Optum Care Network–New Mexico

Provider administrative manual

2021

Optum Care Network–New Mexico
303 Roma Ave. NW, Albuquerque, NM 87102

optumcare.com

Provider administrative manual

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Welcome to Optum Care Network–New Mexico

Welcome to Optum Care Network — New Mexico Provider Administrative Manual for AARP Medicare Advantage Plans. This manual has important information on topics such as claims, eligibility and prior authorization guidelines. This manual has useful contact information such as addresses, phone numbers and websites. There is more information located at our Optum Care Website: **optumcare.com**.

The purpose of this manual is to provide key information to our network providers and support you in delivering effective care for patients in accordance with Optum Care Network — New Mexico and industry standards. The vision of Optum Care is to meet individual patient's needs through a connected set of practices and services. We are passionate about assisting physicians in improving the quality, affordability and integration of care they provide. Our role is to support the provider-patient relationship by providing physicians with tools, information and expertise for your practice in the ever-changing health care environment.

Who is Optum Care? Optum Care Network–New Mexico is a patient-centric, physician-led, data-driven Independent Physician's Association. We offer a full range of services to assist physicians and other providers in their managed care and business operations. The network is a health care innovator, with an emphasis on quality, financial stability and extraordinary services. We are well positioned to continually invest in new infrastructure and systems for the benefit of our physicians, and to accommodate the impending changes of health care reform.

This manual is effective January 1, 2021 for all providers currently participating in the Medicare Advantage (MA) network. It is effective for all care providers who join our network on or after January 1st of 2021. This manual is subject to change. We frequently update content in our effort to support our health care providers.

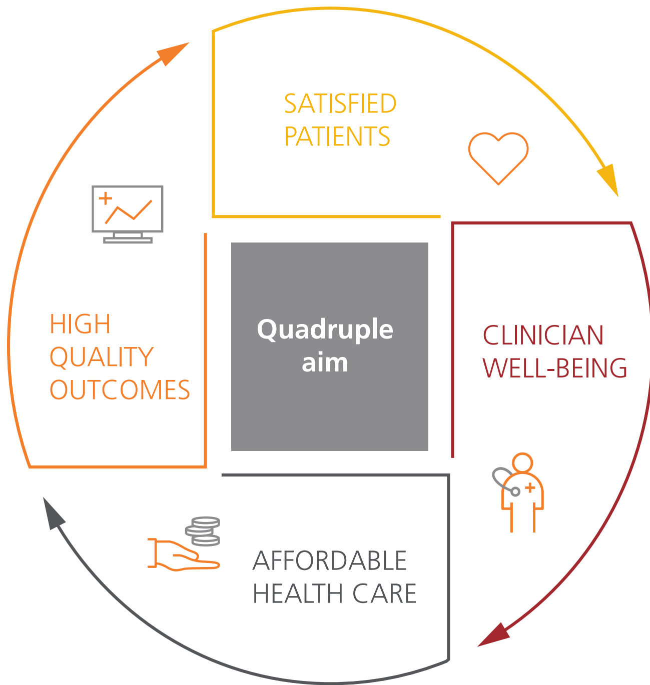
Terms and definitions used in this manual:

- "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. This 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 — NM 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 or digitalcard.

MA policies, protocols and information in this guide apply to covered services you provide to United Healthcare MA members, specifically, to AARP Medicare Advantage Products.

If there is an inconsistency between your agreement and this guide, your agreement controls (except where your agreement provides protocols for our affiliates). If those protocols are a supplement to this guide, those protocols control for services you give to a member submit to the supplement. Per your agreement, you must comply with protocols. Payment will be denied, in whole or in part, for failure to comply with protocols.

Strong values focused on Quadruple Aim



Integrity.
Honor commitments. Never compromise ethics.

Compassion.
Walk in the shoes of people we serve and those with whom we work.

Relationships.
Build trust through collaboration.

Innovation.
We pursue a course of continuous, postive and practical innovation.

Performance.
Demonstrate excellence in everything we do.

Transform health care alongside us

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Optum Care online resources and contact information

Optum Care Website: Our website provides contracted network providers, and patients with access to timely information, updates and resources. Access the secure Optum Care Website at: optumcare.com.

Network Contact Information: For contracting, credentialing and provider data questions please email NMOptumCareNetwork@optum.com.

Electronic Data Interchange (EDI) - EDI is a self-service resource using your internal practice management or hospital information system to exchange transactions with us through a clearinghouse.

The benefit of using EDI is it permits care providers to send batch transactions for multiple members and multiple payers in lieu of logging into different payer websites to manually request information.
Therefore, EDI is usually care providers' first choice for electronic transactions.

- Send and receive information faster
- Identify submission errors immediately and avoid processing delays
- Exchange information with multiple payers
- Reduce paper, postal costs and mail time
- Cut administrative expenses
- EDI transactions available to care providers claim (837)
- Eligibility and benefits (270/271)
- Claims status(276/277)
- Referrals and authorizations (278)
- Hospital admission notifications(278N)
- Electronic remittance advice(ERA/835)

Getting Started

- If you have a practice management or hospital information system, contact your software vendor for instructions on how to use EDI in your system.
- Contact clearinghouses to review which electronic transactions can interact with your software system.

Verify Member Eligibility

You may verify member eligibility at the time of service online, by phone or using electronic data interchange (EDI):
Online: Use the eligibility link via UHCprovider.com
  - You can also use the care provider web portal: optumcare.com.

- **By phone:** Call 1-877-842-3210
- **EDI:** Use transactions 270 (inquiry) and 271 (response) through your vendor or clearinghouse.

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Optum Care is delegated for claims and prior authorization:

- Online: Optum Care Portal-for faster service regarding claims or authorization inquiries, access the secure provider portal. Login at professionals.Optum Care.com/portal-login
- By phone: Optum Care Service Center: Services Advocates are available to answer questions, Monday–Saturday 8:00 a.m.–8:00 p.m.1-800-620-6768.

Prior authorization medical services (urgent and routine):

- Online: Submit request at: optumcare.com. Please include any clinical information associated with the requested service.
- By phone: Call 1-800-620-6768

Referral requests:

Submit referral requests online at: optumcare.com.

Hospital admission notification:

Please notify Optum Care Network of hospital admissions no later than one business day after admission by calling: 1-800-620- 6768 or submitting online at: optumcare.com.

Optum Care claims submission address:

- By mail: Optum Care Network Claims, P.O. Box 30539, Salt Lake City, UT 84130
- Electronically: Payer ID LIFE1 or use your clearinghouse's Optum Care Network payer ID

Claim disputes:

You may submit claim disputes:

- By phone: 1-800-620-6768
- By online: Download Provider Dispute Resolution Form from Optum Care Website: optumcare.com
- By mail: Optum Care Network Claims, P.O Box 30539, Salt Lake City, UT 84130
- By fax: 1-888-905-9495

Additional resources contact information

OPTUM Rx
Phone: 1-800-711-4555
Fax: 1-800-1527-0531

Mental health
Optum Behavioral Solutions 1-800-579-5222

Transplant services
Phone: 1-866-300-7736
Fax: 1-888-361-0502

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Provider responsibilities and requirements

Verifying eligibility, benefits and your network participation status

Check the member's eligibility and benefits prior to providing care. Doing this:

- Helps ensure that you submit the claim to the correct payer
- Allows you to collect co-payments
- Determines if a referral and prior authorization or notification is required
- Reduces denials for non-coverage

One of the primary reasons for claims rejection is incomplete or inaccurate eligibility information. There are three easy ways to verify eligibility and benefits as shown in the Optum Care Online Resources and Contact Information

EDI: Eligibility and benefit inquiry (270) and response (271)

The EDI 270/271 transaction allows you to obtain members' eligibility and benefit information in "real-time." The HIPAA ANSI X12 270/271 format is the only acceptable format for this EDI transaction. Enhancements to these transactions are made periodically and are in the helpful resources section of the 270/271 page.

Understanding your network participation status

Your network status is not returned on 270/271 transactions. Know your status prior to submitting 270/271 transactions. As our product portfolio evolves and new products are introduced, it is important for you to confirm your network status. If you are not participating in the member's benefit plan or are outside the network service area for the benefit plan, the member may have a higher cost or no coverage.

Patient enrollment and assignment

To utilize services from Optum Care contracted physician and ancillary network, individual patients can purchase health care coverage from any of our contracted health plans or government payers, and select a network contracted primary care physician (PCP). Within the network, patients choose their PCP; if a patient does not select a PCP, the health plan will select on their behalf. (Our Service Center is available to assist patients in selecting providers if they need help.)

The Primary Care Provider Change Form is located on the Optum Care Website at: optumcare.com.

Optum Care policy is that changes made prior to the 20th of the month will show up on the 1st of the next month. If it is after the 20th it will not show up until the 1st of the following month. Example: Member changes 1/23/18 will show on 3/1/18 eligibility file.

Optum Care Service Centers: 1-800-620-6768. Advocates are available to answer questions Monday–Saturday, 8 a.m.–8 p.m.

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Member dismissals initiated by a PCP (Medicare Advantage)

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

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

Each dismissal should be carefully considered based on the facts and circumstances specific to the member. In addition, PCPs who wish to terminate their relationship with a Medicare Advantage (MA) member (dismiss) and have a member reassigned must:

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

Required information from the PCP

For member reassignment, we require information from the PCP:

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

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

Medicare opt-out

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

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Additional Medicare Advantage requirements

As an MA organization, Optum Care–NM 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. For additional information, refer to the AARP Medicare Advantage Coverage Summary for Preventive Health Services and Procedures.
- 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 members have adequate access to covered health services.
- You must make sure your hours of operation are convenient to members.
- You must make sure medically necessary services are available to members 24 hours a day, seven days a week.
- Primary care providers must have backups for absences.
- You must adhere to CMS marketing regulations and guidelines. This includes, but is not limited to, the requirements to remain neutral and objective when assisting with enrollment decisions, which should always result in a plan selection in the Medicare beneficiary's best interest. CMS marketing guidance also requires that providers must not make phone calls or direct, urge, or attempt to persuade Medicare beneficiaries to enroll or dis-enroll in a specific plan based on the care provider's financial or any other interest. You may only make available or distribute benefit plan marketing materials to members in accordance with CMS requirements.
- You must provide services to members in a culturally competent manner considering limited English proficiency or reading skills, hearing or vision impairment, and diverse cultural and ethnic backgrounds.
- You must cooperate with our procedures to tell members of health care needs that require follow-up and provide necessary training to members in self-care.
- You must document in a prominent part of the member's medical record whether they have executed an advance directive.
- You must provide covered health services in a manner consistent with professionally recognized standards of health care.
- You must make sure any payment and incentive arrangements with subcontractors 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, and the Anti-Kickback Statute; and (b) HIPAA administrative simplification rules at 45 CFR Parts 160, 162 and164.

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Additional MA requirements continued:

- The payments you receive from us or on behalf of us are, in whole or in part, from federal funds and you are therefore subject to certain laws applicable to individuals and entities receiving federal funds.
- You must cooperate with our processes to disclose to CMS all information necessary for CMS to administer and evaluate the MA program and disclose all information determined by CMS to be necessary to assist members in making an informed choice about Medicare coverage.
- You must comply with our processes for notifying members of your agreement terminations.
- You must submit all risk adjustment data (see definition in glossary), and other MA program-related information we may request, within the time frames specified and in a form that meets MA program requirements. By submitting data to us, you represent to us, and upon our request you shall certify in writing, that the data is accurate, complete, and truthful, based on your best knowledge, information and belief.
- You must comply with our MA medical policies, policy guidelines, coverage summaries, quality improvement programs, and medical management procedures.
- You must cooperate with us in fulfilling our responsibility to disclose to CMS quality, performance, and other indicators as specified by CMS.
- You must cooperate with our procedures for handling grievances, appeals and expedited appeals. This includes, but is not limited to, providing requested medical records within two hours for expedited appeals and 24 hours for standard appeals, including weekends and holidays.
- You must comply with the MA provider group obligations in your provider agreement.

Member communication (CMS approval required)

Member communications require CMS approval. This includes:

- Anything with the MA and/or the AARP name or logo
- Correspondence that describes benefits
- Marketing activities

Approval is not necessary for communications 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

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Health plan information and identification ID cards

Our members receive health care ID cards that include information necessary for you to submit claims, such as the payer ID for electronic claims submission. Information on the cards may vary by health benefit plan. Please check the member's health care ID card at each visit. You may keep a copy of both sides of the health care ID card for your records.
Possession of a health care ID card is not proof of eligibility.

You may verify member eligibility at the time of service online, by phone or using electronic data interchange (EDI):

- **Online:** Use the eligibilityLink viaUHCprovider.com
- **By phone:** Call 1-877-842-3210
- **EDI:** Use transactions 270 (inquiry) and 271 (response) through your vendor or clearinghouse.

Optum Care Network–New Mexico proudly accepts the following health plans to manage all administrative services. Administrative services include:

- Member eligibility verification
- Referral requests
- Prior authorization requests
- Hospital admission notifications
- Claims submission
- Claims disputes

These plans and counties will be **INCLUDED** in these administrative processes:

Plan Identifier	Plan Name	County
H6526-001	AARP Medicare Advantage (HMO)	Bernalillo, Sandoval, Valencia
H6526-002	AARP Medicare Advantage (HMO	Santa Fe
H2228-047	AARP Medicare Advantage Choice (PPO)	Bernalillo, Sandoval, Valencia Torrance
H2228-049	AARP Medicare Advantage Choice (PPO)	Mora, Rio Arriba, San Miguel Santa Fe
H2228-098	AARP Medicare Advantage Choice (PPO)	Bernalillo, Mora, Rio Arriba San Miguel, Sandoval, Santa Fe, Torrance, Valencia

There will be **NO CHANGE** to the administrative services for the members of these plans:

Plan Identifier	Plan Name	County
H0271-010	United Healthcare Medicare Advantage Assure (PPO)	Bernalillo, Sandoval, Valencia Santa Fe
H0271-001	United Healthcare Medicare Advantage Assure (PPO)	Dona Ana, Grant, Hidalgo Luna, Sierra
H2001-822	United Healthcare Group Medicare Advantage (PPO)	All
H2001-825	United HealthcareGroup Medicare Advantage (PPO)	All
H2001-826	United HealthcareGroup Medicare Advantage (PPO)	All
H2228-0213	AARP Medicare Advantage Choice (PPO)	Dona Ana, Grant, Hidalgo Luna, Sierra

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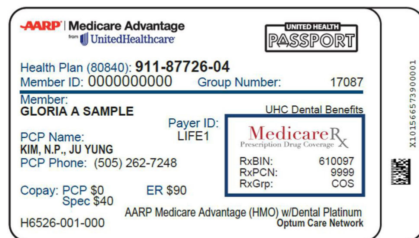
Health plan ID cards

Medicare Advantage (MA) health care ID card

Front



Back

MA ID card legend:

1. **Payer ID:** Indicates claim can be submitted electronically using the number shown on card. Contact your vendor or clearinghouse to set up payer in your system, if necessary.
2. **Dental benefits:** Included if routine dental benefits are part of the benefit plan and/or if the member purchased an optional supplemental dental benefit rider.
3. **PCP name and phone number:** Included for benefit plans that require a PCP selection.
4. **Prescription information:** If the benefit plan includes Part D prescription drug coverage, the Rx Bin, PCN and Group code are visible. If Part D coverage is not included, this area lists information for Medicare Part B drugs.
5. **Copay information including PCP, specialist and ER copays:** Some special needs plans do not list copay information. One PPO plan in New York has two co-payments for PCPs and for specialists. Select Erickson plans have two copayments for PCPs.
6. **Referral requirements identifier:** Identifies benefit plans with referral requirements. Refer to the Medicare Advantage (MA) Referral Required Plans of this guide for more detailed information. If the benefit plan does not require referrals “No referral required” appears on the back of member’s health care ID card.
7. **The benefit plan name:** Identifies the applicable Medicare Advantage benefit plan name.
8. **Plan ID number:** Identifies the plan ID number that corresponds to CMS filings
9. **For members:** Lists benefit plan contact information for themember.
10. **For providers:** Lists benefit plan contact information for the care provider.

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Network participating care provider responsibilities

Primary Care Physicians (PCP)

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

Civil rights

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
- Ethnicity
- National origin
- Religion
- Sex
- Age
- Mental or physical disability or medical condition
- Sexual orientation
- Claims experience
- Medical history
- Genetic information
- Type of paymeny

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

Americans with Disabilities Act (ADA) guidelines

Participating care providers must have practice policies showing they accept any patient in need of the health care they provide. The organization and its care providers must make public declarations (i.e., through posters or mission statements) of their commitment to non-discriminatory behavior in conducting business with all members. These documents should explain that this expectation applies to all personnel, clinical and non-clinical, in their dealings with each member. In this regard, you must undertake new construction and renovations, as well as barrier reductions required to achieve program accessibility, following the established accessibility standards of the ADA guidelines. For complete details go to ADA.gov > Featured Topics > A Guide to Disability Rights Laws. We may request any of the following ADA-related descriptions of:

- Accessibility to your office or facility
- The methods you or your staff use to communicate with members who have visual or hearing impairments
- The training your staff receives to learn and implement these guidelines

Cooperation with quality improvement and patient safety activities

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

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

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Demographic changes

Notice requirements

Notify us, at the address in your agreement within three 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 physicians, 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 physician/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 of 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)
- Email address(es)
- Care provider groups affiliation
- Facility affiliation
- Specialty
- License(s)
- Tax identification number
- NPI(s)
- 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 Optum Care Network — New Mexico roster, which can be provided or for any questions email OptumNMContracting@optum.com.

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

To submit the change, please complete and email the physician and provider update forms to the appropriate email address listed on the form. The forms are located in the Optum Care Website: optumcare.com.

Forms available are: Physician and provider change form or provider roster template. For any questions, please email NMOptumCareNetwork@optum.com.

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Optum Care Website

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

Patient website:

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

- FAQs to address the most common questions from existing and potential patients
- A provider lookup tool that allows patients to find primary care physicians, specialists and facilities in Optum Care
- A page where potential patients can request more information by mail or email
- Information about prior authorizations, urgent care locations, skilled nursing facilities and more
- Health related news and articles on topics such as diabetes, cancer screenings and cardiovascular disease

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

Provider website:

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

- Prior authorization forms and electronic processing
- Home health and care coordination order forms
- Referral reference guides for various specialties, including locations for cardiac services, nephrology, and Skilled Nursing Facilities (SNF)
- User guide for creating an account for the Optum Care Provider Portal
- Coding tips and tools

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Optum Care Provider Portal

About the provider portal

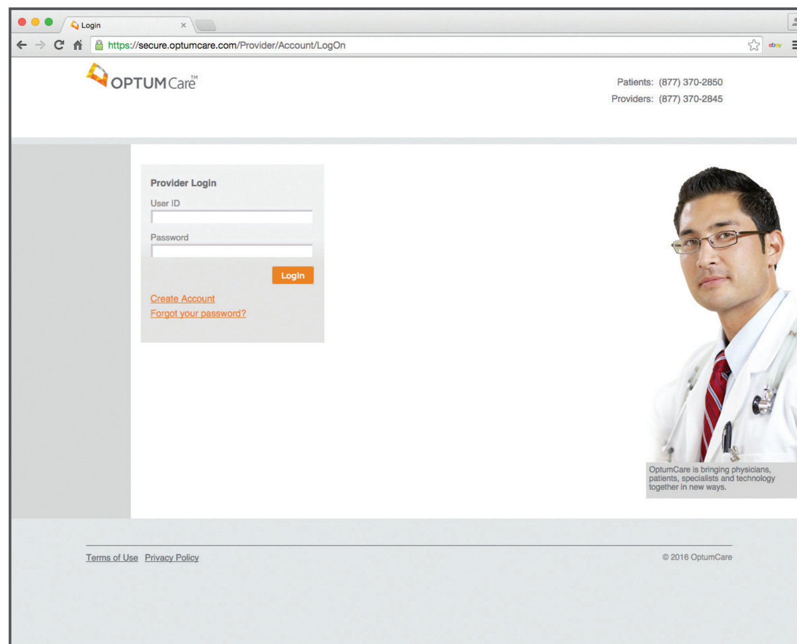
The Optum Care Provider Portal is designed specifically for our contracted providers. It offers provider offices access to key patient authorization and claims information online, along with other value-added services. The provider portal can be a great tool to help eliminate lengthy phone calls and faxes. It can also be of assistance if you are doing paperwork before or after normal business hours.

Using the provider portal, provider's staff can:

- Verify patient eligibility
- Search prior authorizations and claims
- Send secure emails to our service center, utilization management, eligibility and claims staff
- Search for contracted providers to refer patients for services
- Submit requests for prior authorization
- Submit notification of patient hospitalization
- Select data by TIN for multi-TIN providers
- Obtain reports and helpful forms
- Update your account profile and reset your passwords

How to get access:

To gain access to the provider portal, visit: **professionals.optumcare.com/portal-login.**
If your office does not currently have portal access, you will need to designate an account administrator and have them create a new account. The account administrator will be responsible for creating and editing user profiles for your providers, as well as resetting passwords and editing accounts. Once the designated account administrator fills out and submits the registration form found under the "create account" link, your account information will be delivered via email in about two business days.



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Optum Care Customer Service

By phone:

The phone number for provider inquiries to contact Optum Care Customer Services is **1-800-620-6768**. Service advocates are available to answer questions Monday–Friday 8 a.m.–8 p.m.

Online:

For faster service regarding claims or authorization inquiries, access the secure Optum Care Provider Portal at: **professionals.optumcare.com/portal-login**

Experience the benefits of online access:

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

Secure email:

Service advocates can also be reached by secure email through the Optum Care Provider Portal at **professionals.optumcare.com/portal-login.**

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

Language and hearing-impaired assistance

Optum Care wants to make sure that all patients get their questions answered on topics like benefits claims and prior authorization. For those who 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 who are hearing impaired. Let your patients know that assistance is available by using their text telephone (TTY) or by dialing 711 from any telephone.

For more information call Optum Care at **1-800-620-6768**. The TTY/711 and language lines are open 24 hours a day, 7 days a week. The service center is available Monday–Saturday 8 a.m.–8 p.m.

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Eligibility and claims processing

Eligibility:

The eligibility department receives patient information from the health plans on a daily basis.
Once this information has been received, it is loaded electronically into the system. This information is reviewed by the eligibility department staff to ensure that the eligibility data matches the information submitted by the health plans. Information is being constantly updated and revised as it is provided to Optum Care by the health plans.

Claims processing:

ATTENTION: Office managers and billing managers
Provided in the following sections is key information for claim submission and re-submission to initiate claims prompt payment.

Prompt claims processing

We know that you want prompt payment. We work hard to process your claims timely and accurately. This is what you can do to help us:

1. Submit the claim to the correct payer by reviewing the member's eligibility as outlined in: Verifying Eligibility, Benefits, and Your Network Participation Status. Note: When we give you eligibility and benefit information, we are not guaranteeing payment or coverage in any specific amount. Actual reimbursement depends on many factors, such as compliance with administrative protocols, date(s) of services rendered, and benefit plan terms and conditions. For Medicare Advantage (MA) benefit plans, reimbursement also depends on CMS guidance and claims processing requirements.
2. Follow the instructions in the: How to Submit Advance or Admission Notifications/Prior Authorizations section.
3. Prepare complete and accurate claims.
4. Submit claims electronically for fast delivery and confirmation of receipt.
   a. Electronic submissions are preferred for sending claims to Optum Care Network–New Mexico. Payer ID is **LIFE1**.
   b. Our contracts generally require you to conduct business with us electronically. They contain specific requirements for electronic claim submission. Please review your agreement and follow the requirements. While some claims may require supporting information for initial review, we have reduced the need for paper attachments. We request additional information when needed.
   c. Check the status of a claim using EDI 276/277 claim status inquiry and response transactions. Contact your vendor or clearinghouse if these transactions are not available or activated in your system.

HIPAA claim edits and smart edits

When claims are submitted using EDI, HIPAA edits are applied by the clearinghouse to help ensure claims contain specific information. Any claims not meeting requirements are rejected and returned back to the care provider to make corrections and resubmit electronically. Smart edits are an EDI capability which auto-detects claims with potential errors. Smart edits may also be applied to help reduce claim denials and improve the claim processing time. You'll have five calendar days to correct claims that reject due to smart edits before they are automatically processed.

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Electronic Data Interchange (EDI)

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

Payer ID: LIFE1

Benefits of EDI:

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

EDI Format:

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

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Claims and encounter data submissions

Optum Care Claims Submission Address:

P.O. Box 30539, Salt Lake City, UT 84130
Optum Care Service Centers: Phone: **1-800-620-6768.** Advocates are available to answer questions Monday–Saturday, 8 a.m.–8 p.m. – Note: We are open 8 a.m.–8 p.m. in every time zone.

You must submit a claim and/or encounter for your services, regardless of whether you have collected the co-payment, deductible or coinsurance from the member. If you have questions about submitting claims to us, please call us at the phone number listed on the member's health care ID card. It is important to accurately code the claim because a member's level of coverage under their benefit plan may vary for different services.

Complete claims by including the information listed under the requirements for complete claims and encounter data submission section. We prefer to receive claims electronically, but we do accept claims submitted on paper. Send the completed and appropriate forms to the claims address listed on the back of the member's health care ID card.

If we receive a claim electronically with missing information or invalid codes, we may reject the claim, not process it or, if applicable, not submit it to CMS for consideration in the risk adjustment calculation. If we receive a similar claim using the paper form, we may pend it to get the correct information. We may also require additional information for particular types of services or based on particular circumstances or state requirements.

Requirements for complete claims and encounter data submission

We may pend or deny your claim if you do not list:

- Member's name, address, gender, date of birth, relationship to subscriber (policyowner).
- Subscriber's name (enter exactly as it appears on the member's health care ID card), ID number, employer group name and employer group number.
- Rendering care provider's name, signature or representative's signature, address where service was rendered, "remit to" address, phone number, NPI, taxonomy and federal TIN.
- Referring care provider's name and NPI (for Medicare Advantage), as well as TIN (if applicable).
- Complete service information, including date of service(s), place of service(s), number of services (day/units) rendered, current CPT and HCPCS procedure codes, with modifiers where appropriate, current ICD-10-CM diagnostic codes by specific service code to the highest level of specificity. It is essential to communicate the primary diagnosis for the service performed, especially if more than one diagnosis is related to a line item.
- Charge per service and total charges.
- Itemized bill – There may be times when we request an itemized bill to help adjudicate the claim. In an effort to avoid unnecessary delays, please submit itemized bills upon request.
- Detailed information about other insurance coverage.
- Information regarding job-related, auto or accident information, if available.
- Retail purchase cost (or a total retail rental cost) greater than $1,000 for DME.
- Current National Drug Code (NDC) 11-digit number, NDC unit of measure (F2, GR, ML, UN, ME) and NDC units dispensed (must be greater than 0) for all claims submitted with drug codes. Enter the NDC information for the drug(s) administered in the 24D field of the CMS-1500 Form, field 43 of the UB-04 form, or the LIN03 and CTP04-05 segments of the HIPAA 837 professional or institutional electronic form.
- Method of administration (self or assisted) for hemophilia claims – note the method of administration and submit with the claim form with applicable J-CODES and hemophilia factor, to enable accurate reimbursement. Method of administration is either noted as self or assisted.

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Submission of unlisted medical or surgical codes

Include a detailed description of the procedure or service for claims submitted with:

- Unlisted medical/surgical CPT
- "Other" revenue codes
- Experimental services
- Reconstructive services

Additional information needed for a complete UB-04/CMS-1450 form:

- Your claim may be pended or not processed if you do not include:
- Date and hour of admission
- Date and hour of discharge
- Member status-at-discharge code
- Type of bill code (three digits)
- Type of admission (e.g., emergency, urgent, elective,newborn)
- Current four-digit revenue code(s)
- Attending physician ID
- For outpatient services/procedures, the specific CPT or HCPCS codes, line item date of service, and appropriate revenue code(s) (e.g., laboratory, radiology, diagnostic or therapeutic)
- Complete box 45 for physical, occupational or speech therapy services (revenue codes 0420-0449)
- Submit claims according to any special billing instructions that are in your agreement
- On an inpatient hospital bill type of 11x, use the actual time the member was admitted to inpatient status
- If charges are rolled to the first surgery revenue code line on hospital outpatient surgery claims, report a nominal monetary amount ($1 or $100) on all other surgical revenue code lines to assure appropriate adjudication
- Include the condition code designated by the National Uniform Billing Committee (NUBC) on claims for outpatient pre-admission non-diagnostic services that occur within three calendar days of an inpatient admission and are not related to theadmission

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Medicare Advantage claim processing requirements

Section 1833 of the Social Security Act prohibits payments to any care provider unless there is sufficient information to determine the "amounts due to such provider." We apply various claims processing edits based on:

- National and local coverage determinations
- The Medicare Claims Processing Guide
- National Correct Coding Initiative (NCCI)
- Other applicable guidance from CMS, including but not limited to, the Official ICD-10-CM Guidelines for Coding and Reporting

These edits provide us with information to determine:

- The correct amount to pay
- If you are authorized to perform the service
- If you are eligible to receive payment
- If the service is covered, correctly coded, and correctly billed to be eligible for reimbursement
- If the service is provided to an eligible beneficiary, and
- If the service was provided in accordance with CMS guidance

Care providers in our MA network must follow CMS guidance regarding billing, coding, claims submission, and reimbursement. For example, you must report serious adverse events by having the Present on Admission (POA) indicator on all acute care inpatient hospital claims and ambulatory surgery center outpatient claims. If you do not report the "never event," we try to determine if any charges filed with us meet the criteria as a serious reportable adverse event. If you do not follow these requirements, we will deny the claim. You cannot bill the member.

There may be situations when we implement edits and CMS has not issued any specific coding rules. In these cases, we review the available rules in the Medicare Coverage Center. We find those coding edits that most align with the applicable coverage rules. Due to CMS requirements, you are required to use the 837 version 5010 formats. We reject incomplete submissions.

Hospice – MA

When an MA member elects hospice, bill claims for:

- Hospice-related services to CMS
- Services covered under Medicare Part A and B (unrelated to the terminal illness) to the Medicare administrative contractor

We are not financially responsible for these claims. We may be financially responsible for additional or optional supplemental benefits under the MA member's benefit plan such as eyeglasses and hearing aids. Medicare does not cover additional and optional supplemental benefits.

Medicare Crossover

Medicare Crossover is the process by which Medicare, as the primary payer, automatically forwards Medicare Part A (hospital) and Part B (medical) claims to a secondary payer. Medicare Crossover is a standard offering for most Medicare-eligible members covered under our commercial benefit plans. Enrollment is automatic for these members.

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Provider Remittance Advice (PRA)

Information is listed on the PRA in addition to the amount paid. See the end of this section for a detailed explanation of each claim. Denied claims are listed on the PRA with a detailed denial reason or reasons; these are helpful to refer to when submitting a provider dispute, correcting a claim or contacting the service center with questions regarding a claim.

Electronic Funds Transfer (EFT)

Optum Care offers electronic funds transfer (EFT) and electronic remittance advance (ERA) through ePayment with our preferred vendor, InstaMed. ERA/EFT is a convenient, paperless and secure way to receive claim payments. Funds are deposited directly into your designated bank account and include the re-association trace number, in accordance with CAQH CORE Phase III Operating Rules for HIPAA standard transactions.

To register for InstaMed payer payments, please visit: instamed.com

Overpayments

If we inform you of an overpaid claim that you do not disagree with, send us the refund check or recoupment request within 30 calendar days (or as required by law or your agreement), from the date of notification. We may apply the overpayment against future claim payments unless your agreement states otherwise or as required by law. If you find we overpaid for a claim, please call:

Optum Care Customer Service
1-800-620-6768

Send refunds to:

Optum Care Network–New Mexico
P.O. Box 30539
Salt Lake City, UT 84130

Please include documentation that shows the overpayment, including member's name, healthcare ID number, date of service and amount paid. If possible, also include a copy of the provider remittance advice (PRA) that corresponds with our payment. If the refund is owed because of COB with another carrier, provide a copy of the other carrier's EOB/remittance advice with the refund. If we find a claim was paid incorrectly, we may make a claim adjustment. You will see the adjustment on the EOB or PRA.

Disagreement

If you disagree with the claim adjustment, or request for an overpayment refund or recoupment, you may submit your disagreement within 30 calendar days (or as required by law or your agreement) from the date of receipt of notification. You must clearly state the items in your disagreement and include any relevant and supporting documentation.

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Subrogation and coordination of benefits

Our benefit plans are subject to subrogation and coordination of benefits rules.

- **Subrogation** — We have the right to recover benefits paid for a member's health care services when a third party causes the member's injury or illness to the extent permitted under state and federal law and the member's benefit plan.
- **Coordination of Benefits (COB)** — COB is administered according to the member's benefit plan and in accordance with law.
- **Workers' Compensation** — In cases where an illness or injury is employment-related, workers' compensation is primary. If you receive notification that the workers' compensation carrier has denied a claim for services, submit the claim to us. It is also helpful to send us the workers' compensation denial statement with the claim.
- **Medicare** — If the care provider accepts Medicare assignment, all COB types coordinate up to Medicare's allowed amount. Medicare Secondary Payer (MSP) rules dictate when Medicare pays secondary.

Other coverage is primary over Medicare in the following instances:

- Aged employees: For members who are entitled to Medicare due to age, commercial is primary over Medicare if the employer group has 20 or more employees.
- Disabled employees (large group health plan): For members who are entitled to Medicare due to disability, commercial is primary to Medicare if the employer group has 100 or more employees.

End-Stage Renal Disease (ESRD)

If a member has or develops ESRD while covered under an employer's group benefit plan, the member must use the benefits of the employer's group plan for the first 30 months after becoming eligible for Medicare. After the 30 months, Medicare is the primary payer. However, if the employer group benefit plan coverage was secondary to Medicare when the member developed ESRD, Medicare is the primary payer and there is no 30-month period.

Coordination of benefits (COB) when Optum Care is not the primary payer

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

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Continuation of benefits — Consolidated Omnibus Budget Reconciliation Act (COBRA) COBRA provides continued group health benefits to workers and families who lost coverage. COBRA generally requires group health plans with employers who have 20 or more employees, in the prior year, to offer continuation of coverage in certain instances where coverage would end. This coverage is available at the group premium rates. Coverage benefits and limitations for COBRA members are the same to those of the group.

- We are not responsible for initiating a terminated member's election of continuation coverage.
- Interested members should contact the subscriber's human resources office for eligibility information.
- Members eligible for COBRA may elect to convert to an individual health plan, where available.

Coverage begins on the date that coverage would otherwise have been lost and ends at the end of the maximum period. It may end earlier if:

- Premiums are not paid
- The employer ceases to maintain any group health plan
- After the COBRA election, the member obtained coverage with another employer-group health plan that does not contain any exclusion or limitation with respect to any pre-existing condition of such beneficiary. However, if the member obtains other group health coverage prior to electing COBRA, COBRA coverage may not be discontinued, even if the other coverage continues after the COBRA election
- If a beneficiary becomes entitled to Medicare benefits after electing COBRA. However, if Medicare is obtained prior to COBRA election, COBRA coverage may not be discontinued, even if the other coverage continues after the COBRA election

COBRA specifies certain periods of time that continued health coverage must be offered. It does not prevent plans from offering more health coverage beyond the COBRA period.

Note: In some cases, there may be an extensive period where a continuing member does not appear on the eligibility list. If this occurs, contact your network care provider account manager or provider advocate for assistance.

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Timely filing requirements

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.

You are required to submit to clean claims for reimbursement no later than **90 days** from the date of service. 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.

Please see provider dispute section of this manual for the necessary supporting documentation needed for proof of timely filing when filing a dispute.

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Provider dispute resolution process

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

Definition of a provider dispute

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

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

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

If the provider's 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 claims number and the date of service
- Clear explanation of the issue
- Provider's explanation why the action taken is incorrect

If the provider's dispute is not claim related, a clear explanation of the issue and the provider's position on the issue

If the provider's dispute involves an Optum Care member, the following must be provided:

- Member's name and identification number
- A clear explanation of the disputed item such as claim and/or date of service
- Provider's position of the dispute

Sending a provider dispute to Optum Care

Contracted providers must use the provider dispute resolution form which can be downloaded from the Optum Care Website: **optumcare.com**. The provider dispute resolution form must be completed in full and included with the dispute.

All provider dispute resolution forms can be sent:

- **By mail:** Optum Care Provider Dispute Resolution P.O. Box 30539 Salt Lake City, UT 84130
- **By fax:** 1-888-905-9495
- **By email: claimsdispute@optum.com**

Time period of submission of provider disputes

Contracted providers disputes must be received by Optum Care within 365 calendar days from the action of Optum Care such as the initial date of the remittance explanation of payment. Any inquiries regarding status of provider dispute or about filing a provider dispute, please call Provider Dispute Resolution Unit at **1-800-620-6768.**

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Credentialing and re-credentialing

The credentialing department handles provider credentialing/re-credentialing for the Optum Care. The credentialing and re-credentialing verification is performed by the credentialing department. For credentialing questions, email NMOptumCareNetwork@optum.com.

Initial credentialing:

The initial credentialing process takes approximately 30–45 business days to complete, from receipt of completed credentialing application to committee approval. Once received, the credentialing process will begin. The credentialing time frame is directly dependent upon receiving verifications from the primary source verification sources in a timely manner. If receipt of those verifications is delayed in any way, it will hold up completion of the process. If the packet is not complete (e.g., required documents are not attached, fields on application not filled in, etc.), this will also delay the processing of the application. The credentialing department has a streamlined verification process that enables short turn-around-times. An overview of the initial credentialing process is on the following page.

Re-credentialing:

Re-credentialing occurs every three years. Eight months prior to the three-year credentialing anniversary the provider will receive a request to log into CAQH, a universal provider data source, and complete the online application or if provider has already done so, then verify that the attestation is current and up to date. CAQH requires that the re-attestation process be completed every 120 days. The CAQH website is: proview.caqh.org. If you need your CAQH provider ID number or assistance with the re-attestation process, please contact the credentialing department or CAQH provider help desk at 1-888-599-1771.
Providers shall promptly notify Optum Care and credentialing department if they no longer meet the group's credentialing criteria (e.g. medical license revoked, opt-out of Medicare).

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

Optum Care has a form that can be used to report demographic changes, or update NPI information for your practice. If you are adding a provider, changing address, or deleting a provider who may have left your group, please fill out the form and submit it to: NMOptumCareNetwork@optum.com.

The physician/provider update form can be found at the Optum Care website: optumcare.com.

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Health improvement

General information

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 ofcoverage 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, Milliman Care Guidelines, and Hayes criteria). The criteria are applied in a flexible manner based on currently accepted medical or health care practices, consideration of patients with specialized needs (including, but not limited to, patients with disabilities), acute conditions or life-threatening illness and an assessment of the local delivery system.

Upon request from a patient, a patient's representative, the general public, or a physician, the relevant criteria used to support the UM decision-making process may be released. Patients are instructed in their adverse determination letters that they may call the UM department to make a criteria request.

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

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Quality improvement

Introduction to Quality Improvement Medical Management Committee (QIMMC)

QIMMC Purpose

Optum Quality Improvement Medical Management Committee (QIMMC) is established to provide the structure and key processes that enable the organization to carry out its commitment to the ongoing improvement of care and services, the assurance of member safety, and the enrichment of its members' health. The QIMMC is an evolving structure that is responsive to the changing needs of the health plan(s), its customers, and the standards established by the medical community, regulatory agencies, and accrediting bodies.

The policy is reviewed and updated to reflect any changes and is then approved by the Quality Improvement Medical Management Committee (QIMMC). The goals are based on improving member health, satisfaction, as well as operational and financial performance. Related objectives and goals are developed to reflect the organizational priorities.

Optum is guided by clear and concise documented policies and procedure to guide and/or assist their providers and teammates in determining present and future decisions within the framework of the organization's objectives, goals, and management philosophies.

Quality Improvement Medical Management Committee (QIMMC)

The QIMMC ensures that Optum activities comply with all state, federal, regulatory, and accreditation standards. The QIMMC reports an annual QIMMC policy and evaluation to senior leadership.

The QIMMC is responsible for the implementation and ongoing monitoring of the QI program. The QIMMC makes policy decisions, analyzes and evaluates the program, results and outcomes of UM/CCM/PHM QI activities, and institutes any needed actions and follow-up. The QIMMC advises and directs the committee on the focus and implementation of the QI program. The QIMMC reviews data from the QI activities to ensure that the performance meets standards and makes recommendations for improvements to be carried out by its sub-committees or by specific departments.

The care management medical director is the chair of the QIMMC, and membership may include:

- Director of care management
- Medical director, quality improvement
- Chief medical officer
- Medical director, surgical and medical specialties
- Director of network management
- Manager, quality improvement
- Manager, utilization management
- Manager, case management
- Quality improvement staff
- Participating network physician(s)
- Manager, risk management

The care management medical director reports to the Optum chief medical officer.

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QIMMC roles and responsibility

Maintains minutes of meetings that reflect the participation of members and decisions made. Minutes are reviewed and signed by the medical director, medical management.

Utilization Management (UM)

- Development and maintenance of the UM program description, UM policies and procedures, annual UM work plan and program evaluation in compliance with health plan, accrediting and regulatory standards
- Monitoring appropriate resource use data, coordination and continuity of care and designing and implementing interventions to improve performance
- Review and adoption of clinical practice guidelines (chronic, preventive) and implementing interventions to improve performance
- Documentation and communication to the QIMMC regarding any and all potential quality of care, risk management, and member safety issues identified during UM review
- Implementing and/or referring to case and disease management programs
- Assessment of member and clinician experience with UM processes

Complex case management (CCM) and population health/disease management (PHM/DM)

- Development and maintenance of the PHM/DM and CCM program description, policies and procedures, annual PHM/DM and CCM work plan and program evaluation in compliance with health plan, accrediting and regulatory standards
- Operationalizes the PHM/DM, CCM program based upon the needs of the member population
- Ensures the performance of PHM/DM and CCM activities in a manner consistent with the maintenance of high standards of quality care and in accordance with applicable regulatory entities
- Reviews, analyzes and recommends action as necessary on PHM/DM and CCM related statistical reports

Terms of membership

Determined by the medical director, medical management and by the executive leadership team. Membership is reviewed annually.

QIMMC objectives

Objectives are developed and established annually with consideration given to:

- Important aspects of care and service provided by Optum
- Objectives identified from ongoing and annual evaluation
- Changes in policy or procedure
- Changes in member demographics and population characteristics
- Recommendations made by health plans, Optum, CMS, practitioners, practitioner groups, members and accrediting bodies
- Contractually mandated improvement activities
- National, state, and local public health goals
- Delegated activities and delegates' performance
- Member and provider satisfaction data
- Serving culturally and linguistically diverse membership
- Serving members with complex health needs

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QIMMC goals

In addition to the QIMMC objectives, Optum has defined the following goals for the QIMMC:

- Design and maintain programs that improve the care and service outcomes within identified member populations, ensuring relevancy through understanding of the contracted health plan demographics and the Optum population assessment
- Define, demonstrate, and communicate the organization-wide commitment to and involvement in, achieving improvement in the quality of care, member safety and service
- Improve the quality, appropriateness, availability, accessibility, coordination, and continuity of the health care and service provided to members
- Through ongoing and systematic monitoring, interventions and evaluation improve the Optum quality structure, process, and outcomes
- Use a multidisciplinary committee structure to facilitate the achievement of quality improvement goals
- To ensure an annual evaluation of the QI policy

5-star measures

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

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

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

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Medical records standards

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

Patient identification

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

Personal/biographical data

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

Patient language

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

Practitioner identification

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

Entry date

All entries will be dated.

Legible

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

Problem list

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

Allergies

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

Advance directives

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

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

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

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

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

Appropriate use of lab and other studies
Laboratory and other studies ordered will be noted, as appropriate.

Working diagnoses
Working diagnoses are consistent with findings

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

Plan/treatment
Treatment plans are consistent with diagnoses.

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

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

Appropriate use of consultants
Ongoing assessment for under and over utilization where consultation with a board-certified specialty physician is pursued as clinically indicated.

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Continuity of care

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

Consultants/X-rays/lab and imaging report initials

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

Medication documentation

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

Immunization record

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

Preventive services

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

Addendum to record

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

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Appointment access criteria

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

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

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

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Preventive care recommendations

Preventive care recommendations for men and women ages 50 and older

Immunizations	
Flu, annual	Recommended
Hepatitis A	For individuals with risk factors; for individuals seeking protection
Hepatitis B	For individuals with risk factors; for individuals seeking protection
Pneumococcal (pneumonia)	Recommended for individuals 65 and older; and individuals under 65 with risk factors
Td booster (tetanus, diphtheria)	Recommended once every 10 years
Varicella (chickenpox)	Recommended for adults without evidence at immunity; should receive 2 shots
Zoster (shingles)	Recommended for all adults 60 and older

Screenings/Counseling/Services	
AAA (abdominal aortic aneurysm)	For men ages 65–75 who have ever smoked, one-time screening for AAA by ultrasonography
Alcohol misuse	Behavioral counseling
Advanced care planning	Can be performed at the time of the wellness visit or outside of the annual wellness visit, as necessary
Aspirin	Visit to discuss potential benefit of use
Blood pressure, depression, height, weight, BMI, vision, and hearing	At well visit, annually
Breast cancer	Recommended mammogram every 1–2 years for women ages 50–74
Breast cancer chemo prevention	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 can be discontinued if previous tests have been normal
Colorectal cancer	Recommended for adults 50–75
Depression	For all adults

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Screenings/Counseling/Services (continued)	
Diabetes	Recommend Type 2 diabetes screening for individuals with sustained blood pressure greater than 135/80 mm Hg
Domestic violence and abuse	Screening and counseling for interpersonal and domestic violence
Electrocardiogram screening	One time only when provided during the Welcome to Medicare visit
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
Pap/pelvic exam including pelvic exam and pap collection	• Every calendar year for those at high risk (visits do not need to be 12 months apart) • Every two calendar years for women not considered high risk (visits do not need to be 24 months apart)
Prostate cancer	Prostate-specific antigen (PSA) test and digital rectal exam
Sexually transmitted infections	Behavioral counseling as needed
Syphilis	Recommended for individuals at increased risk for infection
Tobacco use and cessation	Screening for tobacco use and cessation intervention

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Heart health

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

Other topics to discuss with patients

Nutrition

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

Sexual health

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

Substance abuse

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

Dental health

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

Other topics

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

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Optum Care care management overview

Care management

The Optum Care care management program provides high-touch care coordination within PCP offices, hospitals, skilled nursing facilities (SNF), and patients' homes. Through a variety of programs, the network assists patients throughout their health care journey. Providers can refer patients into these programs by completing and submitting the member programs referral form found at: optumcare.com.

Optum Care has two localized care management programs: nurse care managers and care coordinators. Both work in collaboration with the patient, the family/support system, providers and key stakeholders in coordinating discharge, health care services, and referrals to the appropriate next level of care and community resources. Both teams work collaboratively when it is in the best interest of the patient.

Key components of the Optum Care management and care coordination programs

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

Additional care management resources

Optum Health behavioral health

For direct referrals regarding behavioral health needs: **1-800-579-5222**

Optum Nurse Line: 1-800-620-6768

24-hour access hot-line for patient to reach a nurse to answer questions regarding health concern.

Medical intervention programs: 1-800-620-6768

Palliative consults: Palliative care is concentrated on reducing the severity of disease symptoms to ultimately prevent suffering and improve quality of life.

Transplant services: For direct referrals regarding transplant case management:
Phone: **1-866-300-7736** or Fax 1-888-361-0502

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Care management referral process

Referrals vs. prior authorization and notification

The referral, advance notification, and prior authorization process are separate functions. All care providers must follow the notification and/or prior authorization requirements when providing a service that requires a notification and/or prior authorization. A referral does not replace the advance notification or prior authorization process.

Medicare Advantage referral required

AARP Medicare Advantage (MA) benefit plans do not require referrals to specialists. These plans focus on coordination of care through the PCP and are network-only benefit products. Subsequent services that result from a referral, may require prior authorization notification and review. Please refer to the Optum Care website for a list of all services that require prior authorization and review.

Though not required, we encourage submission of referrals for patient continuity of care tracking.

Referral submission requirements

Referral forms can be located in the Optum Care website and submitted requests online at: optumcare.com or call 1-800-620-6768. This form can be found as editable, savable PDF on the Optum Care website under provider resources. Communication regarding referrals will occur within one business day.

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Utilization management and prior authorization

Introduction to utilization management (UM) and prior authorization

The Optum Care UM team strives to offer providers and patients the most efficient service possible. The purpose of the Optum Care UM is to determine if medical services are:

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

Advance notification vs. prior authorization

Advance notification is the first step in determining coverage. We also use it for case and condition management program referrals. The information we receive about planned medical services helps support the pre-service clinical coverage reviews and care coordination. Advance notification helps assist members from pre-service planning to discharge planning.
Advance notification is required for services listed on the advance notification/prior authorization list located on the Optum Care Provider Portal at **professionals.optumcare.com/portal-login.**

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

Advance notification/prior authorization requirements

Physicians, health care professionals and ancillary care providers are responsible for:

- Providing advance notification or requesting prior authorization for services on the advance notification/prior authorization list, including for non-emergency air transport services.
- Directing members to use care providers within their network. Members may be required to obtain prior authorization for out-of-network services.

Facilities are responsible for:

- Obtaining prior authorization for inpatient admission to skilled nursing facility, acute inpatient rehabilitation and/or long-term acute care.
- Confirming coverage approval is on file prior to the date of service.
- Providing admission notification for inpatient services even if coverage approval is on file.

If you perform multiple procedures for a member in one day, and at least one service requires prior authorization, you must obtain prior authorization for any of the services to be paid. If you do not follow these requirements, we may deny claims. In that case, you cannot bill the member. Advance notification or prior authorization is valid only for the date of service or date range listed on it. If that specified date of service or date range has passed, you must submit a new request.

Giving us advance notification, or receiving prior authorization from us, is not a guarantee of payment, unless required by law or Medicare guidelines. This includes regulations about care providers on either a sanction and excluded list, and/or care providers not included in the Medicare Provider Enrollment Chain and Ownership System (PECOS)* list. Payment of covered services is based on:

- The member's benefit plan
- If you are eligible for payment
- Claim processing requirements
- Your agreement

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Information required for advance notification/prior authorization requests

Your request must have the following information:

- Member name and member health care ID number
- Ordering care provider name and TIN or National Provider Identification (NPI)
- Rendering care provider name and TIN or NPI
- ICD-10-CM diagnosis code
- All applicable procedure codes
- Anticipated date(s) of service
- Type of service (primary and secondary) procedure code(s) and, if relevant, the volume of service
- Place of service
- Facility name and TIN or NPI where service will be performed (when applicable)
- Original start date of dialysis (End Stage Renal Disease (ESRD) only)

If the member's benefit plan requires a clinical coverage review, we may request additional information.

Advance notification/prior authorization list

The list of services that require advance notification and prior authorization is the same. The process for providing notification and submitting a prior authorization request is the same. Services that require prior authorization require a clinical coverage review based on medical necessity. Advance notification/prior authorization lists are available online through the Optum Care Provider Portal **professionals.optumcare.com/portal-login**. They are subject to change.

When to submit advance notification or prior authorization requests

We recommend that you submit advance notification with supporting documentation as soon as possible, but at least two weeks before the planned service (unless the advance notification requirements states otherwise). Following a facility discharge, advance notification for home health services and durable medical equipment is required within 48 hours after the start of service. After submitting your request, you get a service reference number. This is not an authorization. When we make a coverage determination, we issue it under this reference number. It may take up to 15 calendar days (14 calendar days for standard MA requests and 72 hours for expedited requests) for us to make a decision. We may extend this time if we need additional information.

How to request prior authorization:

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

- Online: optumcare.com
- By phone: 1-800-620-6768

Note: You don't need to submit another prior authorization request to Optum Care Network — New Mexico, if a request was previously reviewed and approved by United Healthcare for dates of service starting Jan. 1, 2021, and later. Optum Care Network will honor United Healthcare approvals and reimburse for services provided to eligible members.

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Hospital admission notification

Requirements for admission notification

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

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

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

Admission notification by the facility is required even if the physician supplied advance notification and a pre-service coverage approval is on file. Receipt of an admission notification does not guarantee or authorize payment. Payment of covered services is contingent upon coverage within an individual patient's benefit plan, the facility being eligible for payment, any claim processing requirements, and the facility's participation agreement with Optum Care.

Hospital admission notification by phone at **1-800-620-6768** or submitting online at: optumcare.com

Admission notification must contain the following details regarding the admission:

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

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

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Optum Population Health Management Program

Program purpose and goals

The purpose of the Optum Population Health Management Program (PHMP) is to improve the health outcomes of members and enable real-time information exchange and point of care decision making. Population health management is a proactive, population-based approach to managing specific conditions and disease states. The program includes systematic identification of populations with specific conditions, risk stratification and interventions designed to address the needs of individual members.

The PHMP is designed to deliver optimal clinical and financial outcomes by targeting the areas with the greatest potential for impact. Interventions are focused on achieving the quadruple aim: improve population health, enhance member experience, improve clinician experience and reduce medical costs.

The program is based on approved evidence-based guidelines. Our PHMP is a key initiative to help us realize our mission of empowering members to take ownership of their health: To help people live healthier lives and to help make the health system work better for everyone.

Key components of the program include provision of educational support, self-management techniques, care coordination and interventions to support informed decision making and the physician's treatment plan.

The goals of the Optum PHMP are to:

- Improve the quality of care, quality of life and health outcomes of members.
- Provide education to help individuals understand their condition, recognize changes in symptoms, and actively manage their condition to prevent exacerbations.
- Empower members to effectively manage their condition and co-morbidities.
- Improve physical activity tolerance and reduce or eliminate health risk factors such as excess weight, obesity and smoking.
- Reduce unnecessary hospital admissions and emergency department visits related to complications of the disease.
- Improve coordination of care.
- Continue to improve member engagement.
- Prevent disease progression and other illnesses related to poorly managed chronic conditions.
- Support member empowerment and informed decision making to maintain a healthy lifestyle and adhere to physician treatment plans and medication regimens.
- Improve member satisfaction with effectively managing their condition and co-morbidities, including depression.

Program scope

The scope of the PHMP extends throughout the continuum of care and includes the treating provider, member/caregiver, education and engagement, and member self-management. The population health programs included are complex case management and disease management. The programs are designed to support nurse case managers (NCM) to objectively assess, plan, implement, monitor and evaluate the efficiency and appropriateness of care for participating members enrolled in the program. Members are evaluated for social determinants impacting their care and connected with community resources as indicated. Social work case managers are utilized to facilitate referrals for community and/or behavioral health resources as need identified.

The program focuses on medium and high-risk populations in the Optum Medicare Advantage plans. The program provides interventions for this population which are primarily delivered through in person clinic visits, video visits, and telephonically. Optum membership does not currently include children and adolescents.

Risk adjustment data – Medicare Advantage (MA)

CMS risk adjustment program for MA benefit plans uses Hierarchical Condition Categories (HCCs) to calculate an annual patient risk score that represents the specific patient's disease burden. Every year, CMS requires information about the demographic and health of our members. Diagnoses do not carry forward to the following year and must be assessed and reported every year.

The risk adjustment data you give us, including clinical documentation and diagnosis codes, must be accurate and complete. It is critical for you to refer to the ICD-10-CM coding guide to code claims accurately. To comply with risk adjustment guidelines, specific ICD-10-CM codes are required.

- Medical records must support all conditions coded on the claims or encounters you submit using clear, complete and specific language.
- Code all conditions that co-exist at the time of the member visit and require or affect member care, treatment or management.
- Never use a diagnosis code for a "probable" or "questionable" diagnosis. Code only to the highest degree of certainty for the encounter/visit. Include information such as symptoms, signs, abnormal test results and/or other reasons for the visit.
- Specify whether conditions are chronic or acute in the medical record and in coding. Only choose diagnosis code(s) that fully describe the member's condition and pertinent history at the time of the visit. Do not code conditions that no longer exist.
- Carry the diagnosis code all the way through to the correct digit for specificity. For example, do not use a three-digit code if a five-digit code more accurately describes the member's condition.
- Check the diagnosis code against the member's gender.
- Sign chart entries with credentials.
- All claims and/or encounters submitted to us for risk adjustment consideration are subject to federal and/or Optum Care Network — New Mexico audit. Audits may come from CMS, HHS, or us, where we may select certain medical records to review to determine if the documentation and coding are complete and accurate. Please give us any requested medical records quickly. Please provide all available medical documentation for the services rendered to the member.
- Notify us immediately about any diagnostic data you have submitted to us that you later determine may be erroneous.

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CMS Hierarchical Condition Categories (HCC) model

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

Hypothetical illustration payment under the adjusted average per capita cost	
Mr. Smith • Lives in Marlboro County • 78 years old	**Mr. Carter** • Lives in Marlboro County • 78 years old
Has: • CHF • Diabetes • Renal failure	**Has:** • Not seen a doctor in two years
Medicare monthly payment: $500	**Medicare monthly payment:** $500

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Hypothetical illustration payment under the Principle Inpatient Diagnostic Code Grouping (PIP-DCG):	
Mr. Smith • Lives in Marlboro County • 78 years old	**Mr. Carter** • Lives in Marlboro County • 78 years old
Has: • CHF (with hospital admit) • Diabetes • Renal failure	**Has:** • Not seen a doctor in two years
Medicare monthly payment: $1,599	**Medicare monthly payment:** $500

Hypothetical illustration payment under the CMS HCC:	
Mr. Smith • Lives in Marlboro County • 78 years old	**Mr. Carter** • Lives in Marlboro County • 78 years old
Has: • CHF (with hospital admit) • Diabetes • Renal failure	**Has:** • Not seen a doctor in two years
Medicare monthly payment: $1,599	**Medicare monthly payment:** $289

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Keys to success with risk adjustment:

- Good coding and documentation practices – the medical record documentation must support the ICD-10 submitted on the encounter of annual health assessment form
- High reporting levels of encounter data
- Patient retention

Coding and documentation:

- Use the current version of ICD-10 and code to the highest level of specific
- Do code all conditions when they become certain
- Do not code probable, suspected, rule-out or working diagnoses

Documentation:

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

Annual wellness visits/routine physicals

Annual wellness visit/routine physical exam visit frequency should be every calendar year (visits do not need to be 12 months apart)

- Established or updated record of member's medical and family history.
- Review of member's potential risk factors for depression.
- Review of member's functional ability and level of safety, including hearing impairment, daily living activities, fall risk and home safety.
- Review of member's full list of medications and supplements, including calcium and vitamins.
- An exam with height, weight, body mass index, blood pressure and other routine measurements.
- List or updated list of member's medical care providers and suppliers.
- Detection of any cognitive impairment.
- Established or updated screening schedule for the next five to 10 years, as appropriate.
- Established or updated list of a member's risk factors.
- Personalized health advises and appropriate referrals to health education or preventive services.

For further education and training, please contact your network manager or send your request to NMOptumCareNetwork@optum.com

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Glossary of claims terminology

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

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

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

Billed charges: The dollar amount billed by a provider as their usual and customary charge.

Capitation: Method of payment for health services in which a 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.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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.

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APPENDIX A – New administrative process for some United Healthcare Medicare Advantage plans.

P.O. Box 30449 Salt Lake City, UT 84130-0449

Re: New Administrative Processes for Some United Healthcare Medicare Advantage Plans Starting Jan. 1, 2021

Dear (Physician Name):

We're making changes to certain administrative processes to help improve your overall experience as we work toward achieving improved health outcomes by providing more affordable and efficient care for your patients who are members of certain UnitedHealthcare Medicare Advantage plans in New Mexico.

What This Means for You

Starting Jan. 1, 2021, Optum Care Network, an affiliate of UnitedHealthCare, will mange administrative service to help you understand which members are affected by this change and to help you prepare to work with Optum Care Network

This change won't affect your UnitedHealthcare contract or participation agreement, and you'll continue to be an in-network care provider for members of these plans. Starting Jan. 1, 2021, it will change how you submit:

- Prior authorization requests
  - Online: at optumcare.com
  - Call: 1-800-620-6768
- Hospital admission notifications (no later than one business day after admission)
  - Call: 1-800-620-6768
- Claims
  - Electronic: Payer ID LIFE1
  - Mail: Optum Care Network Claims, P.O. Box 30539, Salt Lake City, UT 84130

Who's Affected

Members in the affected plans will get new member ID cards with payer ID **LIFE1**:

- AARP Medicare Advantage (HMO)
- AARP Medicare Advantage Choice (PPO)
- AARP Medicare Advantage Patriot (PPO)

This change will not impact members enrolled in the following plans:

- UnitedHealthcare Medicare Advantage Assure (PPO)
- UnitedHealthcare Group Medicare Advantage (PPO)

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P.O. Box 30449 Salt Lake City, UT 84130-0449

Working With Optum Care Network

Optum Care Network provides health care administrative services such as utilization management, the management of referrals and prior authorization requests, and claims processing for these members. Optum Care Network will administer quality incentive programs for primary care providers (PCPs). You can also go to optumcare.com to learn more about Optum Care Network and the services they provide.

We're here to help

If you have any questions, please call us at: 1-877-842-3210. Thank you.

Sincerely,

Jamie Clark
VP, UHC Networks Arizona and New Mexico

enclosure

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APPENDIX B – New Mexico AARP Medicare Advantage UHC ID card samples

AARP | Medicare Advantage
from UnitedHealthcare
UNITED HEALTH PASSPORT

Health Plan (80840): **911-87726-04**
Member ID: 0000000000 Group Number: 17087
Member:
GLORIA A SAMPLE
UHC Dental Benefits
Payer ID: LIFE1
PCP Name:
KIM, N.P., JU YUNG
PCP Phone: (505) 262-7248
MedicareRx Prescription Drug Coverage
RxBIN: 610097
RxPCN: 9999
RxGrp: COS
Copay: PCP $0 Spec $40 ER $90
AARP Medicare Advantage (HMO) w/Dental Platinum
Optum Care Network
H6526-001-000

X101566573900001

Customer Service Hours: 8 am - 8 pm 7 days/week Printed: 10/17/2020

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

For Providers www.OptumCare.com 1-800-620-6768
Medical Claim Address: P.O. Box 30539, Salt Lake City, UT 84130
Provider Authorizations: 1-800-620-6768
UHC Dental Providers: www.UHCdental.com 1-877-816-3596
UHC Renew Active NO Referral Required OPTUM
For Pharmacists 1-877-889-6510
Pharmacy Claims OptumRx P.O. Box 650287, Dallas, TX 75265-0287

AARP | Medicare Advantage
from UnitedHealthcare
UNITED HEALTH PASSPORT

Health Plan (80840): **911-87726-04**
Member ID: 0000000000 Group Number: 38013
Member:
SAMPLE SAMPLE
UHC Dental Benefits
Payer ID: LIFE1
PCP Name:
GREAT, M.D., HERE FOUAD
PCP Phone: (999) 555-1212
MedicareRx Prescription Drug Coverage
RxBIN: 610097
RxPCN: 9999
RxGrp: COS
Copay: PCP $0 Spec $40 ER $90
AARP Medicare Advantage (HMO)
Optum Care Network
H6526-001-000

X437899118000001

Customer Service Hours: 8 am - 8 pm 7 days/week Printed: 10/02/2020

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

For Providers www.OptumCare.com 1-800-620-6768
Medical Claim Address: P.O. Box 30539, Salt Lake City, UT 84130
Provider Authorizations: 1-800-620-6768
UHC Dental Providers: www.UHCdental.com 1-877-816-3596
UHC Renew Active NO Referral Required OPTUM
For Pharmacists 1-877-889-6510
Pharmacy Claims OptumRx P.O. Box 650287, Dallas, TX 75265-0287

AARP | Medicare Advantage
from UnitedHealthcare
UNITED HEALTH PASSPORT

Health Plan (80840): **911-87726-04**
Member ID: 0000000000 Group Number: 38011
Member:
SAMPLE SAMPLE
Payer ID: LIFE1
PCP Name:
GREAT, M.D., HERE FOUAD
PCP Phone: (999) 555-1212
MedicareRx Prescription Drug Coverage
RxBIN: 610097
RxPCN: 9999
RxGrp: COS
Copay: PCP $5 Spec $50 ER $90
AARP Medicare Advantage (HMO)
Optum Care Network
H6526-002-000

X437123133000001

Customer Service Hours: 8 am - 8 pm 7 days/week Printed: 10/02/2020

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

For Providers www.OptumCare.com 1-800-620-6768
Medical Claim Address: P.O. Box 30539, Salt Lake City, UT 84130
Provider Authorizations: 1-800-620-6768
UHC Renew Active NO Referral Required OPTUM
For Pharmacists 1-877-889-6510
Pharmacy Claims OptumRx P.O. Box 650287, Dallas, TX 75265-0287

AARP | Medicare Advantage
from UnitedHealthcare
Medicare National Network

Health Plan (80840): **911-87726-04**
Member ID: 0000000000 Group Number: 17077
Member:
BONNIE L SAMPLE
UHC Dental Benefits
Payer ID: LIFE1
PCP Name:
RODRIGUEZ-LUGO, M.D., MIRTA M.
PCP Phone: (505) 839-2300
Optum Care Network
Part B Drugs
RxBIN: 610494
RxPCN: 9999
RxGrp: COS
Copay: PCP $0 Spec $40 ER $90
AARP Medicare Advantage Patriot (PPO) w/Dental Platinum
Medicare limiting charges apply.
H2228-098-000

X117948699500001

Customer Service Hours: 8 am - 8 pm 7 days/week Printed: 10/19/2020

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

For Providers www.OptumCare.com 1-800-620-6768
Medical Claim Address: P.O. Box 30539, Salt Lake City, UT 84130
Provider Authorizations: 1-800-620-6768
UHC Dental Providers: www.UHCdental.com 1-877-816-3596
UHC Renew Active NO Referral Required OPTUM
For Pharmacists 1-877-889-6510
Part B RX Claims OptumRx P.O. Box 650287, Dallas, TX 75265-0287

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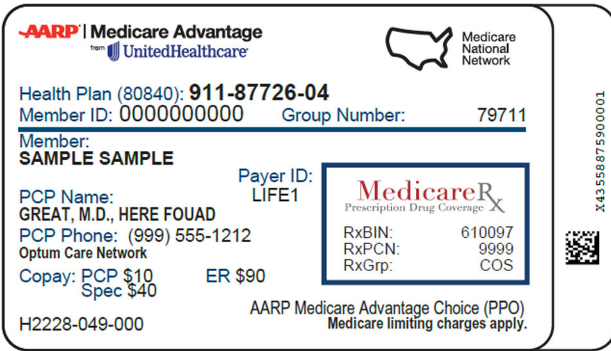
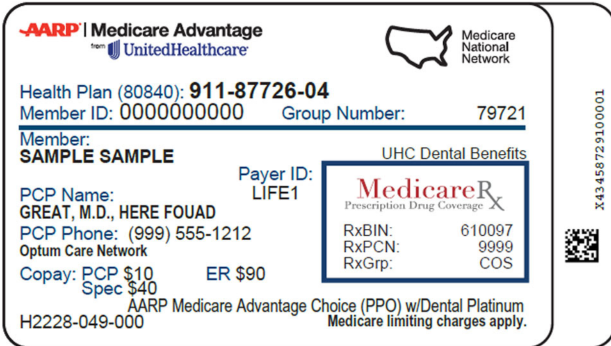
APPENDIX B – New Mexico AARP Medicare Advantage UHC ID card samples





United Healthcare

Health Plan (80840): **911-87726-04**
Member ID: 0000000000 Group Number: 77016

Member:
SAMPLE SAMPLE

UHC Dental Benefits

Payer ID:
87726

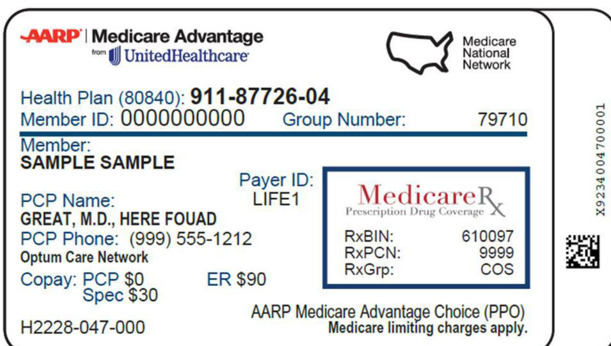
PCP Name:
GREAT, M.D., HERE FOUAD
PCP Phone: (999) 555-1212

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

UnitedHealthcare Medicare Advantage Assure (PPO)
Medicare limiting charges apply.

H0271-010-000

X333083814000001



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