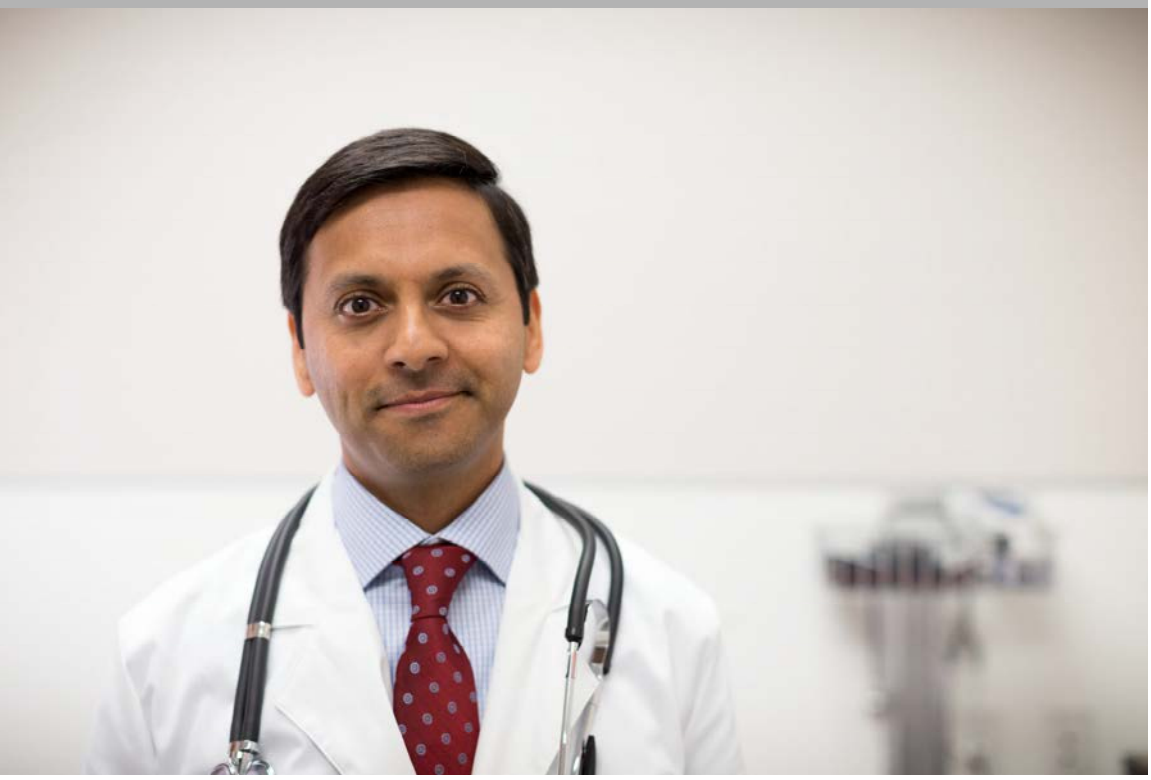
2022 Claims Provider Manual



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Chapter 1: Overview

Purpose and use of this guide

The guide contains important information about Optum Care Network (OCN) claims submission and reconsideration requests.

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

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

Medicare compliance expectations and training

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

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

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

Standards of conduct awareness

What you need to do

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

Fraud, waste, and abuse and general compliance training

What you need to do

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

Exclusion checks

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

Medicare compliance expectations and training continued

What you need to do

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

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

Preclusion list policy

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

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

Medicare compliance expectations and training continued

Reporting Misconduct

If you identify compliance issues and/or potential fraud, waste or abuse, please report it to us immediately. Please refer to your OCN Provider Manual for reporting resources and detail.

Privacy

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

Guide Updates

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

Chapter 2: Claims submission

Electronic data interchange (EDI)

Optum Care's preferred method of claim submission is electronic, known as the Electronic Data Interchange (EDI). EDI is the computer to computer transfer of data transactions and information between payers and providers. Electronic claims submission allows the provider to eliminate the hassle and expenses of printing, stuffing and mailing claims to the network. It substantially reduces the delivery, processing, and payment time of claims. EDI is a fast, inexpensive, and safe method for automating the business practices that take place on a daily basis. There is no charge from Optum Care for submitting claims electronically to the network. Providers are able to use any major clearinghouse.

For electronic claim submissions, use **Payer ID: LIFE1**. Claim submissions should be in a HIPAA-compliant 837 I or P format.

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

Click here for additional information regarding CMS HIPAA EDI submission requirements.

Benefits of EDI:

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

Paper claims , reconsideration, and refund submissions

Optum Care prefers to receive claims electronically, but we do accept claims submitted on paper. If necessary, paper claims and correspondence may be submitted to the following addresses dependent upon member location:

Midwest • Indiana • Ohio	Optum Care Claims P.O. Box 30781 Salt Lake City, UT 84130
Mountain West • Arizona • Colorado • Nevada • New Mexico • Utah	Optum Care Claims P.O. Box 30539 Salt Lake City, UT 84130
Northeast • Connecticut	Optum Care Claims P.O. Box 2500 Rancho Cucamonga, CA 91719 Attn: Claims Intake/Claims Manager
Pacific Northwest • Oregon • Washington	Optum Care Claims P.O. Box 30788 Salt Lake City, UT 84130
Tristate • New York	Optum Care Claims P.O. Box 30781 Salt Lake City, UT 84130

How to complete the 1500 claim form

Patient information

Box 1a: Members External ID

Box 2-6: Member demographics to include Name, DOB, Address, and Gender

Box 9D: Other Insurance information—i.e. another Primary Payer

Provider/line item details

Box 17: Referring Provider

Box 19: Provider Comments—i.e. Corrected Claim, 911

Box 21: Diagnostic Codes

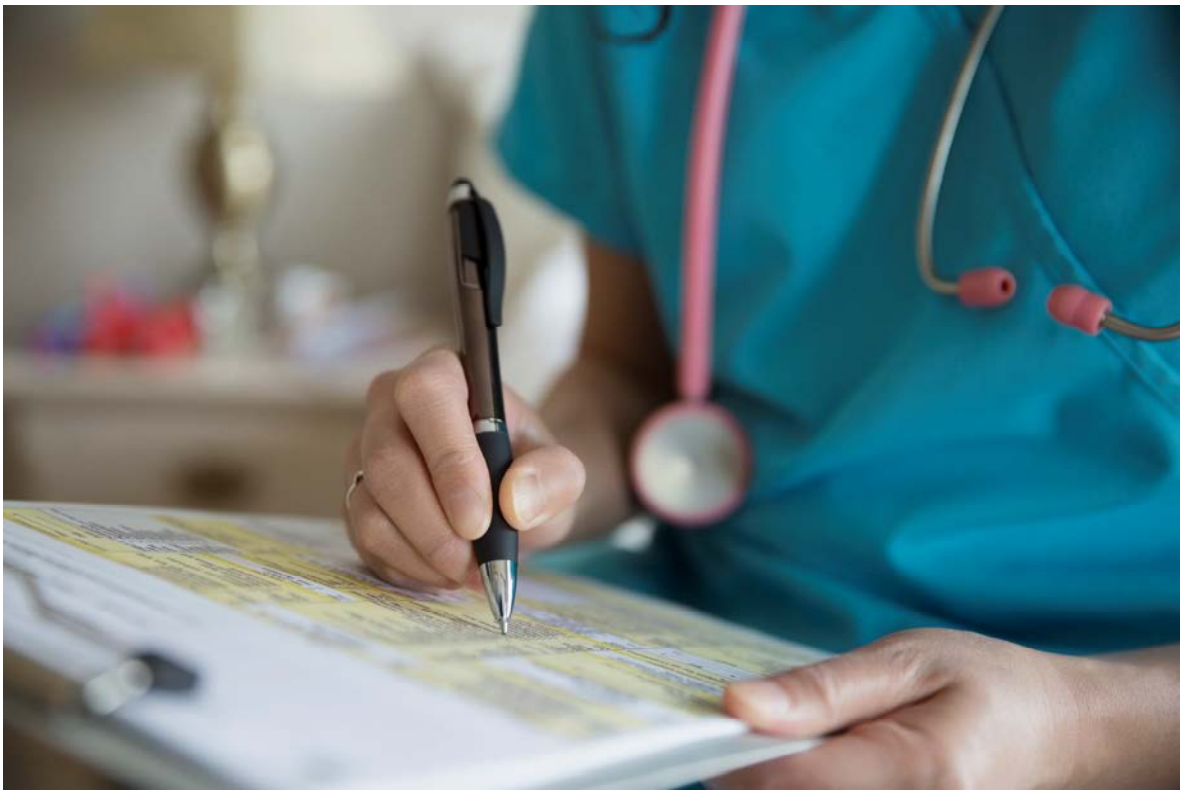
Box 22: Resubmission Code (if 7 in box—claim is a corrected claim to one previous sent)

Box 24A-G, 28, 29: Line Item details/charges about services rendered by Provider

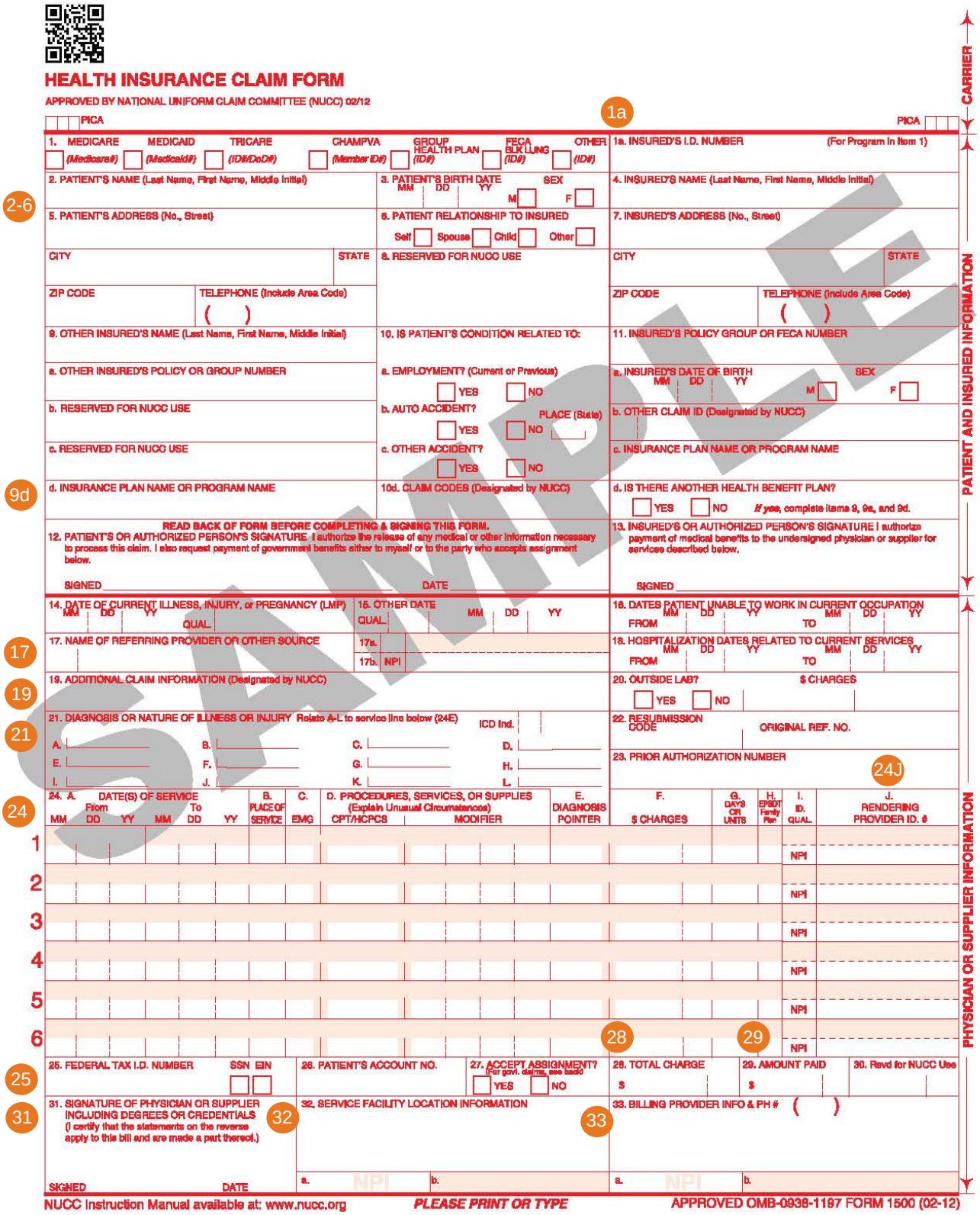
Box 24J, 25, 31: Rendering Provider Info

Box 32: Location services were rendered

Box 33: Billing Provider—Sometimes Provider Group info



1500 claim type image



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code)

ZIP CODE TELEPHONE (Include Area Code)

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, complete items 9, 9a, and 9d.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL

15. OTHER DATE QUAL MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY | B. PLACE OF SERVICE | C. EMG | D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER | E. DIAGNOSIS POINTER | F. $ CHARGES | G. DAYS OR UNITS | H. EPSDT Family Plan | I. ID. QUAL. | J. RENDERING PROVIDER ID. #

1 NPI

2 NPI

3 NPI

4 NPI

5 NPI

6 NPI

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

1a 2-6 9d 17 19 21 24 24J 25 28 29 31 32 33

SAMPLE

How to complete the UB04 (1450) claim form

Box 1: Provider Name and Address

Box 2: Pay-To Name and Address—if different than Box 1

Box 3a/b: Patient Control Number, Medical Record Number

Box 4: Bill Type

Box 5: Facility Tax ID

Box 6: Statement Covers Period—DOS

Box 7: Administrative Necessary Days

Member validation

Box 8a-b: Patient Name

Box 9a-d: Patient Address

Box 10: Patient DOB

Box 11: Patient Gender

Admission information

Box 12: Admission Date

Box 13: Admission Hour

Box 14: Admit Type—Reason for Admission

Box 15: Source of Admission

Box 16: Discharge Hour

Box 17: Patient Discharge Status

Box 18-28: Condition Codes

Box 29: Accident State—State in which accident occurred

Box 30: Accident Date

Box 31-34: Occurrence Codes and Dates

Box 35-36: Occurrence Span

Box 39-41: Value Codes

Line items

Box 42-49: Contain the claim lines with information on services and charges provided

Box 56: Facility NPI

Patient insured information:

Box 58-62: This could have additional information as far as External ID listed that can be used to validate the member

Box 67 A-Q: Diagnosis Codes

Other providers

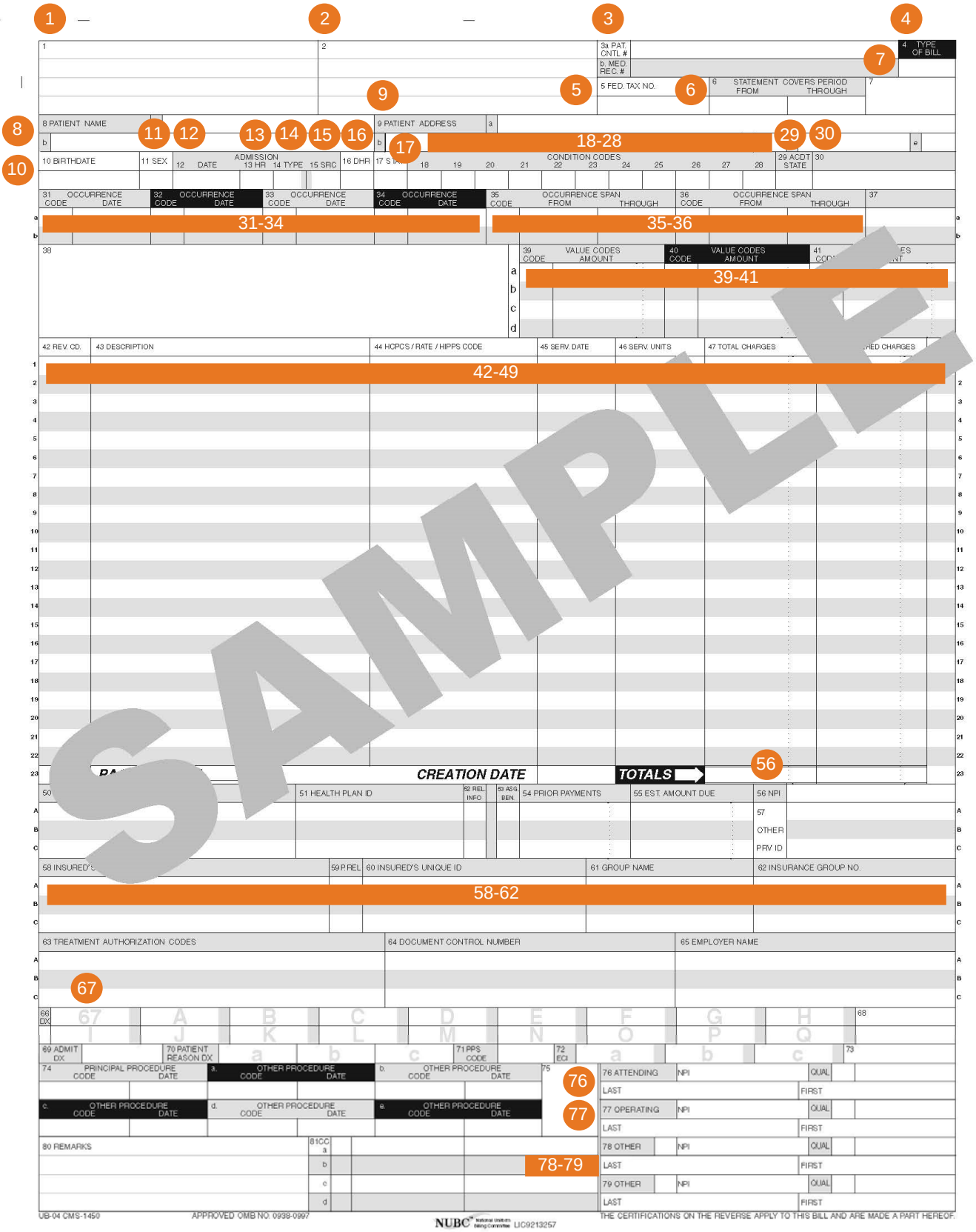
Box 76: Attending (Admitting) Name

Box 77: Operating ID

Box 78-79: Other Provider ID

Click here for additional information regarding completing and processing the Form CMS-1450 Data Set.

UB04 (1450) claim type image



Chapter 3: Timely filing guidelines

Submission timeframes

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

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

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

Some examples of claims that may be denying as untimely include:

- Resubmitted claims in which the original claim was denied for additional information or processed incorrectly.
- Resubmitted corrected claims for reprocessing (e.g., additional/reduced charges, updated fee schedule).
- Submitted claims where the members' insurance info was outdated and Optum Care was either the primary or secondary payer.

Reconsiderations and payment disputes

Submitter: Timely filing limit is typically 60 days or per the provider contract. A request submitted after this time frame may be denied. In the event of a conflict or inconsistency between this administrative guide and your network contractual agreement or applicable federal and state statutes and regulations, the terms of the contractual agreement along with federal and state statutes and regulations shall control.

Chapter 4: Common billing errors

Corrected claims

- Professional (1500) bill type:
    - Resubmission code of 7 required in box 22 with the original reference/claim number
- Facility (1450) bill type:
    - Resubmission code of 7 (type of bill) required in box 4
- Include all codes for rendered services that should be considered for payment
- Resubmission code of 8 required in box 22 for a voided claim
- The billing terms of the contractual agreement, if applicable, along with federal and state statutes and regulations shall control

Common billing errors continued

Helpful billing and claims tips

Things to remember when billing and submitting claims:

- EDI submission is Optum Care's preferred method of claims submission. It's fast, easy and cost effective.
- Always verify the patient's eligibility at the time of service.
- Submit the most current information. This will support with accurate payment processing.
- Provide accurate data and complete all required fields on the claim.
- If the provider has time limits for claims submission in the contract, be sure to know what they are and submit accordingly.
- Know the contract(s). Be sure all billing staff is familiar with current billing and contract requirements.
- To verify and view claims status, go to the Optum Care provider portal at: secure.optumcare.com/provider/account/logon or contact the Optum Care provider service center.

Chapter 5: Common denial codes

Code	Definition	Healthcare Claim Adjustment Reason Code (CARC) and Descriptions	Remittance Remark Codes (RARC) and Descriptions
CDD	Duplicate of service previously submitted.	18—Exact duplicate claim/service.	Not applicable
ST/S23	Claimant not effective or terminated for this date of service.	27/26—Expenses incurred prior to coverage. / Expenses incurred after coverage terminated.	Not applicable
TF1	Claim not received within the timely filing limit.	29—The time limit for filing has expired.	Not applicable
H31	Category II Reporting Code(s) and/or Category III Emerging Technology Code(s).	246—This non-payable code is for required reporting only.	Not applicable
0IT	Not a clean claim. Billed information not complete or inconsistent with level of service. Please resubmit corrected billing.	16—Claim/service lacks information or has submission/billing error(s).	N380—The original claim has been processed, submit a corrected claim.
WFL	Not a credentialed provider with this group on the date of service.	B7—This provider was not certified/eligible to be paid for this procedure/service on this date of service.	Not applicable
z88	LCD/NCD: Missing or invalid Part B Diagnosis.	50—These are non-covered services because this is not deemed a 'medical necessity' by the payer.	N115—This decision was based on a Local Coverage Determination (LCD).

Chapter 6: Reconsideration requests

Provider dispute resolution

Definition of a provider dispute

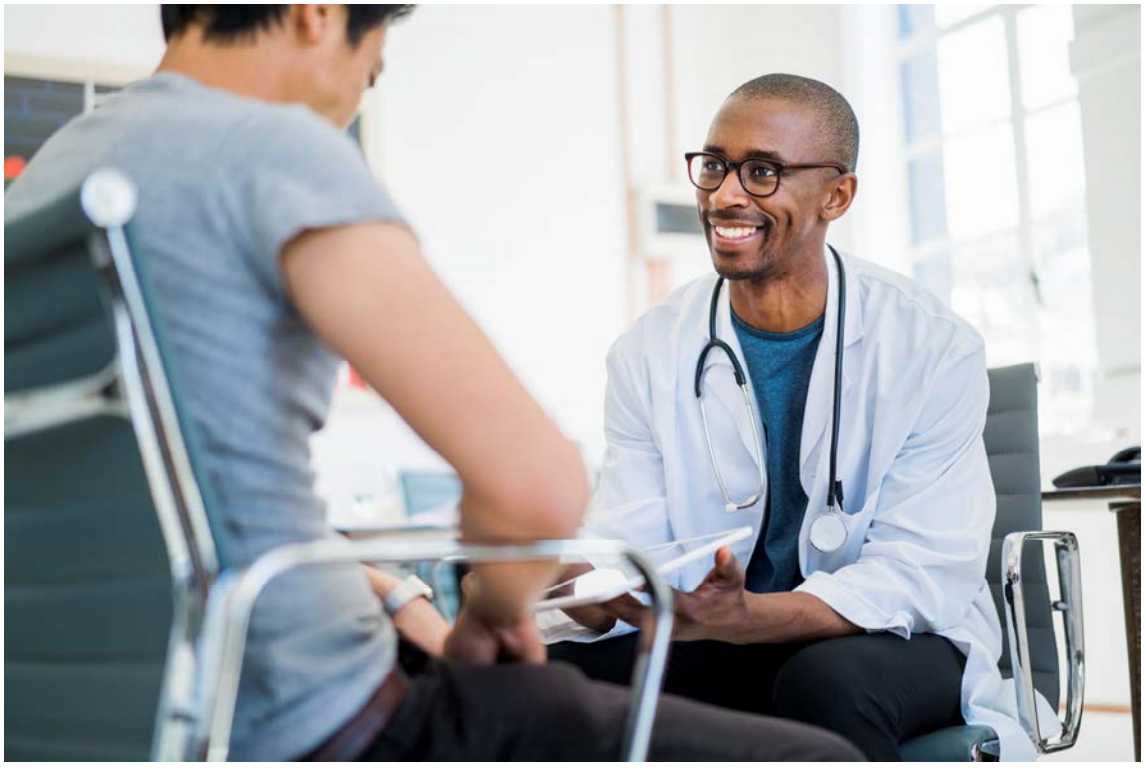
A provider dispute is a provider's written notice challenging and requesting the reconsideration of a claim (or a bundled group of substantially similar multiple claims that are individually numbered) that has been denied, adjusted or contested; or disputing a request for reimbursement of an overpayment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

Each provider dispute must contain the following information:

- Member demographic information
- Provider's name, TIN, and contact information

If the provider dispute concerns a claim or reimbursement of an overpayment of a claim from Optum Care the following must be provided:

- Clear identification of the disputed item, such as the claim(s) number, medical records, and invoices if applicable
- Date of service
- Clear description of the dispute



Provider dispute resolution continued

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

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

Helpful provider dispute submission tips

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

To submit a provider dispute:

- Contact the Optum Care service center at:
  - Midwest Indiana:
    - 1-866-565-3361− Monday – Saturday, 8 a.m. - 9 p.m., EST
  - Midwest Ohio:
    - 1-866-566-4715 − Monday − Saturday, 8 a.m. – 8p.m., EST
  - Mountain West Arizona/Utah:
    - 1-877-370-2845 − Monday − Saturday, 8 a.m. – 8 p.m., MST
  - Mountain West Colorado:
    - 1-888-685-8491− Monday − Saturday, 8 a.m. – 8 p.m., MST
  - Mountain West Nevada:
    - 1-855-893-2297 − Monday − Saturday, 8 a.m. – 8 p.m., MST
  - Mountain West New Mexico:
    - 1-800-620-6768 − Monday – Saturday, 8 a.m. – 8 p.m., MST
  - Northeast Connecticut:
    - 1-888-556-7048 − Monday – Saturday 8 a.m. – 8 p.m., EST
  - Pacific Northwest Oregon:
    - 1-866-565-3664 − Monday – Friday, 8 a.m. – 5 p.m., PST
  - Pacific Northwest Washington:
    - 1-877-836-6806 − Monday – Friday, 8 a.m. – 5 p.m., PST
  - Tri-State New York:
    - 1-866-565-3468 − Monday – Saturday, 8a.m. – 8p.m., EST

Provider dispute resolution continued

- Or send an email to our claims team at :
    - Mountain West Region (AZ/CO/NV/NM/UT) – claimdispute@optum.com
    - Midwest & Tri-State Region (IN/OH & NY) – ocTSMWDispute@optum.com
    - North-East Region (CT) – occtclaimsdispute@optum.com
    - Pacific Northwest Region (OR/WA)– ocndisputewa@optum.com
- Download a copy of the Optum Care provider dispute resolution request form; visit the resources section at the following website: professionals.optumcare.com.

Examples of types of disputes:

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

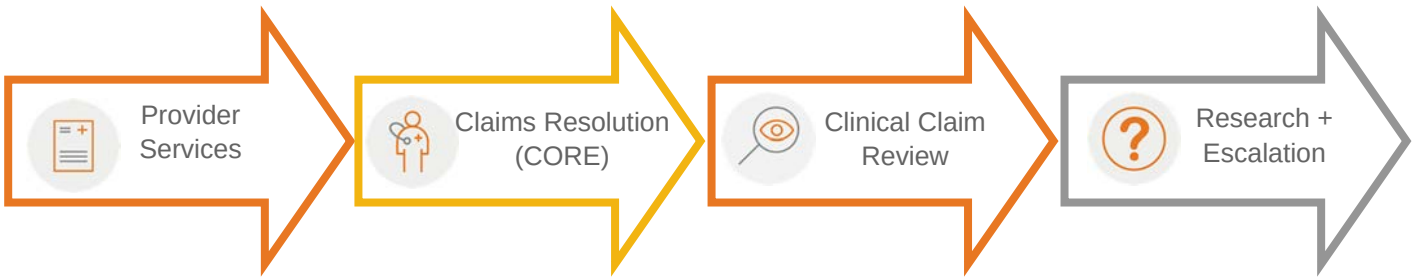
Dispute escalations

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

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

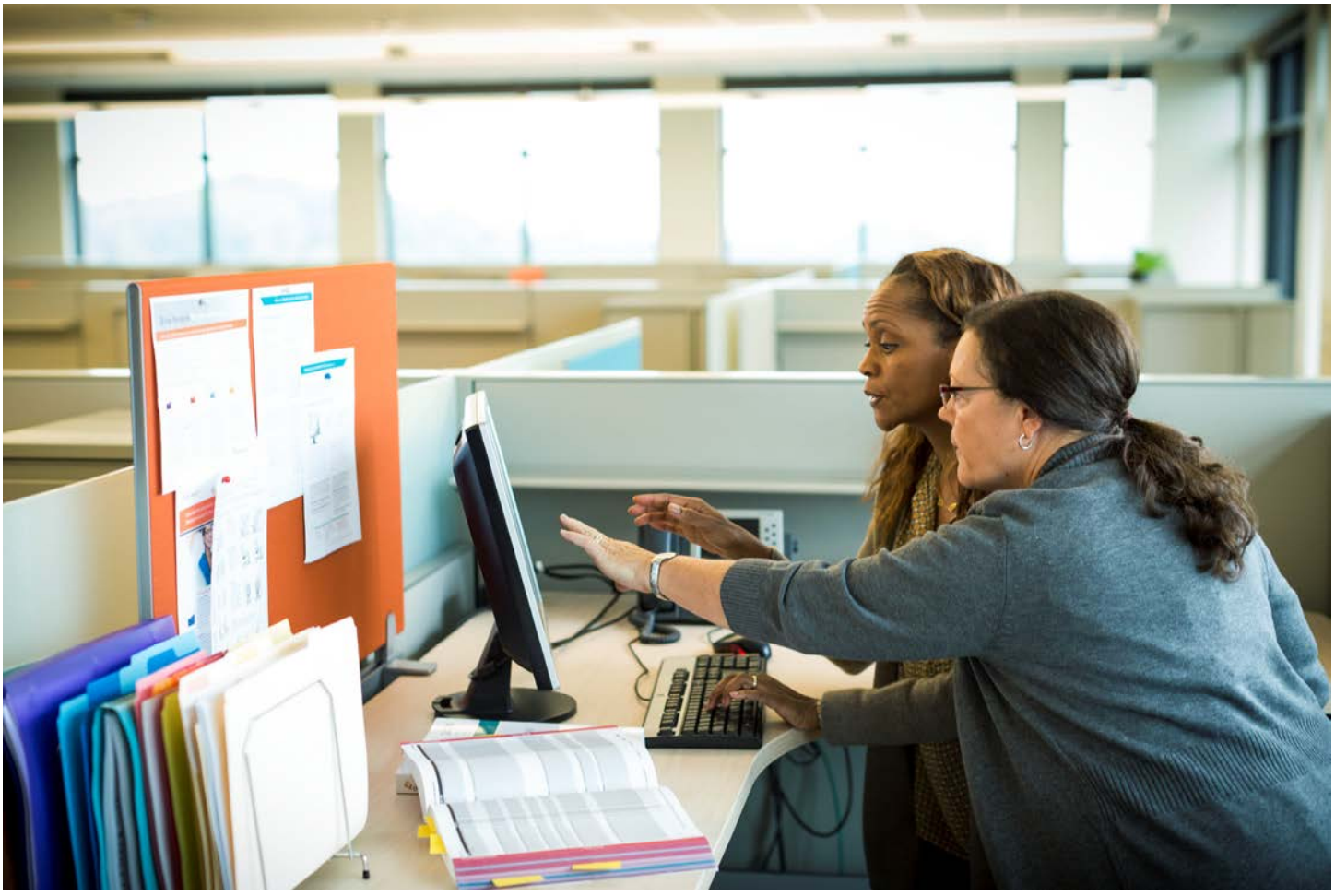
In order to submit a request to the Research and Escalation team, it is required to complete the standard dispute submission process first and include the original dispute tracking number provided by the Provider Services or Claims Resolution departments with your escalation request.

Send an email to our Market Operations Research and Escalation department at opshelp@optum.com.



Provider escalation process

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



Chapter 7: Out-of-network appeals and disputes

UnitedHealthcare appeal language

Pursuant to federal regulations governing the Medicare Advantage program, non-contracted providers may request reconsideration (appeal) of a Medicare Advantage plan payment denial determination including issues related to bundling or down coding of services . To appeal a claim denial, submit a written request **within 60 calendar days** of the remittance notification date and include at a minimum:

- A statement indicating factual or legal basis for appeal
- A signed waiver of liability form (you may obtain a copy at https://www.cms.gov/Medicare/Appeals-and-Grievances/MMCAG/Notices-and-Forms.html)
- A copy of the original claim
- A copy of the remittance notice showing the claim denial
- Any additional information, clinical records or documentation that supports the argument for reimbursement

Mail appeal request to:

UnitedHealthcare Medicare & Retirement
P.O. Box 6106
Cypress, CA 90630 MS: CA124-0157

Humana appeal language

Appeals process for non-contracted Medicare providers

Pursuant to federal regulations governing the Medicare Advantage program, non-contracted providers may request reconsideration (appeal) of a Medicare Advantage plan payment denial determination. To appeal a claim denial, submit a written request **within 60 calendar days** of the remittance notification date and include at a minimum:

- A statement indicating factual or legal basis for appeal
- A signed Waiver of Liability form
- A Waiver form can be obtained on http://www.humana.com/resources/support center/forms.aspx
- A copy of the original claim
- A copy of the remittance notice showing the claim denial Any additional information, clinical records, or documentation

Humana appeal language continued

Fax or mail the appeal request to:

Humana Inc Appeals and Grievance Department
P.O. Box 14165
Lexington, KY 40512-4165
Fax: 1-800-949-2961

Payment dispute process for non-contracted Medicare providers

Pursuant to federal regulations governing the Medicare Advantage program, non-contracted providers may file a payment dispute for a Medicare Advantage plan payment determination. A payment dispute may be filed when the provider disagrees with the amount paid, including issues related to bundling of services. To dispute a claim denial, submit a written request **within 120 calendar days** of the remittance notification date and include at a minimum:

- A statement indicating factual or legal basis for the dispute
- A copy of the original claim
- A copy of the remittance notice showing for the claim payment

Any additional information, clinical records, or documentation to support the dispute fax or mail the payment dispute to:

Humana Inc Appeals and Grievance Department
P.O. Box 14165
Lexington, KY 40512-4165
Fax: 1-800-949-2961

For additional information on the Non-contracted Appeal and Dispute processes including a form that may be used to facilitate your request for appeal or dispute, please go to www.humana.com.

Anthem appeal language

Appeals process for non-contracted Medicare providers

Pursuant to federal regulations governing the Medicare Advantage program, non-contracted providers may request reconsideration (appeal) of a Medicare Advantage plan payment denial determination including issues related to bundling or down coding of services . To appeal a claim denial, submit a written request **within 60 calendar days** of the remittance notification date and include at a minimum:

- A statement indicating factual or legal basis for appeal
- A signed waiver of liability form (you may obtain a copy at https://www.cms.gov/Medicare/Appeals-and-Grievances/MMCAG/Notices-and-Forms.html)

Anthem appeal language continued

- A copy of the original claim
- A copy of the remittance notice showing the claim denial
- Any additional information, clinical records or documentation that supports the argument for reimbursement

Anthem Nevada only:

Anthem Blue Cross and Blue Shield Medicare Advantage
Mail stop: OH0205-A537
4361 Irwin Simpson Rd.
Mason, OH 45040

Payment dispute process for non-contracted Medicare providers

Pursuant to federal regulations governing the Medicare Advantage program, non-contracted providers may file a payment dispute for a Medicare Advantage plan payment determination. A payment dispute may be filed when the provider disagrees with the amount paid. To dispute a claim payment, submit a written request **within 120 calendar days** of the remittance notification date and include at a minimum:

- A statement indicating factual or legal basis for the dispute
- A copy of the original claim
- A copy of the remittance notice showing the claim payment
- Any additional information, clinical records or documentation to support the dispute

Mail payment dispute to:

Optum Care Provider Dispute Resolution
P.O. Box 30539
Salt Lake City, UT 84130

If you have additional questions relating to a dispute decision made, you may contact us at:

Phone: 1-877-370-2845 for Arizona and Utah
Phone: 1-888-685-8491 for Colorado
Phone: 1-855-893-2297 for Nevada
Phone: 1-800-620-6768 for New Mexico
Fax: 1-877-370-2848
Mail: Optum Care Provider Dispute Resolution, P.O. Box 30539, Salt Lake City, UT 84130
Email via our secure web portal: https://professionals.optumcare.com/portal-login.html

Premera appeal language

Appeals process for non-contracted Medicare providers

Pursuant to federal regulations governing the Medicare Advantage program, non-contracted providers may request reconsideration (appeal) of a Medicare Advantage plan payment denial determination. To appeal a claim denial, submit a written request **within 60 calendar days** of the remittance notification date and include at a minimum:

- a statement indicating factual or legal basis for appeal
- a signed Waiver of Liability form (you may obtain a copy on: https://www.cms.gov/Medicare/Appeals-and-Grievances/MMCAG/Downloads /Appendix-7- Waiver-of-Liablility-Notice.pdf)
- a copy of the original claim
- a copy of the remittance notice showing claim denial
- any additional information, clinical records or documentation

Washington only mail the appeal request to:

Premera Blue Cross Medicare Advantage Plans
Attn: Appeals and Grievances
P.O. Box 262527
Plano, TX 75026

Payment dispute process for non-contracted Medicare providers

Pursuant to federal regulations governing the Medicare Advantage program, non-contracted providers may file a payment dispute for a Medicare Advantage plan payment determination. A payment dispute may be filed when the provider disagrees with the amount paid, including issues related to bundling of services. To dispute a claim payment, submit a written request **within 120 calendar days** of the remittance notification date and include at a minimum:

- a statement indicating factual or legal basis for the dispute
- a copy of the original claim
- a copy of the remittance notice showing claim payment
- any additional information, clinical records or documentation to support dispute.

Washington only mail the payment dispute to:

Optum Washington Network
P.O. Box 30788
Salt Lake City, UT 84130-0788

Premera appeal language continued

If you have additional questions related to a dispute decision made, you may contact us at:

Phone: 877-836-6806

Mail: P.O. Box 30788, Salt Lake City, UT 84130-0788

If you do not agree with the dispute determination, you have the option to request a Health Plan dispute review. Please send all dispute requests in writing, accompanied by all documentation to support your position, directly to the Provider Appeals and Disputes team by using the following address:

Premera Blue Cross Medicare Advantage Plans
Attn: Appeals and Grievances
P.O. Box 262527
Plano, TX 75026

The request for Health Plan dispute review must be received 120 calendar days from the determination date of the initial dispute.

Chapter 8: Claims edit system (CES)

Optum Care uses the Claims Edit System® from Optum to automatically check each claim for errors, omissions and questionable coding relationships by testing the data against an expansive database containing industry rules, regulations and policies governing health care claims.

The system also detects coding errors related to unbundling, modifier appropriateness, diagnoses and duplicate claims. The medical necessity edits help plans detect procedures billed without supporting diagnoses, or not medically necessary, based on local and national coverage determinations (LCD/NCD).

As a critical prepayment application and key contributor to payment integrity, it is essential that health plans carefully manage the Claims Edit System updates. With today's dynamic environment and resource constraints, your organization may be challenged to keep the edit system current.

Chapter 9: Payment integrity programs

OrthoNet program overview

OrthoNet is a vendor partner to the Optum Care Payment Integrity program, providing Focused Claims Review (FCR) on professional claims for high-cost procedures and surgeries. Post-service, pre and post-pay claims reviews are completed by specialty physician reviewers for accurate claim coding.

Records requests

Upon receipt of a records request from OrthoNet, please be aware that they are performing the review at the direction of Optum Care Payment Integrity. Providers are encouraged to fulfill all records requests within the designated timeline communicated within the request.

Please provide all information relevant to the claim and date of service requested. Failure to provide all essential documentation may result in a delay of the review, or, denial of the claim line charges due to services not supported. Services denied as not supported will result in adjustment and recoupment of any previously paid charges.

At times there may be a records request for a procedure that was authorized prior. OrthoNet requests are separate from prior authorization review, as these reviews are an attempt to verify services billed and documented.

Review findings

Upon completion of the review, you will receive a findings letter from OrthoNet. This letter will include the procedure for repayment, as well as, reconsideration, if applicable.

Should you believe the review findings are incorrect, you must submit a request for reconsideration in writing within 120 days of receipt of the findings letter. Your reconsideration request should include the reason(s) you feel the claim findings are incorrect, as well as, any supporting additional documentation that was not included with your original records response to OrthoNet. Peer-to-Peer reviews are available and should be documented within your written reconsideration request.

OrthoNet does not provide appeals review, please do not request an appeal in association with their review findings.

Submitting medical records

- Visit https://provider.orthonet-online.com/ProviderDocumentPortal/
- Fill in the form with the claim information.
    - Contract: Optum Care PrePay
    - Claim Number
    - Service Date From

OrthoNet program overview continued

- Complete the verification question
- Click on the 'Locate the Claim' button
- Drag file from your local computer then drop on to Upload Queue area of the screen or select files from your computer to upload
- Read and click the acknowledgement
- Click ‘Upload’ button
- Click on the ‘Done’ button to go back to the Home screen and continue uploading records for other claims
    - Maximum of 5 separate files can be uploaded per claim Maximum file size of 14.5 MB can be accepted Allowed file types: pdf, tif, tiff, gif, png, bmp, jpg, jpeg, xls, xlsx, rtf, dox, docx, txt

Fax: 1-844-811-5245

Mailing Address:

OrthoNet LLC
PO Box 5046
White Plains, NY 10602-5046

Review Dispute Resolution

Phone: 1-833-685-0458
Fax: 1-844-811-5245

Mailing Address:

OrthoNet LLC
PO Box 5046
White Plains, NY 10602-5046

Should you need to call and discuss a review finding, please have the below information available for reference:

Member Name
Member Date of Birth
Procedure Date of Service

Please do not utilize the Optum Care as-signed claim ID for review inquiries. OrthoNet assigns a different reference number in their system for tracking purposes and does not leverage Optum Care claim ID assignment.

Equian program overview

Equian is a vendor partner to the Optum Care Payment Integrity program, providing pre and post-pay reviews on DRG Coding and Compliance, Outpatient Facility, and Itemized Bill Review.

DRG coding and compliance

Post-pay claim reviews for appropriate DRG coding. Equian works directly with the Facility providers, and adjustments are made upon receiving agreement of findings from the Facility.

Outpatient facility

Post-pay claim reviews for appropriate OPPS coding. Equian works directly with the Facility providers, and adjustments are made upon receiving agreement of findings from the Facility.

Itemized bill review (IBR)

Pre-pay claim reviews for DRG claims which have hit an outlier status. Equian works directly with the Facility providers to obtain the itemized bill and assures all outlier charges are billed appropriately.

Records request

Upon receipt of a records request from Equian, please be aware that they are performing the review at the direction of Optum Care Payment Integrity. Providers are encouraged to fulfill all records requests within the designated timeline communicated within the request.

Please provide all information relevant to the claim and date of service requested. Failure to provide all essential documentation may result in a delay of the review, or, denial of the claim line charges due to services not supported. Services denied as not supported will result in adjustment and recoupment of any previously paid charges.

At times there may be a records request for a procedure that was authorized prior. Equian requests are separate from prior authorization review, as these reviews are an attempt to verify services billed and documented.

Review findings

Upon completion of the review, you will receive a findings letter from Equian. This letter will include the procedure for repayment, as well as, reconsideration, if applicable.

Should you be in agreement with the review findings, please sign the attached acknowledgement document and return to Equian via the correspondence submission options listed. Please review for all of the appropriate boxes to be checked on this form.

Should you believe the review findings are incorrect, you must submit a request for reconsideration in writing within 30 days of receipt of the findings letter. Your reconsideration request should include the reason(s) you feel the claim was paid correctly, as well as, any supporting additional documentation.

Equian program overview continued

Please note, you cannot resubmit the initial clam or a revised claim directly to Optum Care in an attempt to get repaid. All review disputes must go through the reconsideration process. Any claims resubmissions will be denied as a duplicate. All adjustments to Equian reviewed claims must come from Equian and the Optum Care Payment Integrity departments.

DRG coding and outpatient facility

Submitting Medical Records

Phone: 1-877-787-2310
Fax: 1-781-240-0509

Mailing Address:

Equian LLC
Attn: DRG Validation
500 Unicorn Park Drive
Woburn, MA 01801

It is requested you do not submit records to Optum Care directly. Records submission to Equian directly via the above submission options is required to ensure delivery to the correct department and assigned reviewer.

Review Dispute Resolution

Phone: 1-877-787-2310
Fax: 1-781-240-0509
Email: reconsiderations@equian.com

Mailing Address:

Equian LLC
Attn: DRG Validation
500 Unicorn Park Drive
Woburn, MA 01801

Please identify the correspondence as a formal dispute, include the documentation and explanations necessary to clarify the questioned charges, and send the formal written dispute via the submission options listed above.

Equian program overview continued

Itemized bill review

Submitting Medical Records

Fax: 1-866-700-5769

Mailing Address:

Equian LLC
Attn: Claims Disputes
600 12th Street
Suite 300
Golden, CO 80401

It is requested you do not submit records to Optum Care directly. Records submission to Equian directly via the above submission options is required to ensure delivery to the correct department and assigned reviewer.

Review Dispute Resolution

Phone: 1-888-895-2254
Fax: 1-866-700-5769
Email: reconsiderations@equian.com

Mailing Address:

Equian LLC
Attn: Claims Disputes
600 12th Street
Suite 300
Golden, CO 80401

Please identify the correspondence as a formal dispute, include the documentation and explanations necessary to clarify the questioned charges, and send the formal written dispute via the submission options listed above.

Should you need to call and discuss a review finding, please have the below information available for reference:

- Member Name
- Member Date of Birth
- Procedure Date of Service

Please do not utilize the Optum Care assigned claim ID for review inquiries. Equian assigns a different reference number in their system for tracking purposes and does not leverage Optum Care claim ID assignment.