes (BPD) –formerly CDCBP	Systolic less than 130	3074F
	Systolic between 130 to 139	3075F
	Systolic greater than/equal to 140	3077F
	Diastolic less than 80	3078F
Controlling High Blood Pressure-(CBP)	Diastolic between 80 to 89	3079F
	Diastolic greater than/equal to 90	3080F
Medication Reconciliation Post-Discharge	Discharge medications reconciled with current medications in outpatient record	1111F
Postpartum Care	Postpartum care visit	0503F
Prenatal Care	Initial prenatal care visit	0500F
	Prenatal flow sheet	0501F
	Subsequent prenatal care	0502F



## Reporting reminders by measure

- **COA Medication Review:** Document both medication list and medication review and report both CPT II codes. Medication review must be completed by a prescribing care provider or clinical pharmacist.
- **EED:** Any provider can report the appropriate CPT II code for the eye exam results. It does not have to be reported by only the ophthalmologist or optometrist.
- **HBD:** Report the appropriate CPT II code for the A1c result value with the date of test, not the date of the office visit when the test was reviewed.
- **BPD and CBP:** Report 2 CPT II codes. One for the lowest systolic value and the one for the lowest diastolic value measured during the encounter.
- **SMD:** Report the appropriate CPT II code for the A1c result value with the date of test, not the date of the office visit when the test was reviewed. Report the appropriate CPT II code for the LDL-C result value.
- **TRC:** Report the medication reconciliation post-discharge when performed either via a telephone call or during the Transitional Care Management office visit.

CPT Category II codes can be reported alone on a claim with \$0.00 value (or \$0.01 value if your system requires it in order for the codes to populate on a claim).

## CPT tips for success

- A CPT-II code can be billed on the claim by itself
- A diagnosis code that pertains to the service being rendered is required when billing CPT-II codes
- A servicing provider is required when billing CPT-II codes
- CPT Category II codes can be submitted by whichever provider performs the service/measurement unless there are specific reporting requirements for the measure (e.g., COA Medication Review must be completed by a prescribing practitioner or clinical pharmacist)
- CPT Category II codes can be submitted on both UB (837I), and HCFA (837P) claim types
- Rural Health Clinic (RHC) status does not impact the CPT-II submission process
- A denial on the Category II code in my remittance does not mean anything was billed incorrectly. Optum assigns a payment reason code to indicate why payment is not made, but it is not a denial, since the codes are for reporting purposes only.

If you have additional questions, please visit the CMS website pertaining to [HCPCS Level II Coding Process & Criteria](#).

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*CPT® is a registered trademark of the American Medical Association.*

## Health Outcomes Survey measures

The Medicare Health Outcomes Survey (HOS) is an outcomes measure reported by patients. It's the first used in care handled by Medicare. The goal is to gather valid, reliable and clinically meaningful health status data from the Medicare Advantage (MA) program. The data is then used in quality improvement activities. The Medicare HOS looks at the following:

- Physical and mental health outcomes measures
- Urinary incontinence in older adults
- Physical activity in older adults
- Fall risk management
- Osteoporosis (brittle bone) testing in older women

Frequency: Annually between July and November

Target population: Medicare Advantage

# 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 expenses and for which the program will pay in whole or in part; subject to any deductible, co-insurance or table of allowance included in the program.

**ASC—Ambulatory Surgery Center:** Used for payments to a surgery center. Billed charges: The dollar amount billed by a provider as their usual and customary charge.

**ASC—Ambulatory Surgery Classification:** used for outpatient hospital claims, paid at OPSS (outpatient perspective payment system).

**Capitation:** Method of payment for health services in which a provider or hospital is paid a fixed amount for each person served regardless of the actual number or nature of services provided each person. This is a per-patient-per-month (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 or adjusted by age/sex of enrollees; percent of premium based on severity ratings.

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

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

**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.

**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).

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

**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.

**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.

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

**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.

**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 funds transfer (EFT):** The electronic exchange of funds between 2 or more organizations.

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

**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.

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

**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.

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

**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.

## Glossary: Definitions and Terminology

**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 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.

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

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

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

**Net promoter 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.

**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.

**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 billed.

**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.

**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.

**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.

**Service area:** Geographic area serviced by an Optum Care contracted provider, as stated in the provider’s agreement with us

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

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

**Utilization management (UM):** The process of evaluating and determining the coverage for and the appropriateness of medical care services, as well as aiding 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.

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## Prior Authorization Request Form

The current form may be accessed online: [Prior Authorization Form for Washington](#).

Sample form:



### Fax cover sheet

professionals.optumcare.com/portal-login

**Fax:** 1-855-402-1684  
1-253-627-4708 (SNF and Inpatient)  
**Phone:** 1-877-836-6806  
1-253-627-4113 (Clinical Team for SNF)

Requestor contact: \_\_\_\_\_  
\_\_\_\_\_  
Phone: \_\_\_\_\_ Ext: \_\_\_\_\_  
Fax: \_\_\_\_\_

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

Patient name: \_\_\_\_\_ DOB: \_\_\_\_\_  
Insurance ID: \_\_\_\_\_  Medicaid  Medicare  Commercial  
Phone: \_\_\_\_\_ Address: \_\_\_\_\_

**Requesting provider**

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

**Servicing provider**

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

**Servicing facility**

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

**Type of service:**  
 Part B  Home health  Other  
 DME: \$ \_\_\_\_\_ purchase/ \$ \_\_\_\_\_ rental  
**Date of service:** \_\_\_\_\_  
**Location of service:**  
 Inpatient  Outpatient  Office  
 SNF  Home  Other \_\_\_\_\_

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

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

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

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

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## Care Management Referral Form

The current form may be accessed online: [Care Management Referral Form for Washington](#).

Sample form:



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

### CARE MANAGEMENT REFERRAL FORM

<b>Date:</b> <a href="#">Click or tap to enter a date.</a>			
MEMBER INFORMATION			
<b>Member Name:</b> <a href="#">Click or tap here to enter text.</a>	<b>Member DOB:</b> <a href="#">Click or tap here to enter text.</a>	<b>Member Health Plan ID:</b> <a href="#">Click or tap here to enter text.</a>	<b>Member Phone:</b> <a href="#">Click or tap here to enter text.</a>
<i>If primary contact is <u>not</u> the member, provide the following:</i>			
<b>Contact Name:</b> <a href="#">Click or tap here to enter text.</a>	<b>Relationship to Member:</b> <a href="#">Click or tap here to enter text.</a>	<b>Contact Phone:</b> <a href="#">Click or tap here to enter text.</a>	
REFERRED BY			
<b>Name:</b> <a href="#">Click or tap here to enter text.</a>	<b>Title:</b> <a href="#">Click or tap here to enter text.</a>	<b>Phone:</b> <a href="#">Click or tap here to enter text.</a>	
LINE OF BUSINESS			
<b>Choose an item.</b>		<i>If Other, please specify:</i> <a href="#">Click or tap here to enter text.</a>	
PRIMARY CARE PROVIDER INFORMATION (OPTIONAL)			
<b>PCP Name:</b> <a href="#">Click or tap here to enter text.</a>	<b>PCP Office Address:</b> <a href="#">Click or tap here to enter text.</a>	<b>PCP Phone:</b> <a href="#">Click or tap here to enter text.</a>	
DIAGNOSIS AND REASON FOR CARE MANAGEMENT REFERRAL			
<b>Diagnosis(s):</b> <a href="#">Click or tap here to enter text.</a>		<b>Reason or Need for Assistance:</b> <a href="#">Click or tap here to enter text.</a>	
PROJECTED OUTCOME FROM CARE MANAGEMENT (OPTIONAL)			
<b>Reason or Need for Assistance:</b> <a href="#">Click or tap here to enter text.</a>			

### INSTRUCTIONS FOR REFERRAL SUBMISSION:

Complete this referral form and fax to

**253-356 5778**

## Provider Group/Practitioner Change Form

The current form may be accessed online: [Provider Change Form for Washington](#).

Sample form:



### Provider Group/Practitioner Change Form

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

<input type="checkbox"/> Practice Name <input type="checkbox"/> Practitioner Name <input type="checkbox"/> Tax ID Number <input type="checkbox"/> Office Location/Address <input type="checkbox"/> Billing Address <input type="checkbox"/> Correspondence Address		<input type="checkbox"/> Telephone Number <input type="checkbox"/> Fax Number <input type="checkbox"/> Email Address <input type="checkbox"/> Adding New Provider(s) <input type="checkbox"/> Terminated Provider(s)	
<b>Section II – Group Demographics</b>			
Practice/organization name: _____			
Current Tax ID (TIN): _____			
National Provider Identifier (NPI): _____ Date issued: _____			
Basis for NPI (applies to organizations only, select only 1 per NPI):			
<input type="checkbox"/> Provider Name <input type="checkbox"/> Tax ID only (entity whose name is in the W-9 form) <input type="checkbox"/> License Number <input type="checkbox"/> NUCC Taxonomy Code <input type="checkbox"/> Place of service address <input type="checkbox"/> Department <input type="checkbox"/> Other (please explain)			
<input type="checkbox"/> Please check here if you have multiple NPIs representing your practice or organization.			
<b>Section III - Practice/Organization change</b>			
<input type="checkbox"/> New tax ID number is: _____ Effective: _____ (please attach a copy of the W-9)			
<input type="checkbox"/> We have moved. Our new address is effective: This new address is a:			
<input type="checkbox"/> Practice address <input type="checkbox"/> Billing address <input type="checkbox"/> Both practice & billing address <input type="checkbox"/> Correspondence address			
Should this new address be in the directory? <input type="checkbox"/> Yes <input type="checkbox"/> No			

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New	Old
Address: _____	Address: _____
Telephone: _____	Telephone: _____
Fax: _____	Fax: _____
Email: _____	Email: _____
<input type="checkbox"/> We have changed our practice name to: _____ Effective: Change pertains to all practitioners under the Tax ID (TIN): _____ Specify physicians/health care providers affected by the change: _____	
<b>Section IV - Adding a New Practitioner</b>	
<input type="checkbox"/> These physicians/health care providers have joined our practice (please attach a copy of the W-9).	
Name: _____ Degree: _____ E-mail _____	
Practice address: _____	
Specialty: _____ Individual NPI: _____	
Effective Date: _____	
Name: _____ Degree: _____ E-mail _____	
Practice address: _____	
Specialty: _____ Individual NPI: _____	
Effective Date: _____	
Name: _____ Degree: _____ E-mail _____	
Practice address: _____	
Specialty: _____ Individual NPI: _____	
Effective Date: _____	
<input type="checkbox"/> Check this box if you do not have a private office and only see patients at the hospital	

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<b>Section V - Terminating a Practitioner</b>
<input type="checkbox"/> These physicians/health care providers have left our practice.
Name: _____ Degree: _____
Practice Address: _____
Specialty: _____ Individual NPI: _____
Effective Date: _____
Reason for Leaving: _____
Name: _____ Degree: _____
Practice Address: _____
Specialty: _____ Individual NPI: _____
Effective Date: _____
Reason for Leaving: _____
Name: _____ Degree: _____
Practice Address: _____
Specialty: _____ Individual NPI: _____
Effective Date: _____
Reason for Leaving: _____

Name of individual completing this form: \_\_\_\_\_

Signature \_\_\_\_\_ Date: \_\_\_\_\_

Telephone: \_\_\_\_\_ E-mail: \_\_\_\_\_

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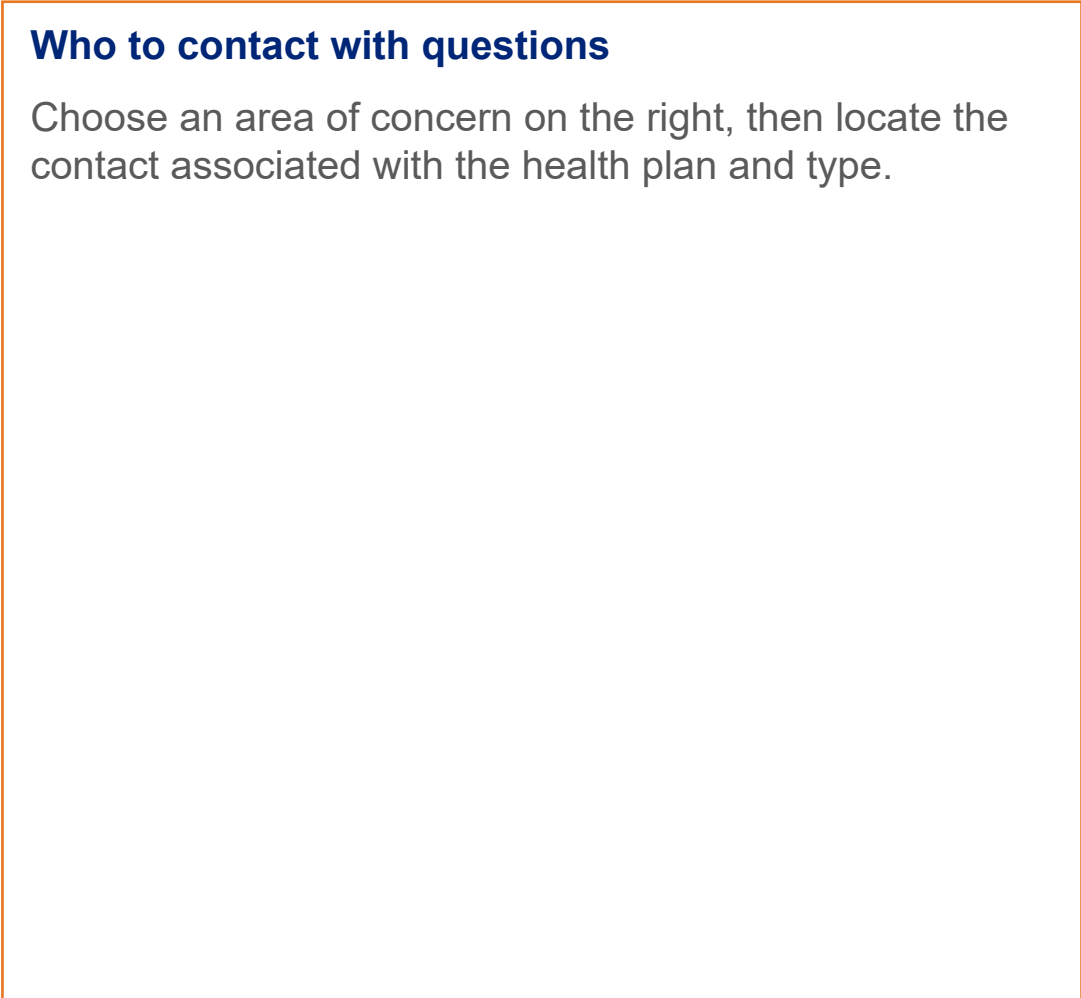
## Behavioral health: Plan resources

- UnitedHealthcare Medicare Advantage
  - **Website:** Enter patient zip code on Provider Listing Page > select *Medicare*
  - Behavioral Health Claims and Authorizations: **1-866-673-6315**
- Humana Medicare Advantage
  - Behavioral Health provider assistance: **1-866-900-5021**, 8 a.m.–6 p.m., ET
  - Patients may call the number on the back of their Humana member ID card
  - Behavioral Health Claims and Authorizations - OCN Utilization Management
- Premera Medicare Advantage
  - Find a Behavioral Health provider **online** or call the designated mental health phone number shown on the back of the member ID card
- UnitedHealthcare Medicaid
  - Behavioral Health Claims and Authorizations **1-800-711-4577**
- Coordinated Care
  - Behavioral Health provider assistance: **1-877-644-4613**



**Who to contact with questions**

Choose an area of concern on the right, then locate the contact associated with the health plan and type.



Locate the health plan and plan type on the right to determine who to contact.

## UHC

Medicare Advantage HMO & PPO	Contact UHC
Medicare Advantage DSNP*	
Medicaid	

## Humana

Medicare Advantage HMO & DSNP*	Contact Optum Care Network
Medicare Advantage PPO	Contact Humana

## Premera

Medicare Advantage PPO	Contact Premera
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## First Choice Health

Contact First Choice Health
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## Coordinated Care

Medicaid	Contact Coordinated Care
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**Behavioral Health**

Locate the health plan and plan type on the right to determine who to contact.

## UHC

Medicare Advantage HMO & PPO	Contact Optum Care Network
Medicare Advantage DSNP*	Contact UHC
Medicaid	Contact Optum Care Network

## Humana

Medicare Advantage HMO & DSNP*	Contact Optum Care Network
Medicare Advantage PPO	Contact Humana

## Premera

Medicare Advantage PPO	Contact Optum Care Network
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## First Choice Health

Contact First Choice Health
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## Coordinated Care

Medicaid	Contact Coordinated Care
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Claims

Locate the health plan and plan type on the right to determine who to contact.

## UHC

Medicare Advantage HMO & PPO	Contact Optum Care Network
Medicare Advantage DSNP*	Contact UHC
Medicaid	Contact Optum Care Network

## Humana

Medicare Advantage HMO & DSNP*	Contact Optum Care Network
Medicare Advantage PPO	

## Premera

Medicare Advantage PPO	Contact Optum Care Network
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## First Choice Health

Contact Optum Care Network
----------------------------

## Coordinated Care

Medicaid	Contact Optum Care Network
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Credentialing

Locate the health plan and plan type on the right to determine who to contact.

## UHC

Medicare Advantage HMO & PPO	Contact Optum Care Network
Medicare Advantage DSNP*	
Medicaid	

## Humana

Medicare Advantage HMO & DSNP*	Contact Optum Care Network
Medicare Advantage PPO	

## Premera

Medicare Advantage PPO	Contact Optum Care Network
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## First Choice Health

Contact First Choice Health
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## Coordinated Care

Medicaid	Contact Coordinated Care
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**Pop Health:**  
Quality & Risk Adj

Locate the health plan and plan type on the right to determine who to contact.

## UHC

Medicare Advantage HMO & PPO	Contact Optum Care Network
Medicare Advantage DSNP*	Contact UHC
Medicaid	Contact Optum Care Network

## Humana

Medicare Advantage HMO & DSNP*	Contact Optum Care Network
Medicare Advantage PPO	Contact Humana

## Premera

Medicare Advantage PPO	Contact Optum Care Network
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## First Choice Health

Contact First Choice Health
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## Coordinated Care

Medicaid	Contact Optum Care Network
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**Pop Health:  
Care Management**

Locate the health plan and plan type on the right to determine who to contact.

## UHC

Medicare Advantage HMO & PPO	Contact Optum Care Network
Medicare Advantage DSNP*	Contact UHC
Medicaid	Contact Optum Care Network

## Humana

Medicare Advantage HMO & DSNP*	Contact Optum Care Network
Medicare Advantage PPO	Contact Humana

## Premera

Medicare Advantage PPO	Contact Optum Care Network
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## First Choice Health

Contact First Choice Health
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## Coordinated Care

Medicaid	Contact Coordinated Care
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**Utilization  
Management**