Provider Manual 2022

OCN – Citrus Valley
OCN – Corona
OCN – Desert Cities
OCN – Hemet Valley
OCN – Inland Valley
OCN – Moreno Valley
OCN – North County SD
OCN – Redlands
OCN – Riverside
OCN – RPN
OCN – San Bernardino
OCN – Sun City
OCN – Southwestern Valleys
OCN – Valley Physicians

PrimeCare Medical Group of Chino Valley, Inc.

Mercy Physicians Medical Group, Inc.

PRIMECARE Medical Network, Inc.

3390 Concours St.
Suite 500
Ontario, CA 91764

P 1-800-956-8000

optum.com

May 13, 2022

Rebrand update

We are proud to announce that we are officially changing our name to Optum. While being part of a national organization allows us to strengthen our brand, we know that healthcare is a local endeavor. We will continue to partner with you to provide quality care to the patients we serve together.

IPA networks will begin using the Optum name and logo on June 13th, 2022.

On this date, each of our IPA networks will be renamed to **Optum Care Network** with a distinct sub-network name; please see the table in the following FAQs for a full breakdown. After the go-live date, you will start to see the name and logo change within communication, payor provider directories, referral, credentialing for new clinicians and ID cards for new patients. This rebranding process will not result in any changes to our TIN, NPI, or our legal name. However, given the timing of the change, you may continue to see both the legacy brand names and Optum in the market for a short period of time.

While our name is changing, our focus on providing patients with high quality coordinated care will remain in place and we are committed to making certain that patient care will not be impacted. We are working hard to ensure your workflows and processes with us will not change, just our name. We will maintain all our health plan relationships and we will continue our relationships with our valued physician, hospital, and ancillary partners.

Below are some FAQs about the brand launch and what it means to our hospital partners and patients. ***Please forward this information to your admission and billing departments, plus any applicable medical staff.***

Thank you for your ongoing support and partnership. We are committed to evolve and accelerate our growth and strategic position in the market, while continuing to provide physicians with the support, stability and innovative models for strategic alignment and partnership under our new name, Optum. We look forward to continuing to work closely with you in our shared mission to provide the highest quality care possible to our patients and community.

Thank you in advance to your prompt attention to this matter.

Sincerely,

Howard Saner

Howard Saner
Vice President, Network Operations

Optum

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FAQ's:

Q. What does this mean to patients?
A: The high quality of care and services we provide our patients in partnership with you will remain the same. We are not making changes to cost, insurance coverage, or the excellent experience patients have come to expect.

Q. Are patients aware of the name change?
A: We are informing IPA patients through a mailer targeted to go out early May, but it is likely some will have missed the communication. Patients may refer to us as the legacy brand names and Optum as they adjust to the transition.

Q. Will patients be receiving different ID cards?
A. Some patients may be sent a new ID card. However, most health plans will not update ID cards until the next open enrollment. As we go through this transition, you may see ID cards with Optum, or the legacy network names listed.

Q. The provider contracts with more than one Optum Care Network (PrimeCare, Empire Physicians, Valley Physicians, etc.). How will I be able to distinguish which network my patient belongs to after the name change?
A. Member ID cards and health plans will distinguish the network by the name that follows "Optum Care Network" for example, "Optum Care Network–Corona".

Q. Will the provider get multiple 1099s for the calendar year 2021?
A. You should only be issued one 1099 under the current legal entity name at the time of issuance.

Q. How will I be able to distinguish which network my patient belongs to after the name change?
A. Member ID cards and health plans will distinguish the network by the name that follows "Optum Care Network". Please see below for a breakdown of the new network names:

Current Network Name	Post-Rebrand Network Name
Empire Physicians Medical Group	Optum Care Network–Desert Cities
Inland Faculty Medical Group	Optum Care Network–Inland Faculty MG
Primary Care Associates	Optum Care Network–North County SD
PrimeCare of Citrus Valley	Optum Care Network–Citrus Valley
PrimeCare of Corona	Optum Care Network–Corona
PrimeCare of Hemet Valley	Optum Care Network–Hemet Valley
PrimeCare of Inland Valley	Optum Care Network–Inland Valley
PrimeCare of Moreno Valley	Optum Care Network–Moreno Valley
PrimeCare of Redlands	Optum Care Network–Redlands
PrimeCare of Riverside	Optum Care Network–Riverside
PrimeCare of San Bernardino	Optum Care Network–San Bernardino
PrimeCare of Sun City	Optum Care Network–Sun City
PrimeCare of Temecula	Optum Care Network–Southwestern Valleys
Riverside Physician Network	Optum Care Network–RPN
Valley Physicians Network	Optum Care Network–Valley Physicians

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Business Overview

Who is Optum?

Optum develops and manages provider networks, offering a full range of services to assist physicians and other providers in their managed care and business operations (the "Clients"). For over 20 years, Optum has been an innovator in health care with a record of accomplishment for quality, financial stability, extraordinary services and superior electronic capabilities. Optum is well positioned to continually invest in its infrastructure and systems for the benefit of its Clients and to accommodate the impending changes that will come forth from healthcare reform.

The Optum Clients represent a network of over 800 primary care physicians and over 2,500 specialists and work with the premier hospitals in their respective markets.

A key affiliate in Optum operations is Prime Care Medical Network, Inc. ("PMNI"). PMNI has a limited California Knox-Keene license for the counties of Riverside, San Bernardino, and San Diego enabling PMNI to accept both institutional and professional risk to enhance the coordinated care model. PMNI currently accepts global capitation and full risk for most of its senior plans and some of its commercial plans. As a Knox-Keene licensee, the Department of Managed Health Care subjects PMNI to stringent measures to ensure that they maintain financial solvency requirements and compliance to multiple operational standards.

Optum clients include:

Optum Care Network – Citrus Valley
Optum Care Network – Corona
Optum Care Network – Desert Cities
Optum Care Network – Hemet Valley
Optum Care Network – Inland Valley
Optum Care Network – Moreno Valley
Optum Care Network – North County SD
Optum Care Network - Redlands
Optum Care Network - Riverside
Optum Care Network - RPN
Optum Care Network – San Bernardino
Optum Care Network – Sun City
Optum Care Network – Southwestern Valleys
Optum Care Network – Valley Physicians
PrimeCare Medical Group of Chino Valley, Inc.
Mercy Physicians Medical Group, Inc.

Mission

To be the most trusted name in healthcare.

Vision

We believe that improving quality will result in the most efficient health care delivery system and that we have a societal responsibility to utilize health care resources appropriately.

Values

Do what is right
Project pride
Care for people
Respond to needs
Be the standard

Purpose

The purpose of this manual is to provide key information to contracted network providers so they can effectively care for mutual members in accordance with Optum and industry standards.

Optum Website

Optum's website www.optum.com/primecare provides contracted network providers and members with access to timely, IPA specific information as well as Optum corporate data.

An important component of the website is the personalized IPA home pages for each of our managed care organizations. With these customized pages, existing and potential members can explore the various services found within each of the IPAs, including physician directories, urgent care resources, hospitals, Health Plans and current news. Existing and potential members can access our physician search mechanism, which allows members to review our updated list of affiliated physicians. The physician search mechanism was designed to assist members in identifying a doctor that best meets their current needs within their preferred service area by specialty, name and location.

Other key components of the external website are member access to Health Education classes on Chronic Disease Management, Wellness Programs and Preventative Care. Additional member information on access standards, preventative health guidelines, rights and responsibilities and accommodation services are available.

Current Optum corporate data regarding the vision, values, management team, vision and value added services, news and careers is easily accessible as well.

Optum Service Area

IPA Contact Information

IPA	Address	City/State	Zip Code	Phone/Fax
Optum Care Network – Desert Cities	34-160 Gateway Dr., Suite 100	Palm Desert, CA	92211	P: 760-770-8678 F: 760-770-7609
Mercy Physicians Medical Group	3900 Fifth Ave., Suite 370	San Diego, CA	92103	P: 619-543-8800 F: 619-296-5160
Optum Care Network – North County SD	450 S Melrose Dr., Suite 220	Vista, CA	92081	P: 760-542-6757 F: 760-542-6747
PrimeCare Medical Group of Chino Valley	15315 Fairfield Ranch Rd., Suite 275	Chino Hills, CA	91709	P: 909-465-1397 F: 909-465-6629
Optum Care Network - Citrus Valley Corona Moreno Valley Riverside	2275 Sampson Ave., Suite 111	Corona, CA	92879	P: 951-371-8440 F: 951-371-5074
Optum Care Network - RPN	1650 Iowa Ave., Suite 220	Riverside, CA	92507	P: 951-788-9800 F: 951-788-1630
Optum Care Network – Hemet Valley Valley Physicians	24630 Washington Ave., Suite 203	Murrieta, CA	92545	P: 951-704-1900 F: 866-861-3291
Optum Care Network – Inland Valley	3990 Concours Ave, Suite 201	Ontario, CA	91764	P: 909-466-8000 F: 909-484-6825
Optum Care Network - San Bernardino Redlands	560 East Hospitality Lane, Suite 200	San Bernardino, CA	92408	P: 909-792-5375 F: 909-792-8462
Optum Care Network – Southwestern Valleys Sun City	41391 Kalmia Street, Suite 310	Murrieta, CA	92562	P: 951-461-0762 F: 951-698-5194

Definitions

Whenever used in this manual, the following terms shall have the following meanings:

Add-on Code Edits:

- Consist of a listing of HCPCS and CPT add-on codes with their respective primary codes. An add-on code is eligible for payment if and only if one of its primary codes is also eligible for payment.

Allowed Charges:

- Charges for services rendered or supplies furnished by a healthcare 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.

Ancillary Services – Medicare Provider Reimbursement Manual, Section 2202.8 states:

- Ancillary services in a hospital or SNF include laboratory, radiology, drugs, delivery room (including maternity labor room), operation room; (including post anesthesia and post-operative recovery rooms), and therapy services (physical, speech, occupational). Ancillary services may also include other special items and services for which charges are customarily made in addition to a routine service charge.

APC – Ambulatory Surgery Classification:

- Used for outpatient hospital claims, paid at OPPS (outpatient perspective payment system)

ASC – Ambulatory Surgery Center:

- A free standing outpatient surgery center.

Balance Bill:

- Illegal practice of hospitals, clinics, doctors' offices and other medical facilities billing patients for the balance between what they want to charge their patients for services and what the insurance company has already reimbursed them.

Billed Charges:

- The dollar amount billed by a provider as their Usual and Customary charge.

Capital Equipment & Monitors/Pumps:

- Equipment commonly available to patients in a particular setting or ordinarily furnished during the course of a procedure is considered routine and not billed separately. Supplies used in conjunction with the equipment are also considered routine. The cost of the equipment should be incorporated into the charge for the procedure.

Capitation:

- Method of payment for health services in which a physician or hospital is paid a fixed amount for each person served regardless of the actual number or nature of services provided each person. This is a per member per month (pmpm) payment to a provider/provider organization that covers contracted services and paid in advance of delivery of any services. The rate can be fixed, adjusted by age/sex of enrollees, percent of premium based on severity ratings.

Case Rate:

- A fixed dollar amount established as payment for a service.

Charges:

- Medicare Provider Reimbursement Manual, section 2202.4 states:
  Charges refer to the regular rates established by the provider for services rendered to both beneficiaries and to other paying patients. Charges should be related consistently to the cost of

the services and uniformly applied to all patients whether inpatient or outpatient. All patients' charges used in the development of apportionment rations should be recorded at the gross value; i.e., charges before the application of allowances and discounts deductions.

Clean Claim:

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

Clearing House: Trading Partner:

- A service that transmits claims and other electronic transactions to insurance carriers.

Contested Claim:

- The DMHC defines a contested claim as "A claim, or portion thereof, is reasonably contested where the health plan has not received the completed claim and all information necessary to determine payer liability for the claim or has not been granted reasonable access to information concerning provider services. Information necessary to determine payer liability for the claim includes, but is not limited to, reports of investigations concerning fraud and misrepresentation, and necessary consents, releases and assignments, or a claim on appeal/dispute or other claim information necessary for the plan to determine the medical necessity for the healthcare services provided. Department of Managed Health Care regulation 1371.

Copayment:

- Those charges, including coinsurance and deductibles, which may be collected directly from a Group Member for Covered Services rendered to such Group Member. Provider agrees that cost sharing for dual eligible enrollees is limited to the Medicaid cost sharing limits; and that for those dual-eligible enrollees, Provider will accept the compensation listed in Exhibit B of Provider's agreement as payment in full or will separately bill the appropriate state source for any amounts above the Medicaid cost sharing.

Designated Record Set:

- A group of records maintained by or for a covered entity that is used, in whole or in part, by or for the covered entity to make decisions about individuals.

Dietary Services:

- Dietary supplements used for tube feeding or oral feeding, such as elemental high nitrogen diet, even if written as prescription items by a physician.

DOFR:

- Division of financial responsibility. A contractually executed grid that designates financial responsibility between group, plan and occasionally facility.

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 hospital 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 members.

DRG Rate:

- A fixed dollar amount based on averaging 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 hard copies.

Remittance Advice:

- Detailed explanation received from payee regarding the payment or denial of benefits billed.

Fee for Service – FFS:

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

Fee Schedule:

- A fee schedule can be any list of professional services and rates at which they are reimbursed by the payer.

Global Period:

- A time period set aside before and after 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.

Mandated Time Frames:

- Refers to the regulatory agencies' set payment times which the plans and provider organizations must adhere to. The DMHC, CMS and Medi-Cal have mandated the time frames for payment of clean and unclean claims.

Maximum Out of Pocket – MOOP:

- Expenses that are paid by the member and are not reimbursed by the health plan. Out of pocket expenses are co-pays, deductibles and co-insurance. The health plan caps the out of pocket expenses, meaning when the member reaches the maximum out of pocket costs, the health plan takes over and provides coverage for rest of year.

ME Edits:

- Many procedure codes cannot be reported together because they are mutually exclusive of each other. Mutually exclusive procedures cannot reasonably be performed at the same anatomic site or same patient encounter.

Medical Necessity:

- Medical service or procedure performed for treatment of an illness for inquiry not considered investigational, cosmetic or experimental.

Misdirected Claim:

- A claim that is submitted to the incorrect payor.

Modifiers:

- A code that provides the means by which the reporting physician can indicate that a service or procedure that has been performed has been altered by some specific circumstance but has not changed in its definition or code.

Medically Unlikely Edits (MUE):

- Units-of-service edits for practitioners, ambulatory surgical centers, outpatient hospital services, and durable medical equipment. This component defines for each HCPCS/CPT code the number of units of service that is unlikely to be correct.

NCCI:

- National Correct Coding Initiative comprised of three types of edits: NCCI Procedure to Procedure (PTP), Medically Unlikely Edits (MUE) & Add-on Code Edits.

Net Amount:

- Dollar amount paid for the billed service minus any member cost share.

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 member's responsibility.

Patient Convenience Items:

- Items that do not meaningfully contribute to the treatment of patient's illness or injury or the functioning of a malformed body member.

Per Diem:

- A flat amount paid for each day the member is hospitalized regardless of the services rendered.

PHI (Protected Health Information):

- Individually identifiable health information, including demographic information collected from an individual, and:
  1. Is created or received by a health care provider, health plan, employer, or health care clearinghouse.
  2. Relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and
     2.1 That identifies the individual; or
     2.2 With respect to which there is a reasonable basis to believe the information can be used to identify the individual.

PTP – **(Procedure to Procedure)**:

- Identification of services not appropriately billed together. If a provider reports the two codes of an edit pair for the same beneficiary on the same date of service, the column one code is eligible for payment but the column two code is denied unless a clinically appropriate NCCI – associated modifier is billed.

Reciprocity:

- Contractual agreement between parties to extend the terms of the parties' agreement to a non-contracted risk-bearing provider who renders services to a member.

Risk:

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

Routine Laboratory Services:

- Routine specimen collections

Routine Medical/Surgical Supplies:

- Considered to be packaged into the procedure or room charge and should not be separately billable to Optum. These items are customarily used during the course of treatment as needed, are stocked at the nursing station or in floor bulk stock and generally available to all patients receiving supplies in that location and are not tracked individually. (e.g., alcohol preps,

applicators, band –aids, Maalox, aspirin and other non-legend drugs ordinarily kept on hand, suppositories and tongue depressors, gloves, paper masks, linen savers, cotton balls).

Routine Nursing Services:

- All general nursing services, including administration of oxygen and related medications, monitoring patients, hand feeding, incontinency care, tray service, enemas, and other bedside nursing services.

Routine Pharmacy Services:

- Flush and Irrigation supplies

Routine Services:

- Medicare Provider Reimbursement Manual, Section 2202.6 states:
  "Inpatient routine services in a hospital or skilled nursing facility generally are those services included in the daily service charge – sometimes referred to as the "room and board" charge. Included in routine services are the regular room, dietary and nursing services, minor medical and surgical supplies, medical social services, psychiatric social services, and the use of certain equipment and facilities for which a separate charge is not customarily made."

Supplies:

- Items which are utilized by individual recipients but which are reusable and expected to be available in an institution providing a skilled level of care: e.g., ice bags, bedrails, canes, crutches, walkers, wheelchairs, IV poles and pumps, traction equipment and other durable medical equipment.

Unclean Claim:

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

Unbundling:

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

Usual, Customary and Reasonable – UCR:

- A method of reimbursement to providers on a fee for service payment which reflects the usual and customary reimbursement rates for other providers for similar services in a geographic location

Member Enrollment and Assignment

Individual members or employer groups can purchase healthcare coverage from any of Optum's contracted health plans and utilize services from Optum's contracted physician and ancillary network.

Health Plan Contact Information

Optum proudly accepts the following Health Plans:

COMMERCIAL PLANS

Plan	IPAs	Plan Phone
Aetna	PMNI, MPMG, OCN – Desert Cities, OCN – North County SD	(800) 624-0756
Anthem Blue Cross	PMNI, MPMG, OCN – Desert Cities, OCN – North County SD	(800) 677-6669
Blue Shield	PMNI, MPMG, OCN – Desert Cities, OCN – North County SD	(800) 541-6652
Cigna	PMNI, MPMG, OCN – Desert Cities, OCN – North County SD	(800) 882-4462
Health Net	PMNI, MPMG, OCN – Desert Cities, OCN – North County SD	(800) 522-0088
Sharp (San Diego County only)	OCN – North County SD	(800) 359-2002
Scripps Health Plan Services	MPMG, OCN – North County SD	(888) 680-2273
United Healthcare	PMNI, MPMG, OCN – Desert Cities, OCN – North County SD	(800) 624-8822

SENIOR PLANS

Plan	IPAs	Plan Phone
Aetna	PMNI, MPMG, OCN – Desert Cities, OCN – North County SD	(800) 282-5366
Alignment Health Plan	PMNI, MPMG, OCN – Desert Cities, OCN – North County SD	(844) 310-2247
Anthem Blue Cross	PMNI, MPMG, OCN – Desert Cities, OCN – North County SD	(800) 677-6669
Blue Shield	PMNI, MPMG, OCN – Desert Cities, OCN – North County SD	(800) 258-3091
Brand New Day	OCN – RPN Only	(866) 255-4795
Cigna	PMNI	(800) 882-4462
Central Health Medicare Plan	CHI and OCN – San Bernardino Only	(866) 314-2427
Health Net	PMNI, MPMG, OCN – Desert Cities, OCN – North County SD	(800) 275-4737
Humana	PMNI, MPMG, OCN – Desert Cities, OCN – North County SD	(800) 457-4708
Inland Empire Health Plan (IEHP)	PMNI	(877) 273-4347
InterValley Health Plan	OCN – San Bernardino Only	(800) 251-8191

SCAN	PMNI, MPMG, OCN – Desert Cities, OCN – North County SD	(800) 559-3500
United Healthcare	PMNI, MPMG, OCN – Desert Cities, OCN – North County SD	(800) 950-9355

Member Transfer or Disenrollment

Health Plans recognize the Provider's need to address situations where there is a material breakdown in the physician-patient relationship due to a number of circumstances. Consequently, Optum has implemented a process by which the Provider may request that a member be removed from his/her panel. The policies and procedures regarding this process are explained in this section.

*Until the member is transferred, the Provider must ensure that the required services are available, accessible and are furnished in a manner that ensures continuity of care.

Disenrollment Policy and Procedures

Member Discipline and Disenrollment

Scope

All employees of Optum and its affiliated entities shall follow the procedures set forth in this section.

Purpose

To establish standardized criteria and procedures for member disenrollment from a Health Plan.

Policy

Optum and its affiliated entities may discipline members as per this policy. The disenrollment of a member will be handled in accordance with the Health Plan's policies and procedures regarding disenrollment. Optum affiliated physicians have contractual obligations to provide care or arrange for the provision of care of all members assigned to the network. Contractually, the practitioners shall provide medical care to the member until the transfer of care and/or disenrollment has been completed.

Procedures

1. Conditions for recommending discipline of disenrollment include, but are not limited to:

    a. Patient conduct interfering with rendering effective health care
    b. Disruptive behavior exhibited in the course of seeking or receiving services
    c. Member is non-compliant in following recommended treatment or procedures and the physician believes that there is no alternative treatment or procedure that is acceptable to the patient, which meets the standards of proper medical care. The refusal by the member would have to endanger the health of the member or aggravate an existing condition.
    d. Fraud involving an Optum affiliated medical care.

e. Threatening or physically abusive behavior towards the physician and/or physician staff, Optum or affiliate entity personnel, other members, visitors or physical facilities.

2. IPA Staff (PSR, PSC, Executive Director, IPA Manager):
    a. Provide the physician's office guidance and assistance regarding discipline and disenrollment of a member based upon established policies and procedures (see Exhibit A).
    b. Upon receipt of notification from physician, establish potential patient discipline and disenrollment file.
    c. Fax or mail the discipline or termination request with all supporting documentation to the member's Health Plan.
    d. Interface with the physician and Health Plan as necessary to complete resolution of the issue.
    e. Forward copy of all correspondence to QI department for tracking of member issues.

3. UM Staff:
    a. Provide the physician's office guidance and assistance regarding discipline and disenrollment of a member based upon established policies and procedures (see Exhibit A).
    b. Upon receipt of notification from physician, establish potential patient discipline and disenrollment file.
    c. Forward copy of all correspondence to PSR and QI department for tracking of member issues.

4. QI Staff:
    a. Provide the IPA staff and physician offices guidance and assistance regarding discipline and disenrollment of members based upon Optum and Health Plan policies and procedures.
    b. Upon receipt of notification from physician or IPA, establish potential discipline and disenrollment file and enter into QI database for tracking of member issues.

5. Affiliated Physician and Staff:
    a. Upon determining that conditions for discipline exist as per Exhibit A:
        i. Create a letter to the member stating the reason for disenrollment and include the following :
            1. All levels of behavior
            2. Documentation of each issue, factually and professionally
            3. Documentation of counseling sessions for the unacceptable behavior and any follow up written notifications.

ii. The letter should be sent to the member by certified mail with return receipt requested. Warning letters should state that the behavior is unacceptable and reaffirm that the member has been counseled.

b. Continue to provide or arrange for patient care until notified in writing by the Health Plan, but not less than 30 days.

Supplemental Information: Exhibit A
Sample Letters
Treatment Plan Agreement

Exhibit A: Discipline and Disenrollment Coordination with the Health Plan

PATIENT BEHAVIOR: The following are Optum definitions and practices. They may require modification based on the patient's Health Plan policies and procedures.

A. **Level A Behavior** – Disruptive behavior exhibited in the course of seeking or receiving services from an affiliated physician and/or vendor (eg. placing unreasonable demands for service or care either through the physician's office or directly to member's Health Plan).
    1. Level A behavior must occur on three (3) separate occasions and occur despite warnings in writing by the physician. All occurrences must be factually and professionally documented in the patient's medical record.
    2. The second occurrence which results in the same action as the first, outlining the behavior problem and the possible consequences if such behavior persists.
    3. After the third occurrence of such behavior, the physician may send a written request to the member's Health Plan to transfer the member. The transfer of the member will be handled in accordance with the Health Plan's policies and procedures regarding member transfers.
    4. See **Sample Letter A** for an idea of what to send to the member.

B. **Level B Behavior** – Patient is non-compliant in following recommended medical treatment or procedures, and the physician believed there is no alternative treatment or procedure that is acceptable to the member which meets the standards of proper medical care. The refusal by the member would have to endanger the health of the patient or aggravate an existing condition (eg. the patient leaves the hospital against medical advice).
    1. Level B behavior must occur twice within twelve (12) consecutive months, despite written notice from the physician regarding the medical consequences of the failure to follow the recommended treatment. At the first occurrence, the physician must counsel the patient and should send a certified letter with return receipt. The letter should state that the behavior is unacceptable and reaffirm that the patient has been counseled. A counseling session must be documented and copies of the letter and supporting documentation of the incident are to be sent to the member's Health Plan.
    2. After the second occurrence, the physician may send a written request to the member's Health Plan to immediately terminate the patient.
    3. See **Sample Letter B** for an idea of what to send to the member.

C. **Level C Behavior** – Level C behavior need only occur once to request immediate discipline or transfer.
    1. Fraud (eg. prescription forgery, using false identification to obtain services).
    2. Threatening or physically abusive behavior toward office staff, Optum personnel, other patients, visitors or physical facilities.
    3. Disruptive or abusive behavior toward Health Plan personnel, other patients, visitors or physical facilities.
    4. See **Sample Letter C** for an idea of what to send to the member.

Sample Letter for Level A Behavior

Disruptive behavior exhibited in the course of seeking or receiving services from an affiliated physician and/or vendor (eg. placing unreasonable demands for service or care either through the physician's office or directly to member's Health Plan).

Date

Member Name
Member Address
Member Address

Re: Unacceptable Behavior

My primary concern is to accommodate your medical needs and deliver quality health care services. However, your recent behavior is interfering with my ability to assess and respond to your health care needs in a complete and professional manner.

Your recent behavior in my office has been (describe behavior, e.g.: disruptive, threatening, etc.) Specifically, you (describe occurrence such as: were verbally inappropriate with my staff on date; by contacting the health plan requesting referrals leaves me being unable to provide you with coordinated care. ETC.) , which is unacceptable and specifically hinders my ability to treat you effectively.

I am requesting your cooperation in: (describe recommendations for appropriate behavior)

We are committed to providing you with quality healthcare, but if I can no longer maintain a compatible physician-patient relationship to provide the medical care you require, I will request your health plan to disenroll you from my practice and no longer be available as your physician.

If you have any questions regarding this letter, or need to schedule an appointment, please feel free to contact my office at XXX-XXX-XXX.

Sincerely,

Physician Name
IPA

Cc: Patient File/IPA

Sample Letter for Level B Behavior

Patient is non-compliant in following recommended medical treatment or procedures, and the physician believed there is no alternative treatment or procedure that is acceptable to the member which meets the standards of proper medical care. The refusal by the member would have to endanger the health of the patient or aggravate an existing condition (eg. the patient leaves the hospital against medical advice).

Date

1st Warning

Member Name
Member Address
Member Address

Re: Medical Non-Compliance

Dear (Member Name):

It has come to my attention that you are not adhering to the medical treatment plan I have instructed you to follow. It is necessary for you to (insert advice, regime or recommendation) for important health reasons. Specifically, if you fail to do so, it may have the following effects on your health: (insert consequences of not following treatment).

For you to get your treatment course back on track, it is necessary for you to (inert what the patient must do to get back on track).

We are committed to providing you with quality healthcare, but to do so, we must count on you to follow your prescribed treatment. You are a critical part of the healthcare team. If you have any questions about what you must do, please call our office at (insert phone number).

Sincerely,

Physician Name
IPA name

Cc: Patient File
IPA

Sample Letter for Level C Behavior

Level C behavior need only occur once to request immediate discipline or transfer.

Date

Immediate/Final Disenrollment

Member Name
Member Address
Member Address

Re: Non-Compliance

Dear (Member Name):

This letter is to inform you that, although I am concerned about your health, I am requesting (name of member's health plan), your Health Plan, withdraw me from your care as your treating physician for the following reasons:

- ✓ **(State your reason)**
- ✓ **(State your reason)**
- ✓ **(State your reason)**

I can no longer maintain a compatible physician-patient relationship to provide the medical care you require and will no longer be available as your physician.

I will be available to treat you for the next thirty (30) days only. It is extremely import that you place yourself under the care of another physician without delay. There are many fine physicians in this community. If you are unable to locate one, I suggest you contact your health plan for a referral.

Enclosed is an authorization form to release a copy of your medical records to the physician of your choice. Upon receipt of the signed form, my office will forward a copy of the records promptly to the physician you designate. Also, I will be available to discuss my evaluation and treatment of you with your new physician.

Sincerely,

Physician Name
IPA

Cc: Patient file
Health Plan/IPA

Treatment Plan Agreement

(**IPA Name**) recognizes the vital role of active patient participation in maintaining optimal health (**IPA Name**) is committed to the goal of having its patient understand and be involved in the delivery of medical care. (**IPA Name**) wishes to provide assistance to its members in reaching their medical goals but this cannot be accomplished without the cooperation of the member.

At the meeting held _____ (date) at the _____ (location of meeting) attended by _____ (member's name, and person's assisting the member and any office/IPA staff present), the following treatment guidelines were established and agreed upon at the meeting;

1.
2.
3.
4.

(The agreements should be stated simply and should be as specific as possible. They should include dates whenever possible. For example, "Starting today you will make monthly appointments with Dr._____. For your prenatal care until you deliver your baby. You agree to arrive at the scheduled time for each appoint")

(If an interpreter is necessary, the interpreter should write out the specific agreements, on this same document, in the patient's primary language)

The failure to follow the agreement(s) listed above may result in the referral of your case to your Health Plan with the possible result of our disenrollment form (Name of practice/IPA).

Your signature below indicates your understanding and acceptance of this agreement.

_____ _____

(Member Signature) (Date)

_____ _____

(Physician/Representative) (Date)

This meeting was conducted with aid of an interpreter, at the _____ (the member, physician office, etc.)_____ (name of interpreter) acted as the interpreter and translated the conversations during the meeting and the specific written agreement(s) listed above, for the member, into _____ (language).

_____ _____

(Interpreter) (Date)

Cc: Member's Medical Record/IPA

Credentialing and Recredentialing

The Credentialing Department handles provider credentialing/recredentialing for Optum's statewide network. The credentialing and recredentialing verifications are performed by the Credentialing Department.

Initial Credentialing

To add new providers or extenders (PA and NPs) to the network, initial requests should go through your contracted IPA and/or the Contracting Department. The Provider Services Representatives and/or Contracting Representatives will forward the initial credentialing application and/or CAQH provider ID number along with the required supporting documents to the Credentialing Department for processing. The PSRs and Contracting Reps will also be your contact person for status on the credentialing application.

Our initial credentialing process takes approximately 60-90 days to complete, from receipt of completed credentialing application to Committee approval. The credentialing timeframe is directly dependent upon receiving a completed credentialing packet. A complete credentialing packet consists of a current CAQH on-line application (not expired or blocked) or CPPA application and current supporting documents as indicated below:

- Current copy of California Medical License
- Current copy of DEA certificate with California address listed or a letter from provider stating who will cover prescriptions
- Current copy of Malpractice Insurance Face Sheet
- Current Hospital admitting privileges or alternate coverage clearly identified in application. If not, then a letter identifying who will cover admits
- NPI must show a California address as the practice address (Verification may be queried from **https://npiregistry.cms.hhs.gov/**)
- Current Curriculum Vitae. **Please ensure work history is updated and includes your current practice information. Also, ensure there are NO GAPS and please make sure the dates are MM/YY NOT just YYYY for the beginning and end date for each position.
- NP/PA Scope of Services and/or Protocols

*To register with CAQH, log on to https://proview.caqh.org/. Please contact CAQH directly at 888-599-1771 if you are having problems or need assistance completing your on-line application.

Recredentialing

Recredentialing occurs every three years. Eight months prior to the three-year credentialing anniversary provider will receive a request to log into CAQH, a Universal Provider Datasource, and complete the online application or if provider has already done so, then verify that the attestation is current and up to date. The CAQH website is https://proview.caqh.org/Login/. If you need your CAQH provider ID number, please contact the credentialing department and they will provide it.

Providers shall promptly notify the IPA and Credentialing Department if they no longer meet the Group's credentialing criteria (e.g. medical license revoked, opt-out of Medicare, sanctions or restrictions from medical board)

Please Note: If provider or their group is adding a physician and/or a Nurse Practitioner (NP) / Physician Assistant (PA), the credentialing must be completed and there must be an executed contract in place prior to the practitioner seeing IPA members. It is fraudulent practice to bill under one physician when services are actually provided by another physician/provider.

Should a provider have a change in any address, phone or fax numbers, provider must notify their Provider Services Representative in writing.

Utilization Management

Introduction to Utilization Management (UM)

Optum's UM staff are assigned to each IPA and strive to offer providers and members the most efficient service possible. Their goal is to process authorizations within the following timeframes:

- ✓ Routine authorization requests within 5 working days.
- ✓ Medically urgent requests within 72 hours.
- ✓ Reminder for Contracted Providers ONLY: We no longer process retrospective authorization requests except in the following circumstances: If provider provides emergent or urgent services that were not prior authorized and submit request to the Medical Management department within 72 hours, Medical Management will review for medical necessity and urgency. Failure to submit within 72 hours will result in a *Contractual Denial*.

Case Management – (CM)

Optum Case Managers are available to assist with managing your patients. The department is designed to coordinate comprehensive, cost effective care for your patients that have multiple chronic illnesses, non-adherence concerns, health plan benefit questions, behavioral health issues, social determinant concerns and/or catastrophic injuries. The clinical case management staff at Optum includes RN's, LVN's and Social Workers. Complex Case Management and Care Coordination programs are available. The case management program successfully integrates medical and behavioral concerns for all age ranges and health plans. Home social work visits are available upon request.

Case Management is a requirement for all members of our contracted Cal Medi-Connect and SNP programs. All physician providers are required to attend an annual refresher course on the SNP and Medi-Connect Model of Care (MOC). In addition, each member and their PCP enrolled in CM, will be provided with a care plan with their patient's goals and plans to achieve these goals. Regular scheduled weekly Team Meetings are held with the interdisciplinary team to review and approve the care plans. The Medical Director, Pharmacist, Nurses and Social Workers are in attendance. Optional attendees include the members, health plan case managers and PCP's. Authorization Portal messaging is the primary referral source for CM and social work referrals. In addition, CM phone calls, Outlook emails and faxes are utilized by the physicians.

The CM department also has a Diabetic Nurse Educator that is available to contact patients and enroll them in an individualized diabetic education case management program. The program provides 6 month telephonic education and self-management techniques to members with Diabetes and CKD.

To assist with Transitions of care, case management also has an automated telephonic discharge calling system survey IVR (interactive Voice Response) that is used for patients after discharge from the hospital. The calling system makes calls within 2-3 days after discharge. The areas that alert are sent to the case managers for follow-up. This IVR program is to designed to detect problems early enough to avoid readmissions or ER visits for your patients.

For case management referrals and questions please contact us at (909) 493-2390

Appointment of Representative

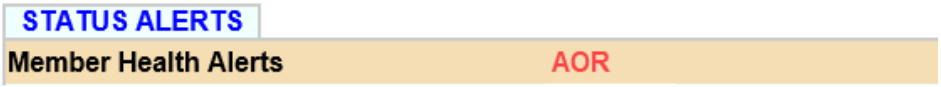
The Appointment of Representative (AOR) includes a required form which supports the process to allow for those times when a Medicare member authorizes a person other than themselves to make a request for healthcare services (including those for behavior health) on their behalf. A member can appoint any individual, including an attorney or physician, at any time to represent him/her when requesting a health care service. A completed Appointment of Representative form (CMS-1696), which is preferred, or a letter can be submitted assigning the designated person. This is different from a Power of Attorney or an Advanced Directive.

If member is submitting a letter, it must include the following:

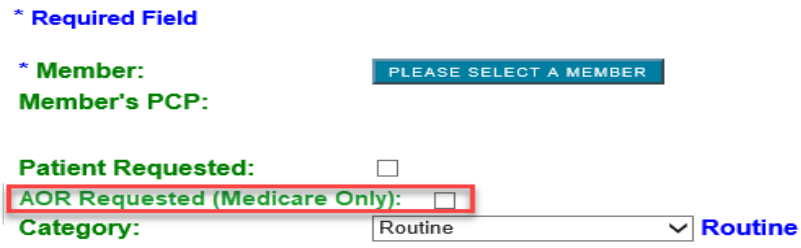
- Be in writing
- Signed and dated by the member and representative (the representative's signature must be dated within 30 days of the member's signature)
- Include a statement appointing the representative to act for the member
- Include a written explanation of the purpose and scope of the representation
- Include the names, phone numbers, and addresses of both the member and the representative
- Include the representative's professional status or relationship to the member
- Contain a unique identifier of the represented party
    - If the party is the beneficiary, the Medicare number must be included. If the party is a provider or supplier, the National Provider Identifier (NPI) number is requested.

Once reviewed and determined that an AOR form is necessary, the following steps are required:

- If an AOR is required but not included with request for health care services, staff will review the 'Member Health Alerts' in the authorization system to determine if an AOR is already on file.



When Submitting a Referral Request on behalf of an AOR, you must check off the "AOR Requested (Medicare Only):" field.



Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved OMB No.0938-0950

Appointment of Representative

Name of Party	Medicare Number (beneficiary as party) or National Provider Identifier (provider or supplier as party)

Section 1: Appointment of Representative

To be completed by the party seeking representation (i.e., the Medicare beneficiary, the provider or the supplier):
I appoint this individual, _____, to act as my representative in connection with my claim or asserted right under Title XVIII of the Social Security Act (the Act) and related provisions of Title XI of the Act. I authorize this individual to make any request; to present or to elicit evidence; to obtain appeals information; and to receive any notice in connection with my claim, appeal, grievance or request wholly in my stead. I understand that personal medical information related to my request may be disclosed to the representative indicated below.

Signature of Party Seeking Representation		Date
Street Address		Phone Number (with Area Code)
City	State	Zip Code
Email Address (optional)		

Section 2: Acceptance of Appointment

To be completed by the representative:
I, _____, hereby accept the above appointment. I certify that I have not been disqualified, suspended, or prohibited from practice before the Department of Health and Human Services (HHS); that I am not, as a current or former employee of the United States, disqualified from acting as the party's representative; and that I recognize that any fee may be subject to review and approval by the Secretary.
I am a / an _____
(Professional status or relationship to the party, e.g. attorney, relative, etc.)

Signature of Representative		Date
Street Address		Phone Number (with Area Code)
City	State	Zip Code
Email Address (optional)		

Section 3: Waiver of Fee for Representation

Instructions: This section must be completed if the representative is required to, or chooses to, waive their fee for representation. (Note that providers or suppliers that are representing a beneficiary and furnished the items or services may not charge a fee for representation and **must** complete this section.)
I waive my right to charge and collect a fee for representing _____ before the Secretary of HHS.

Signature	Date

Section 4: Waiver of Payment for Items or Services at Issue

Instructions: Providers or suppliers serving as a representative for a beneficiary to whom they provided items or services must complete this section if the appeal involves a question of liability under section 1879(a)(2) of the Act. (Section 1879(a)(2) generally addresses whether a provider/supplier or beneficiary did not know, or could not reasonably be expected to know, that the items or services at issue would not be covered by Medicare.) I waive my right to collect payment from the beneficiary for the items or services at issue in this appeal if a determination of liability under §1879(a)(2) of the Act is at issue.

Signature	Date

****REMINDERS****

- AOR form is only good for one year from the date of the beneficiary's signature
- A photocopy of a completed AOR form is acceptable
- Sections 1 and 2 of the AOR must be completely filled out to be considered complete

Hospital Admission Notification

- ✓ 24 Hour Notification Process
  - For after hours, weekends and holidays, the notification number for all Optum Medical Groups is (844) 364-8304.
  - Please contact the member's medical group/IPA directly Monday – Friday 8 AM- 5PM

MEDICAL GROUP/IPA	TELEPHONE	FAX
Optum Care Network – Desert Cities	760-770-8678	760-770-7609
Mercy Physicians Medical Group	619-543-8800	877-840-0360
Optum Care Network – North County SD	760-542-6757	866-321-1465
PrimeCare of Chino Valley	909-465-1397	866-802-1692
Optum Care Network - Citrus Valley Corona Riverside Moreno Valley	951-371-8440	877-843-4435
Optum Care Network - RPN	951-788-9800	951-788-1630
Optum Care Network – Hemet Valley	909-461-0762	909-465-6629
Optum Care Network – Inland Valley	909-466-8000	877-881-2338
Optum Care Network - Redlands San Bernardino	909-476-1575	877-645-8397
Optum Care Network – Sun City Optum Care Network – Southwestern Valleys	951-461-0762	877-659-8824
Optum Care Network – Valley Physicians	951-704-1900	866-542-9782

- ✓ If Optum fails to respond to a health care provider's first request for authorization to provide necessary post-stabilization medical care **within one hour** of the request, the necessary stabilization medical care shall be deemed authorized.

- ✓ Optum shall pay for all medically necessary health care services provided to full risk members. These services must be necessary to maintain the members stabilized condition up to the time that Optum can effectively coordinate the member's transfer or the member is discharged.

- ✓ Post-stabilization services at a non-participating facility will be covered until:
  - The member is discharged from the hospital

- A local network physician assumes responsibility for the member's care
- The treating physician and the local network hospitalist of primary care physician agree to another arrangement for the appropriate level of care

✓ Optum reserves the right to respond to a health care provider's request for post-stabilization medical care authorization by informing the provider of the decision to transfer the member to another health care provider. The Provider and the UM staff shall coordinate and effectuate the transfer of the member as soon as possible.

✓ All requests for authorizations and results for authorizations for post-stabilization medically necessary health care services which follow the provision of medically necessary health care services shall be fully documented. Documentation shall include, but not be limited to:

- The date and time of the care transition request
- The decision or status of the care transition request
- The name of the health care provider making the request
- The name of the representative Case Manager responding and coordinating the post-stabilization transfer.

Electronic Connectivity

Optum's Information Technology Department offers a variety of electronic connectivity services to help providers do what they do best: take care of their patient's health care needs. Our goal is to provide useful technology and easy to use tools which maximize operational and administrative efficiencies and enhance all levels of customer service.

To improve the coordination of patient care and to assist physicians with meeting Meaningful Use objectives as specified by CMS, Optum offers an Electronics Health Record (EHR) adoption program in its connectivity strategy Providers interested in obtaining more information about the EHR program, please contact your IPA.

Optum Provider Portal

Optum Provider Portal, www.nammnet.com, includes access to a web-based application offering Optum provider offices access to key member authorization, claims and benefit information online as well as other value added services available to Optum contracted providers.

Provider and staff can:

- ✓ View RAF and Annual Health Assessment Status
- ✓ Print Reports and Submit Annual Health Assessments on your members
- ✓ Check on claim status
- ✓ Check on authorization status
- ✓ Submit authorizations
- ✓ Request additional office visit days on authorizations
- ✓ Review preventive care and quality measures data

Optum Provider Portal is free. There is no cost to Optum providers to sign up and use it.

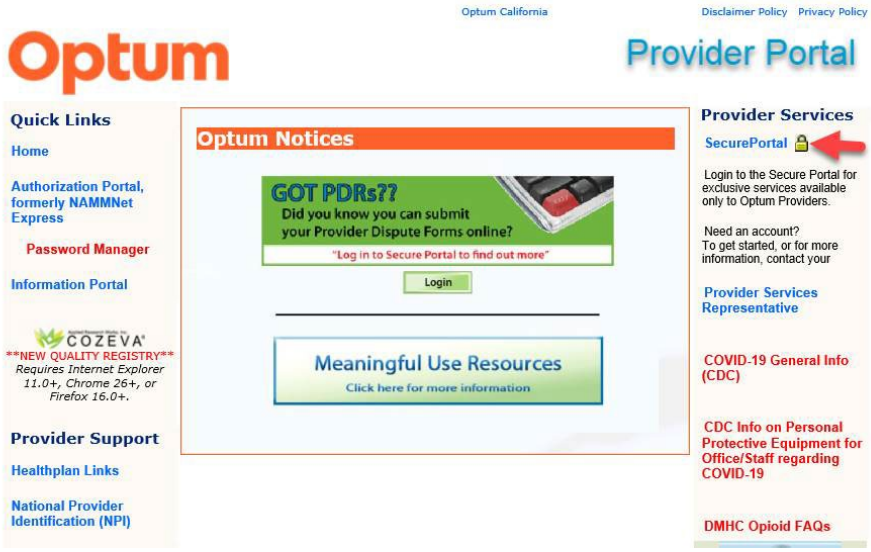
Optum Provider Portal requires a personal computer with Internet connectivity and a standard Internet browser such as Internet Explorer; No extra software is needed. It is easy to obtain access and to use. Provider administrative costs can be reduced by eliminating phone calls, faxes and paperwork.

**Contact provider's Optum PSR to get more information or to request enrollment. The PSR will coordinate on-site training for staff to familiarize them on the easy to navigate Optum Provider Portal home page, and other services available from Optum Provider Portal at NAMMNet.com. Contact information is available on page 9 of this Provider Manual or at www.nammnet.com.*

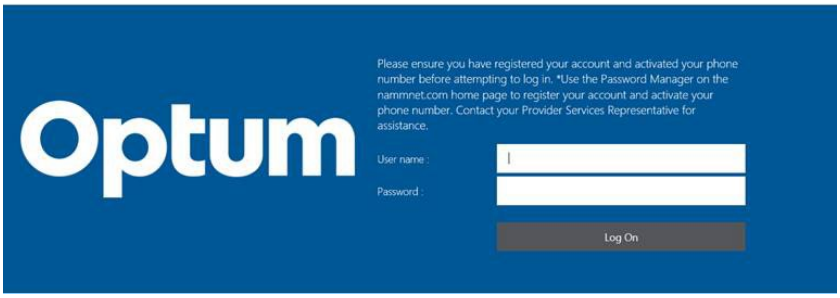
Provider Password Manager

After you are enrolled to access the Optum Provider Portal and you have received your logon credentials, be sure to register on our password self-service portal. It's fast, secure, and easy to use. You can view and or download registration instructions by accessing the Secure Portal following the steps below:

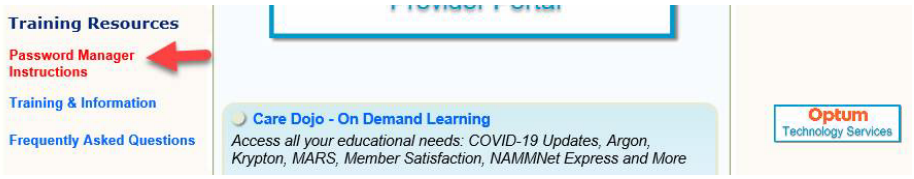
1. Access the Optum Provider Portal: www.nammnet.com
2. Click on the Secure Portal link on the right side column.



3. On the prompt, enter your recently acquired login credentials (provided by your Provider Service Representative).



4. On the next screen, under the Training Resources column to the left, select the ***Provider Password Manager Instructions*** link.



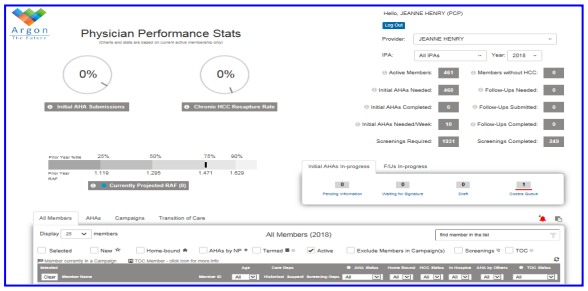
5. The registration instructions will now open.

6. Follow the steps provided to register and take advantage of the following:
    1. *Reset your own passwords to the Optum Provider Portal (no more waiting on phone for support).*
    2. *Unlock your own account.*
    3. *Setup and receive notifications prior to password expiration.*

Argon Portal

The Argon Portal provides a single platform for submitting Annual Health Assessments, reporting Transition of Care, collaborating with the IPA on health related Campaigns, and for providing the Physicians' key performance indicators.

The Argon Portal is accessible from the Optum Provider Portal. The streamlined dashboard presents providers with a view of their Annual Health Assessment (AHA) submission status, Chronic HCC Recapture rate, Current and Target RAF scores, current Membership, Screening Gaps and AHA status. Specific tabs allow you to view All Members, submitted AHA's, a list of



members assigned to Campaigns and a listing of Transition of Care members and submissions. Argon related Announcements and Notifications will also be received by the user.

How to Access the Argon Portal:

1. Go to www.nammnet.com
2. Click the **Secure Portal** link located at the top of the right hand navigation panel
3. Click the **Argon** link
4. Log in with the same credentials used to log into the Secure Portal

Argon Support

- Contact your Provider Services Representative if you are not able to log in with your credentials
- Access to the Argon Portal can be requested via your Provider Services Representative
- Support for issues experienced while logged into the Argon Portal can be obtained by contacting the Health Information Technology support number: (800)956-8000 option 3 or send an email to HITsupport@nammcal.com

Argon Training Support

Training manuals and quick reference video's are available on demand from the secure portal:

1. Go to www.nammnet.com
2. Click the **Secure Portal** link located at the top of the right hand navigation panel
3. Click the **Training & Information** link on the left hand navigation under the **Training Resources** section
4. Then click the **Argon Portal Training** link

Authorization Portal Providers:

The following Authorization Portal information explains in detail how to:

- ✓ Log on to the Authorization Portal System
- ✓ Look up Eligibility
- ✓ Look up a Member
- ✓ View information about the Member
- ✓ Submit Eligibility requests
- ✓ Submit Referrals and view Authorizations
- ✓ Access the Quality Registries in Cozeva
- ✓ Inquire about Claims

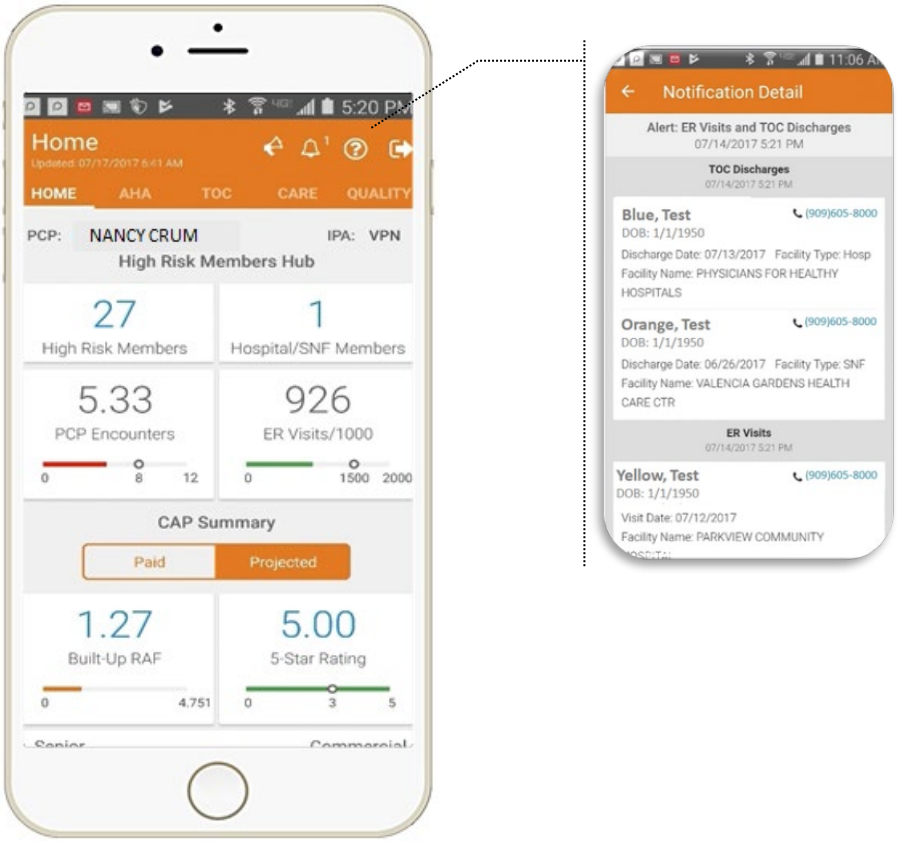
Authorization Portal Training Support:

Training manuals are available on demand from the secure portal:

1. Go to www.nammnet.com
2. Click the Secure Portal link located at the top of the right hand navigation panel
3. Click the Training & Information link on the left hand navigation under the Training Resources section
4. Then click the Authorization Portal Training & Resources link

Krypton

The Krypton Mobile Application provides immediate access to your metrics from a variety of systems right to the palm of your hand. Krypton is a mobile application that is readily available from both the Google Play Store and the Apple App Store. The efficient and modern display allows you intuitively navigate the application to view your Annual Health Assessment, Transition of Care, Care, and Quality metrics. This innovative and HIPAA compliant application also provides you with Push Alerts so that you are instantly notified when one of your patients are Admitted or Discharged from a hospital setting. Simply log into the application and tap the Alert icon to view patient discharge or admit information as well as contact information. Contact your Provider Services Representative for downloading details and training.



Authorization Portal – Authorizations Quick Start Guide

1. Logging in to the Authorization Portal system:

- ✓ Open Microsoft Internet Explorer
- ✓ Type the following address in your address bar: www.nammnet.com
- ✓ Click the Authorization Portal button at the top of the page.
- ✓ Fill in your User Name and Password and click the Submit button.
- ✓ Accept the HIPAA Privacy agreement
- ✓ You are now at the Main Menu.

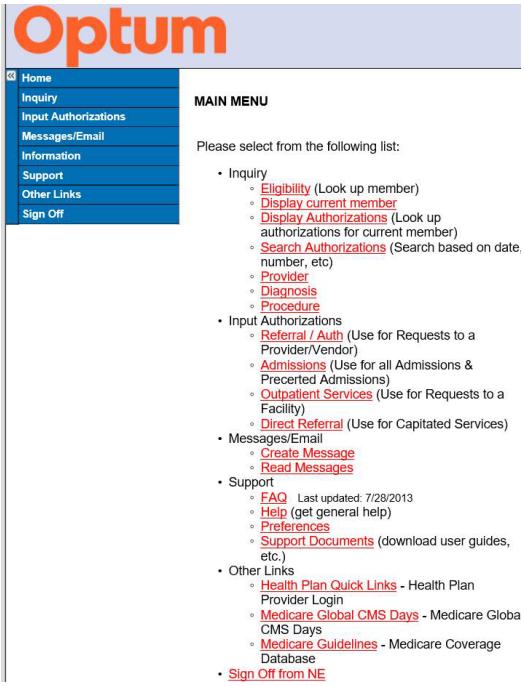
Helpful Hints:

- ✓ Make this page your Home Page so it will display automatically every time you log into the Internet: At the top of Microsoft Internet Explorer Toolbar, select Tools/Internet Options, and then highlight Use Current. Click OK at the bottom of the screen.
- ✓ OR you can add this page to your Favorites: On the top Toolbar, click Favorites, then Add to Favorites, then fill in Authorization Portal. Click OK. You can now find the Login page under Favorites.

System Failure:

- ✓ If there is a system failure, contact your Provider Service Representative to obtain a temporary paper form to use until the system comes back up.

2. The Main Menu



- ✓ The Main Menu lists functions available to each user depending on the security template that is assigned to that user at Setup.
- ✓ There are 5 functional groupings – Inquiry, Input Authorization, Messages/Email, Support, Information, Other Links
- ✓ Scroll to the function you want, then just point and click.
- ✓ You can also navigate through the system with the Main Menu on the left.
- ✓ To display or input an authorization request, or to check claims or authorization history, you must first select a member. To select a member, click on Eligibility.

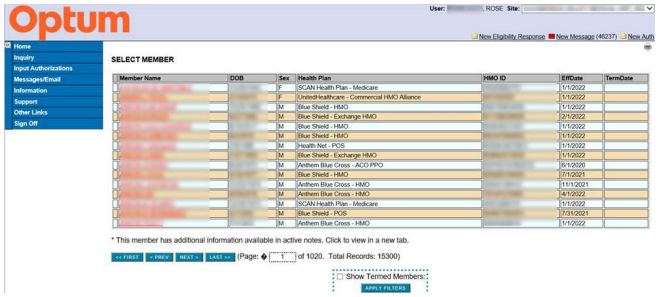
3. Look up Eligibility – Select a Member

- ✓ The Eligibility function is used to look up medical group Health Plan members. Use this screen to lookup a member.
- ✓ PCP Offices must enter search criteria in at least one of the following fields: Member ID, Last Name, DOB, or PCP.
- ✓ Specialist Offices must enter a combination of 1) Last Name, First Name, DOB or 2) Last Name, First name, Health Plan ID
- ✓ Then click on the search button
- ✓ The Select Member screen will appear (See section 4)

Helpful Hints

- ✓ Input the fewest number of letters or numbers plus an asterisk * to generate a list of choices. Then choose the correct entry from the list. This technique minimizes errors due to misspelling and typos.
- ✓ ASTERISK (*) is a wildcard that can be used throughout the Authorization Portal System which means you can use it in place of part of a field to find all occurrences that match your search. Example: Enter Apple* to generate a list of medical group members named Appleseed. Users can also input 'A*' or 'App*' to generate a list of members with last names beginning with A or App.
- ✓ Words that appear red and underlined like those listed at the bottom of most pages indicate links to other windows that allow users to view additional information.
- ✓ Only eligible members return back from the search. Check the Show Termed Member box and click the Apply Filters button to view termed members.

4. The Select a Member Screen:



- ✓ Once a member is identified as a possible match, the user can click on the red underlined Member Name link to display the Selected Member Screen (see section 5) and to make sure the patient information matches the Eligibility data for a specific member.

Helpful Hints:

- ✓ If the member's name was misspelled during data entry, or if a nickname is provided rather than a legal name, there may not be a direct online match through eligibility. Once a list of potential members is created, verify the correct member by matching the DOB (date of birth) and Sex.
- ✓ Use the navigation buttons to view more records.

<< FIRST | < PREV | NEXT > | LAST >>

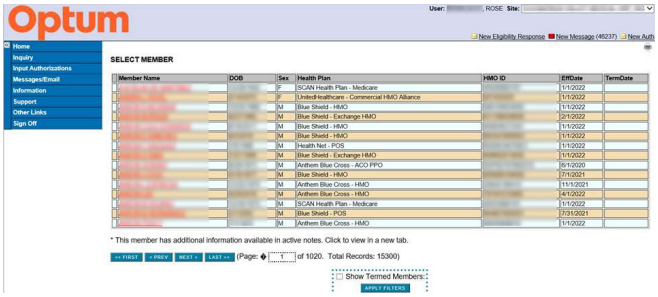
- ✓ Click on the (New Search) or (Modify Search) link to return to the Search Eligibility screen to perform a new search or to modify your search criteria.

The member Effective Date will reflect the most current information for the member that your medical group has received from the Health Plan. Since your group receives regular membership downloads from every plan, long term member information changes must always be made by the member directly contacting the Health Plan

5. View information about the Selected Member

Click on any of the Red Underlined links to view information on the displayed member such as:

- ✓ VIEW AUTHORIZATIONS
- ✓ SEARCH AUTHORIZATIONS
- ✓ SUBMIT REQUESTS TO ELIGIBILITY DEPT.
- ✓ VIEW ELIGIBILITY HISTORY
- ✓ VIEW CLAIMS



6. Submit Eligibility Requests

- ✓ You can submit corrections to the member screen if your patient's address is incorrect or incomplete by clicking on the (Submit request to eligibility department) from the Selected Member screen (shown above).
- ✓ The Eligibility Request screen can be used to correct the members Current Address, Health Plan ID and ID Number.
- ✓ If Request is for referral processing, request must be marked Urgent with a comment to state: For UM Referral Processing.

7. Referrals & Authorizations

There are four classes of Authorizations that can be entered by the UM and provider office staff:

- ✓ Referrals/Auth: completed by Provider offices to request visits to a specialist/Vendor and by Specialist offices to request additional visits/follow-ups, such as Ambulance, DME, Home Health and Hospice type referrals.
- ✓ Admissions: Use for all Admissions & Pre-certification Admissions, such as Skilled Nursing Facility (SNF), Acute Rehab/Subacute, Pre-certification, Observation/MSS, Long Term Care, Inpatient.
- ✓ Outpatient Services: Use for requests to a Facility, such as Outpatient Treatment/Diagnostic, Outpatient Surgery, Emergency Room or Dialysis.
- ✓ Direct Referral: Use for Capitated Services

8. How to get started with Authorizations

1. The first step in every Authorization is Member Eligibility. You must first have the Selected Member screen displayed. (Refer to section 3 for instruction on displaying the Selected Member screen)
2. From the Selected member screen you may submit a Referral or Authorization by selecting the appropriate authorization class from the Menu on the left.
3. Once the referral/authorization screen appears you will need to check the box to indicate if the Referral or Authorization was requested by the Patient or Representative.
4. Select a 'Referred from' provider from the drop-down box. The list of providers are limited to those in your site.
5. Select a 'Referred to' or 'Facility/Company' provider. A list of Providers will appear in the 'Select a physician' drop-down box based on frequently selected. If the drop-down does not contain the desired provider, click on 'OTHER PHYSICIAN' or 'OTHER FACILITY/COMPANY. You may search by specialty or by entering the provider name in the 'Name" field. A list of providers will appear based on your entry. Click on the provider name in red to select.
6. Select Place of Service
7. Select a Diagnosis, a list of diagnosis will appear in the 'Select a Diagnosis' drop-down box based on frequently selected. If the drop-down does not contain the desired Diagnosis, click on 'Select Diagnosis 1'. You may search by entering the diagnosis code in the 'Diagnosis Code' field or enter the description in the 'Description' field, then click 'SEARCH'. A list of diagnosis will appear, select a diagnosis by clicking on the Code in blue. You may enter additional Diagnosis up to 8.
8. Select a Procedure, a list of procedures will appear in the 'Select a Procedure' drop down based on frequently selected. If the drop-down does not contain the desired Procedure, click on 'SELECT PROCEDURE 1'. You may search by entering the procedure code in the 'Procedure Code' field or a description in the 'Description' and click 'SEARCH'. A list of Procedures will appear, select a procedure by clicking on the code in blue.
9. Enter the Number of Units (or visits depending on the type of authorization). Default is one (1) unit. If needed, adjust the number of units, and then proceed.
10. Requested Service is a description of the services being requested (up to 255 characters). The Notes field is the medical justification for services being requested. This field is viewable to everyone. This entry might include reasons for the urgency of the referral.
11. When all the information has been entered for this Referral, click the Submit button. The Authorization Submitted screen will appear confirming your request. Once the Referral is reviewed, the physician office will see the AUTH message icon, will allow the physician's office to view or print any authorizations they received.

Health Plans and Lines of Business in the Authorization Portal and HIP

Each health plan is assigned an identification code in the Optum Provider Portal. The grid below gives a description of those health plans and lines of business

HMO Name	HMO ID	Plan Type
Aetna - HMO	610USHC	H01
Aetna - HMO Deductible HRA	610USHC	D01
Aetna - POS	610USHC	P01
Aetna - Medicare	610USHC	H02
Agua Caliente Acess Plan – HMO	610AGUA	T01
Alignment Health Plan – Medicare	610ALIG	H02
Anthem - ACO	610BLCR	A07
Anthem - HMO	610BLCR	H01
Anthem - POS	610BLCR	P01
Anthem – Exchange HMO	610BLCR	E01
Anthem - Medicare	610BLCR	H02
Anthem – Special Needs Medi-Medi	610BLCR	M02
Blue Shield - ACO	610BLSH	A07
Blue Shield - HMO	610BLSH	H01
Blue Shield - POS	610BLSH	P01
Blue Shield - Exchange HMO	61BLCR	E01
Blue Shield - Medicare	610BLSH	H02
Blue Shield California Health Plan - Special Needs Medi-Medi	610BLSH	M02
Brand New Day – Medicare	610BNDH	H02
Brand New Day – Special Needs Medi-Medi	610BNDH	M02
Central Health Plan – Medicare	610CHPC	H02
Central Health Plan – Special Needs Medi-Medi	610CHPC	M02
Cigna - HMO	610CIGN	H01
Cigna - POS	610CIGN	P01
Cigna - Narrow Network	610CIGN	W01
Cigna – Medicare	610CIGN	H02
Health Net - HMO	610HNET	H01
Health Net - POS	610HNET	P01
Health Net - Exchange HMO	610HNET	E01
Health Net - Medicare	610HNET	H02
Health Net - Special Needs Medi-Medi	610HNET	M02
Humana - Medicare	610HUMA	H02
Inland Empire Health Plan - Dual Medicare/Medi-Cal CCI	610IEHP	C02
Inland Empire Health Plan - Special Needs Medi-Medi	610IEHP	M02
Inter Valley Health Plan - Medicare	610IVHP	H02
SCAN Health Plan - Medicare	610SCAN	H02
SCAN Health Plan - Special Needs Medi-Medi	610SCAN	M02
Scripps Health Plan - HMO	610SHPS	H01
Sharp Health Plan - HMO	610SHP_	H01
UnitedHealthcare – ACO	610PACC	A07
UnitedHealthcare – HMO Alliance	610PACC	G01
UnitedHealthcare - HMO	610PACC	H01
UnitedHealthcare - HMO Deductible HRA	610PACC	D01
UnitedHealthcare – HMO Harmony	610PACC	Y01
UnitedHealthcare – Medicare	610PACC	H02
UnitedHealthcare – Freedom Medicare POS	610PACC	R02

Lines of Business

Special Needs Plan

A coordinated care plan was created by Congress for Medicare beneficiaries who are either institutionalized, dual eligible (medi-medi) or suffering from severe or disabling chronic conditions. The goal of these programs are to improve access for all services, improve coordination of care through an identified point of contact, improve transitions of care across healthcare settings and providers, assure appropriate utilization of services and improve member outcomes.

Medicare chronic special needs plans (cSNP) are for those beneficiaries with chronic diseases. Some health plans offer cSNP products for a variety of chronic diseases which may vary each year. The qualified cSNP members are expected to require a higher level of care. Therefore, primary care physicians receive additional capitation for these members. PCPs are offered additional incentives for participation in Annual Health Assessment Programs. This is to facilitate prompt focus on the more acute health care needs of cSNP members.

To support cSNP patients, their family members, physicians and office staff, patients have a single point of contact with the SNP Case Manager for accessing quality care, including assistance in appointment scheduling, prescription refills, expedited referrals and arrangements for transportation. Contact the Case Management Department with any questions at 909-605-8000 x13129.

Commercial Plans

A commercial managed care plan provides coverage through a specified group of providers in a particular service area. The providers may be under contract with the commercial health insurance plan and receive payment based on the number of patients assigned (i.e., capitation payment, fee-for-service, etc.)

Commercial managed care plans require recipients to use a designated network of providers to receive a designated schedule of health service benefits. Non-network providers (i.e., providers who do not have a contract with the recipients' commercial managed care plan) will be reimbursed by the commercial managed care plan only if they obtain a referral or provide an emergency service by legal definition.

Senior Plans

An expanded set of options for the delivery of health care under Medicare was established by the Balanced Budget Act of 1997. Most Medicare beneficiaries can choose to receive benefits through the original fee-for-service program or through Medicare Advantage plans which are coordinated care plans (such as health maintenance organizations, provider sponsored organizations, and preferred provider organizations).

Effective January 1, 2021, there are two new Medicare Advantage plans with PMNI IPAs that participate in global risk. A Medicare Advantage POS plan "Freedom Plan" has been added with United Healthcare. PMNI is participating in Cigna's Medicare Advantage EGWP (employer group

waiver plan) which is a customized Medicare Advantage plan developed for specific group retirees. Not all IPAs may be participating. ACO (PPO) PMNI participates in an Accountable Care Organization (ACO) agreement with Anthem Blue Cross for the Commercial preferred provider organizations (PPO) line of business.

PMNI is responsible for care coordination only and will not process referrals or be responsible for claims payment. The Health Plan remains responsible for authorizations and claims payments according to the provider's PPO agreement with the health plan. Participating providers will receive benefits such as reports and prompts to help manage their individual PPO patients participating in this program.

Point of Service (POS) Plan

A type of managed care plan combining features of health maintenance organizations (HMO) and preferred provider organizations (PPOs). Members can decide whether to go to a network provider and pay a flat dollar or to an out-of-network provider and pay a deductible and/or a coinsurance charge. When members elect to use their PPO benefits, under most circumstances, these claims are paid directly by the Health Plan.

Exchange Plans

In 2010 California was the first state in the nation to enact legislation to implement the federal Affordable Care Act (ACA) by creating Covered California. Covered California offers two types of exchanges – an "Individual Exchange" and the "Small Business Health Options Program" (SHOP) each offering HMO and/or PPO. Optum is contracted with two plans for the Exchange Product line of business:

1. HealthNet (Community Care Individual Exchange) – all Optum IPAs including Optum Care Network – North County SD (Shared Risk)
2. Anthem Blue Cross – all Optum IPAs excluding PrimeCare Chino, (Global Risk) and PrimeCare Chino, Optum Care Network – Desert Cities & North County SD (Shared Risk)
3. Blue Shield of California (Trio HMO Plan) – PrimeCare Chino, , Optum Care Network – Inland Valley, Citrus Valley, Corona, Moreno Valley, Riverside, Sun City, Southwestern Valleys, and Valley Physicians

Hospice

Hospice includes palliative care for the incurably ill given in such institutions as hospital, nursing homes, or patients' private place of residence.

A member must meet all of the following criteria to be eligible for hospice care:

- Eligible for Part A Medicare (for Medicare members)
- Certified by the member's doctor and the hospice medical director to be terminally ill with a life expectancy of less than six months
- Sign a statement choosing hospice care instead of routine covered benefits for the terminal illness
- Receive care from a Medicare approved (Medicare members) or health plan approved (Commercial members) hospice program

Capitation and claim payments are not paid by the IPA for members who have elected hospice care. Senior hospice member claims should be directed to the member's health plan for processing or the Hospice carrier.

Eligibility

The Eligibility Department receives member information from the Health Plans at various intervals. Once this information has been received it is loaded electronically into the Optum healthcare management system. A reconciliation review is performed for each health plan and IPA/Medical Group to ensure accuracy.

Reconciliation activities are completed prior to capitation calculations. Discrepancies may be experienced in the eligibility information because information is being constantly updated and revised.

Per the Health Plan contracts, retroactive changes (additions and/or removals) are not to exceed an agreed upon time frame. While this varies depending on the Health Plan contract language, the time frame generally falls somewhere between 90 to 180 day for commercial plans. Medicare, on occasion, may institute different requirements.

Health Plan Eligibility and Member Service Numbers

HEALTH PLAN	PHONE NUMBER	DEPT	WEB SITE ADDRESS
Aetna Commercial Aetna Senior	800-624-0756 800-282-5366	Eligibility & Member Services Eligibility & Member Services	www.aetna.com www.aetna.com
Alignment Health Plan Medicare only	866-634-2247	Eligibility and Member Services	www.alignmenthealthplan.com
Anthem Blue Cross Commercial/Senior	800-677-6669	Eligibility & Member Services	www.anthem.com
Blue Shield Commercial/Senior Blue Shield 65 Plus	800-541-6652 Medicare Member Services: 800-776-4466	Eligibility & Provider Services Medicare Member Services	www.blueshieldca.com
Brand New Day Medicare Only	Member Services: 866-255-4795	Eligibility & Member Services	www.bndhmo.com
Central Health Plan Medicare only	866-314-2427	Member Services	www.centralhealthplan.com Memberservices@centralhealthplan.com
Cigna Commercial** Cigna Medicare**	Benefit Services: 800-244-6224 Website Assistance (24 Hours a Day/365 days a year): 800-853-2713 Medicare Member Services: 800-668-3813 (TTY Device: Dial 711)	Eligibility & Benefits Member Services	www.cigna.com
Health Net Commercial* Health Net Seniority Plus*	Employer/Group Plans: 800-522-0088 Commercial Provider Services: 800-641-7761 Medicare Provider Services: 800-275-4737	Eligibility Member Services Eligibility Member Services	www.healthnet.com
Humana	800-457-4708	Eligibility & Member Services	www.humana.com
IEHP	Dual Choice: 877-273-4347 TTY: 800-718-4347	Member Services	www.iehp.org memberservices@iehp.org
Inter Valley Health Plan	800-251-8191 (TTY Device: Dial 711)	Member Services	www.ivhp.com
SCAN	800-559-3500	Eligibility & Member Services	www.scanhealthplan.com
Sharp	800-359-2002 858-499-8300	Member Services	www.sharphealthplan.com
United Healthcare Commercial*	800-542-8789: Provider Services 800-624-8822: Member Services	Eligibility Member Services	www.uhc.com
United Healthcare Senior	800-542-8789: Provider Services 855-356-6098: UHC Medicare Specialist	Eligibility Member Services	www.uhc.com

*AUTOMATED ELIGIBILITY LINE AVAILABLE 24 HOURS, SEVEN DAYS A WEEK. CONFIRMATION THROUGH FAX AVAILABILITY

**24 HOUR ELIGIBILITY LINE ONLY. NO CONFIRMATION THROUGH FAX

ELIGIBILITY / MEMBERSHIP Frequently Asked Questions

Can I use the Authorization Portal to verify member Eligibility?
No. The Health Plan is the source of truth for member eligibility. When confirming member eligibility, the Provider Office is encouraged to check the Health Plan portal for eligibility details. These could include effective/term dates, co-pay amounts, PCP assignment and other pertinent benefit details.

How is an Urgent ticket defined?
Urgent is only if an authorization is needed.

I need to submit an Authorization but can't locate member in the Authorization Portal, what should I do?

1. Submit an Urgent ticket through the Authorization Portal to add the member.
2. In the Notes section of the ticket, please include "For UM Referral Processing"

What is the turnaround time for an Urgent Ticket?
Urgent is 3 hours and only when the member is not found in the Authorization Portal.

What is the turnaround time for a Non-Urgent Ticket?
Non-Urgent is 24-48 hours. Turnaround times are known to increase in January and February due to new adds and shifts in membership. The primary cause is timing of membership data from respective Health Plans.

I submitted an Authorization Portal ticket to add a member but I still can't locate the member?

1. Check the Eligibility department response for full details
2. If no response from Eligibility department, ticket is still in queue to be worked
3. If the member was added within the last few hours, the refresh of data from the source system to the Authorization Portal has not yet occurred.

Member is active on the Health Plan website but I can't locate them in the Authorization Portal?
There could be a couple of reasons why a Provider may not see a member:

1. If the Provider Office used the Health Plan website and confirmed member was eligible with Optum or an affiliate, the Provider should proceed with appointment scheduling. Note: It is expected that the Health Plan will provide Optum with the member details in the next scheduled transmission of membership data.
2. If the member was added within the last few hours, the refresh of data from the source system to the Authorization Portal has not yet occurred.

How often is the Authorization Portal refreshed to reflect updated information?

1. UM Referral requests will be visible within 30 minutes after the ticket has been completed for members that were not found in the Authorization Portal.
2. All other requests are usually visible within a 3-hour window after the ticket has been completed.
    a. By Default, the Authorization Portal is refreshed approximately every 2 hours

A member's residence address is incorrect in the Authorization Portal, how can it be updated?
The member must contact the Health Plan to update their residence address. The Health Plan will then provide the updated address in the next scheduled membership file.

How often does Optum receive membership data from the Health Plans?
Here's the cadence of membership data from each Health Plan

	Daily	Weekly	Monthly
Agua			X
Aetna			X
Alignment			X
Anthem*	X		X
Blue Shield*	X		X
Central			X
CIGNA		X	X
HealthNet		X	X
Humana			X
IEHP	X		X
SCAN			X
SCRIPPS		X	X
SHARP		X	X
United Healthcare		X	X

***Cadence varies by Senior/Commercial membership**

Capitation

Capitation is paid in accordance with the current Provider Services Agreement. Executive Directors may submit cap adjustments for inclusion in the monthly cap reports. These adjustments are reflected outside the cap reports. Executive Directors are responsible for providing back up to the individual providers for any adjustments made (claims deductions, retro-active rate increases/decreases, etc.).

Once approvals have been received, cap is forwarded to Accounts Payable for processing and forwarded to the IPA's for disbursement (exceptions are those providers who have chosen direct deposit). Specialty checks (unless otherwise indicated) are mailed directly to the providers.

Claims

ATTENTION: Office Managers and Billing Managers

Provided below is key information for claim submission and re-submission to initiate claims payment.

Topics addressed:

- EDI (Electronic Data Interchange)
  - EDI Format
  - Electronic Remittance Advice Form
  - Electronic Funds Transfer Form
- Claim Payment Policy & Processing Standards
- Billing
- Reading Paper Remittance Advice
- Timeframes
- Helpful hints

Electronic Data Interchange (EDI)

Optum has been a leader in California for many years in encouraging and supporting Electronic Data Interchange (EDI), particularly claims and encounters. EDI is the computer to computer transfer of data transactions and information between trading partners (payers and providers). Electronic claims submission allows providers to eliminate the hassle and expense of printing, stuffing and mailing claims to Optum. It substantially reduces the delivery, processing and payment time of claims. **There is no charge for submitting claims electronically to Optum.**

Optum works with two leading national claims clearinghouses: **Office Ally** and **Change Healthcare.** Providers can submit electronic claims to Optum using either of these two clearinghouses.

Trading Partners

Partner	Payor ID	Claim Type
Change Healthcare	E3510	Professional & Institutional
Office Ally	IP079	Professional & Institutional

**Contact provider's Optum PSR to get more information on initiating electronic claims submission. The phone numbers to local IPAs can be obtained on www.optum.com/primecare.*

Benefits of EDI:

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

EDI Format:

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

As of March 31, 2012 healthcare providers must be compliant with version 5010 of the HIPAA EDI standards.

The current format that is used is 837, ANSI x12.

- 837i – institutional claims
- 837p – professional claims

Additional transactions performed by Optum:

Electronic Fund Transfer (EFT):

Considering **Electronic Fund Transfer (EFT)** as a method of receiving your claims payments?

EFT allows a provider to receive claims payments within **two** business days of finalization of the claim directly to a designated bank account. A copy of the EFT summary and associated Remittance Advice will continue to be mailed to the provider's remittance address for reconciliation.

Becoming an EFT provider is easy; visit the provider portal – forms, EFT Authorization form. Forward the completed and signed EFT Authorization form, via email to edioperations@nammcal.com or fax it to 866-596-7210 Attention: Check Processing Coordinator.

**ERA Enrollment form and ERA instructions to complete to follow
**EFT Enrollment form and EFT instructions to complete to follow

If provider is not currently submitting EDI claims and is interested in more information or would like to become an EDI submitter please email: edioperations@nammcal.com.

For paper submissions, please review the following to ensure that your claim is received and processed accordingly.

Paper Submission:

- Professional vendors must submit on a CMS 1500
  - Ambulatory surgery centers with appropriate modifier SG or TC
- Hospital and Facility vendors must submit on a UB04
  - Ambulatory surgery centers
- Refer to the *Billing section* below to locate current *claim submission mailing addresses*

ERA Enrollment Form

Electronic Remittance Advice (ERA) Enrollment Form

Return Completed Forms to:
Email:
EDIOperations@nammcal.com
Fax: (866) 596-7210
Mail: EDI Department
3990 Concours, Suite 500
Ontario, CA. 91764

Please PRINT clearly
Please note: Upon enrollment processing, Provider will receive both Paper Explanation of Payment and Electronic Remittance Advice (ERA) for 31 calendar days, after which time Provider will only receive ERA.

Provider Information (REQUIRED)

Provider Name:		
Provider Address Street:		
City:	State/Province:	Zip Code/Postal Code:

Provider Identifiers (REQUIRED)

Provider Federal Tax Identification Number (TIN) or Employer Identification Number:	
National Provider Identifier (NPI):	

Provider Contact Information

Provider Contact Name:		Title:
Telephone Number:	Telephone Number Extension:	Email Address:

Electronic Remittance Advice Information (REQUIRED)

Preference for Aggregation of Remittance Data (e.g., Account Number Linkage to Provider Identifier)
SELECT ONE

☐ Provider Tax Identification Number (TIN) ☐ National Provider Identifier (NPI)

Electronic Remittance Advice Clearinghouse Information

Clearinghouse Name:

Submission Information

Reason for Submission: ☐ NEW Enrollment ☐ CHANGE Enrollment ☐ CANCEL Enrollment

The undersigned hereby certifies that the information provided herein is true and accurate in all respects and that he/she has been duly authorized by all necessary and appropriate corporation action, where applicable, to execute this agreement on behalf of the above mentioned Provider Name to form a legally binding contract. The undersigned authorizes Optum, PrimeCare Medical Network, Inc. (PMNI) and their affiliates (collectively referred to as "OPTUM") to transmit electronic remittance advice (ERA) detail for claims processed by OPTUM to the provider listed above. In addition, the undersigned hereby agrees that upon completion of enrollment processing, OPTUM will concurrently send paper explanation of payment and ERA for a period of 31 calendar days, after which time provider will only receive ERA.
This Authorization is to remain in full force and effect until OPTUM has received written notification of its termination in such time and manner as to afford OPTUM a reasonable opportunity to act on it.

Authorized Signature:_____ Date:_____

_____
Printed Name of Person Submitting Enrollment

Instructions for completing the **ERA enrollment form:**

Provider Information

Provider Name - Complete legal name of institution, corporate entity, practice or individual provider
Provider Address/Street - The number and street name where a person or organization can be found
City - City associated with provider address field
State/Province - ISO 3166-2 two-character code associated with the State/Province/Region of the applicable Country
Zip Code/Postal Code - System of postal-zone codes (zip stands for "zone improvement plan") introduced in the U.S. in 1963 to improve mail delivery and exploit electronic reading and sorting capabilities

Provider Identifiers

Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN) - A Federal Tax Identification Number, also known as an Employer Identification Number (EIN), is used to identify a business entity
National Provider Identifier (NPI) – A Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard. The NPI is a unique identification number for covered healthcare providers. Covered healthcare providers and all health plans and healthcare clearinghouses must use the NPIs in the administrative and financial transactions adopted under HIPAA. The NPI is a 10-position, intelligence-free numeric identifier (10-digit number). This means that the numbers do not carry other information about healthcare providers, such as the state in which they live or their medical specialty. The NPI must be used in lieu of legacy provider identifiers in the HIPAA standards transactions

Provider Contact Information

Provider Contact Name - Name of a contact in provider office for handling ERA issues
Telephone Number - Associated with contact person
Email address - An electronic mail address at which the payer might contact the provider

Electronic Remittance Advice Information

Preference for Aggregation of Remittance Data (e.g., Account Number Linkage to Provider Identifier) - Provider preference for grouping (bulking) claim payment remittance advice – must match preference for EFT payment

Provider Tax Identification Number- most commonly used
National Provider Identifier – used when enrolling only a sub-part

Submission Information

Reason for Submission – New Enrollment or Change Enrollment or Cancel Enrollment

ERA Enrollment Inquiries – Providers can contact SMBA-EDI@nammcal.com to inquire about ERA enrollment status. Please allow3-5 business days for Electronic Remittance Advice (ERA) enrollment processing. Once ERA enrollment has been processed, Providers will continue to receive paper explanation of payment and ERA for 31 calendar days, after which time provider will only receive ERA.

For more information about Optum, PrimeCare Medical Network Inc., and it affiliates please visit us at www.optum.com/primecare

EFT Enrollment Form

Optum

Electronic Funds Transfer (EFT) Enrollment Form

Return Completed Forms to:
Email:
EDIOperations@nammcal.com
Fax: (866) 596-7210
Mail: EDI Department
3990 Concours, Suite 500
Ontario, CA. 91764

Please PRINT clearly
Please allow 7-10 working days for Electronic Funds Transfer (EFT) enrollment processing.

Provider Information (REQUIRED)

Provider Name:		
Provider Address Street:		
City:	State/Province:	Zip Code/Postal Code:

Provider Identifiers (REQUIRED)

Provider Federal Tax Identification Number (TIN) or Employer Identification Number:	
National Provider Identifier (NPI):	

Provider Contact Information

Provider Contact Name:		Title:
Telephone Number:	Telephone Number Extension:	Email Address:

Financial Institution Information (REQUIRED)

Financial Institution Name:	
Financial Institution Routing Number:	Type of Account at Financial Institution: **(SELECT ONE)** ☐ **CHECKING** ☐ **SAVINGS**
Provider's Account Number with Financial Institution:	

Account Number Linkage to Provider Identifier: **(SELECT ONE)**

☐ Provider Tax Identification Number (TIN) ☐ National Provider Identifier (NPI)

Submission Information

Reason for Submission: ☐ NEW Enrollment ☐ CHANGE Enrollment ☐ CANCEL Enrollment

Include with Enrollment Submission (at least one) ☐ Voided Check ☐ Bank Letter

The undersigned hereby certifies that the information provided herein is true and accurate in all respects and that he/she has been duly authorized by all necessary and appropriate corporation action, where applicable, to execute this agreement on behalf of the above mentioned Provider Name to form a legally binding contract. The undersigned authorizes Optum, PrimeCare Medical Network, Inc. (PMNI) and their affiliates (collectively referred to as "OPTUM") to deposit payments for claims paid by OPTUM into the accounts listed above. In addition, the undersigned hereby agrees that OPTUM may initiate credit entries and/or initiate error adjustments for duplicate or erroneous entries made to the account listed above.
This Authorization is to remain in full force and effect until OPTUM has received written notification from the undersigned of its termination in such time and manner as to afford OPTUM a reasonable opportunity to act on it.

Authorized Signature:_____ Date:_____

_____
Printed Name of Person Submitting Enrollment

EFT Instructions for Completing Enrollment Form

Instructions for completing the **EFT enrollment form:**

Provider Information

Provider Name - Complete legal name of institution, corporate entity, practice or individual provider
Provider Address/Street - The number and street name where a person or organization can be found
City - City associated with provider address field
State/Province - ISO 3166-2 two-character code associated with the State/Province/Region of the applicable Country
Zip Code/Postal Code - System of postal-zone codes (zip stands for "zone improvement plan") introduced in the U.S. in 1963 to improve mail delivery and exploit electronic reading and sorting capabilities

Provider Identifiers

Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN) - A Federal Tax Identification Number, also known as an Employer Identification Number (EIN), is used to identify a business entity
National Provider Identifier (NPI) – A Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard. The NPI is a unique identification number for covered healthcare providers. Covered healthcare providers and all health plans and healthcare clearinghouses must use the NPIs in the administrative and financial transactions adopted under HIPAA. The NPI is a 10-position, intelligence-free numeric identifier (10-digit number). This means that the numbers do not carry other information about healthcare providers, such as the state in which they live or their medical specialty. The NPI must be used in lieu of legacy provider identifiers in the HIPAA standards transactions

Provider Contact Information

Provider Contact Name - Name of a contact in provider office for handling EFT issues
Telephone Number - Associated with contact person
Email address - An electronic mail address at which the payer might contact the provider

Financial Institution Information

Financial Institution Name - Official name of the provider's financial institution
Financial Institution Routing Number - A 9-digit identifier of the financial institution where the provider maintains an account to which payments are to be deposited
Type of Account at Financial Institution - The type of account the provider will use to receive EFT payments, e.g., Checking, Saving
Provider's Account Number with Financial Institution – Provider's account number at the financial institution to which EFT payments are to be deposited
Account Number Linkage to Provider Identifier - Provider preference for grouping (bulking) claim payments – must match preference for v5010 X12 835 remittance advice

Submission Information

Reason for Submission – New Enrollment or Change Enrollment or Cancel Enrollment
Include with Enrollment Submission – (check at least one)

VOIDED Check - A voided check is attached to provide confirmation of Identification/Account Numbers
Bank Letter - A letter on bank letterhead that formally certifies the account owners routing and account numbers

EFT Enrollment Inquiries – Providers can contact EDIOperations@nammcal.com to inquire about EFT enrollment status. Please allow 7-10 business days for Electronic Funds Transfer (EFT) enrollment processing.

IMPORTANT:

If you are/have enrolled to receive Electronic Remittance Advice (ERA), it is highly recommended that Providers contact the ACH division/department at their financial institution to arrange for the delivery of the CCD+ addenda records to ensure proper re-association of EFT payment and ERA.

IPA Billing Addresses

Southern California (Inland Empire):

OCN – Citrus Valley
P.O. Box 6903
Rancho Cucamonga, CA 91729-6903

OCN – Corona
P.O. Box 6903
Rancho Cucamonga, CA 91729-6903

OCN – Desert Cities
P.O. Box 3200
Rancho Cucamonga, CA 91729-3200

OCN – Hemet Valley
P.O. Box 6903
Rancho Cucamonga, CA 91729-6903

OCN – Inland Valley
P.O. Box 6903
Rancho Cucamonga, CA 91729-6903

OCN – Moreno Valley
P.O. Box 6903
Rancho Cucamonga, CA 91729-6903

OCN – Riverside
P.O. Box 6903
Rancho Cucamonga, CA 91729-6903

Southern California (cont):

OCN – RPN
P.O. Box 6903
Rancho Cucamonga, CA 91729-6903

OCN – Redlands
P.O. Box 6903
Rancho Cucamonga, CA 91729-6903

OCN – San Bernardino
P.O. Box 6903
Rancho Cucamonga, CA 91729-6903

OCN – Sun City
P.O. Box 6903
Rancho Cucamonga, CA 91729-6903

OCN – Southwestern Valleys
P.O. Box 6903
Rancho Cucamonga, CA 91729-6903

OCN – Valley Physicians
P.O. Box 6903
Rancho Cucamonga, CA 91729-6903

PrimeCare Medical Group of Chino Valley
P.O. Box 6903
Rancho Cucamonga, CA 91729-6903

San Diego County:

OCN – North County SD
P.O. Box 6906
Rancho Cucamonga, CA 91729-6906

Mercy Physicians Medical Group
P.O. Box 6907
Rancho Cucamonga, CA 91729-6907

Provider Disputes – ALL REGIONS:

Provider Dispute Resolution Department
P.O. Box 6902
Rancho Cucamonga, CA 91729-6902

Billing:

Complete (clean) claims are those claims and attachments or other documentation that include all reasonably relevant information necessary to determine Payor liability. To be considered a complete claim, the claim should be prepared in accordance with the National Uniform Billing Committee standards, and should include, but not be limited to the following information:

1. A claim form that contains:

    a. A description of the service rendered using valid CPT, ICD-10 , HCPCS, and/or Revenue codes, the number of days or units for each service line, the place of service code/bill type and the type of service code;
    b. Member (patient) demographic information;
    c. Provider of service name, address, National Provider Identifier (NPI) number and tax identification number;
    d. Date(s) of service
    e. Amount billed
    f. Signature of person submitting payment; and
    g. Other documentation necessary in order to adjudicate the claim, such as medical or emergency room reports, claims itemization or detailed invoice, medical necessity documentation, other insurance payment information, referring provider information (or copy of referral), attending provider information and associated NPI as applicable

2. Prior authorization documentation, such as an authorization number on claim, a copy of the authorization form or referral form attached to the claim for services in which authorization is required.

Incomplete claims or claims requiring medical records in order to make a determination of Payor liability will be contested back to the provider via Remittance Advice with a descriptive reason code informing the provider what additional information is needed. Medicare claims will be developed in accordance with CMS regulations. Any claims submitted with invalid codes or claims missing required billing elements will be mailed back to the provider with reason codes attached requesting a corrected claim.

All payments and co-payments are subject to the benefit information as defined by the member's specific health plan benefit plan. Claims payment is always dependent on member eligibility status on the date of service as determined by the health plan.

For a list of the current billing addresses to be used when submitting paper claims to PMNI and Optum go to www.nammcal.com/ClaimsContact.aspx

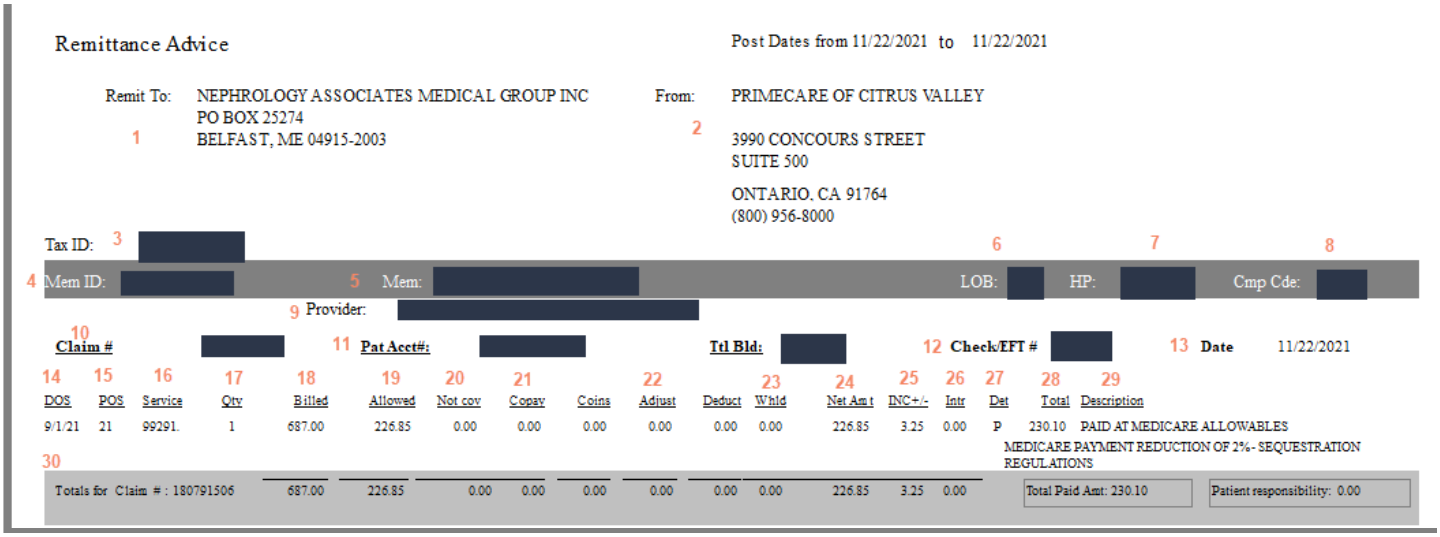
Reading Paper Remittance Advice:

- Information is listed on the Remittance Advice in addition to the amount paid. See example located at the end of this section for a detailed explanation of each field.
- Denied claims are listed on the Remittance Advice with a detailed denial reason or reasons; which are helpful to refer to when submitting a provider dispute, correcting a claim or contacting Customer Service with questions regarding a claim.

Remittance Advice – Field Descriptions

1	**Remit –** Provider of Service
2	**From –** IPA payer
3	**Tax ID –** Claim payee's Tax ID number
4	**Mem ID –** Member (or subscriber) ID is provided for verification of eligibility
5	**Mem** - Member's full name is listed
6	**LOB** – Line of business, i.e. commercial, senior, point of service
7	**HP –**Health Plan
8	**Cmp Cde –** Company code of IPA
9	**Provider** – Group
10	**Claim #** - Assigned claim number for reference purpose
11	**Pat Acct #** - Account number assigned by provider
12	**Check #** - Check number that was issued for payment of claim
13	**Date –** Date claim posted
14	**DOS** – Date of service
15	**POS** – Place of service
16	**Service** – CPT codes
17	**QTY** – Quantity
18	**Billed** – Amount billed on submitted claim
19	**Allowed** – Allowed amount of billed claim
20	**Not cov –** Not covered amounts on billed claim
21	**Copay** – Member's co-payment, due on date of service
22	**Adjust** – Any deduction or adjustment in allowed claim
23	**Whld** – Withhold amount is listed by claim
24	**Net Amt** – Total amount due from each billed charge
25	**INC +/-** - Amount reflects a positive or negative incentive payment; per line
26	**Intr –** Interest amounts paid on detail line
27	**Det –** Coding for claim status: Paid, Denied, Capitated, Adjustment, Informational
28	**Total –** Totals for each detail line
29	**Description –** Claim reason code detailed description
30	**Totals for Claim #** - All amounts are total for each claim

Remittance Advice Form



Remittance Advice

Post Dates from 11/22/2021 to 11/22/2021

Remit To: NEPHROLOGY ASSOCIATES MEDICAL GROUP INC
PO BOX 25274
1 BELFAST, ME 04915-2003

From: PRIMECARE OF CITRUS VALLEY
2
3990 CONCOURS STREET
SUITE 500
ONTARIO, CA 91764
(800) 956-8000

Tax ID: 3 [redacted]

4 Mem ID: [redacted] 5 Mem: [redacted] 6 LOB: [redacted] 7 HP: [redacted] 8 Cmp Cde: [redacted]

9 Provider: [redacted]

10 Claim # [redacted] 11 Pat Acct#: [redacted] Ttl Bld: [redacted] 12 Check/EFT # [redacted] 13 Date 11/22/2021

14 DOS	15 POS	16 Service	17 Qty	18 Billed	19 Allowed	20 Not cov	21 Copay	Coins	22 Adjust	Deduct	23 Whld	24 Net Amt	25 INC+/-	26 Intr	27 Det	28 Total	29 Description
9/1/21	21	99291.	1	687.00	226.85	0.00	0.00	0.00	0.00	0.00	0.00	226.85	3.25	0.00	P	230.10	PAID AT MEDICARE ALLOWABLES
																	MEDICARE PAYMENT REDUCTION OF 2%- SEQUESTRATION REGULATIONS
30 Totals for Claim # : 180791506				687.00	226.85	0.00	0.00	0.00	0.00	0.00	0.00	226.85	3.25	0.00		Total Paid Amt: 230.10	Patient responsibility: 0.00

Claim Payment Policy and Processing Standards:

Optum, as a Management Services Organization, adheres to the following claim payment policies. Any modifications to these policies must be written in the provider's contract.

Medicare Guidelines

The commercial and Medicare claims payment process is in accordance with Medicare guidelines as indicated below and paid according to the current Medicare Fee Schedule, unless otherwise specified in Provider's contract.

- Center for Medicare & Medicaid Services (CMS) guidance, including but not limited to Medicare Provider Reimbursement Manual (PRM) – relating to charge and cost reporting guidelines. Internet-only manuals (IOM) relating to Medicare coverage, benefits, coding, billing and payment, CMS Transmittals, MLN Matters Articles, frequently asked questions, Medicare contractors, National Correct Coding Initiative (NCCI), Medically unlikely Edits (MUE), National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs).
- National benchmarks & industry standards
- National Uniform Billing Committee (NUBC) Guidelines
- American Medical Association (AMA) / Current Procedural Terminology (CPT®)
- Healthcare Common Procedure Coding System (HCPCS)
- International Classification of Disease, 9th edition/Revision (ICD-10) code sets
- Diagnosis Related Group (DRG)
- National Drug Codes (NDC)
- National Health Care Billing Audit Guidelines
- Charge Master Guidelines as they relate to and define services billed.
- UB-04 Data Specifications Manual ICD-10-CM Official Guidelines for Coding and Report
- Uniform Billing (UB) Editor
- American Society of Anesthesiologists (ASA) relative values for the basic coding, regarding Provider, Vendor and Facility claims.

This policy applies to all Heath Care Services billed on either a CMS 1500 / UB04 form, 837p/837i or future claim form.

Criteria for Billing Services:

- Must be medically necessary and furnished at the direction of a physician. Documentation in the patients' medical records must be provided.
- Must be covered in accordance with current Medicare regulations and guidelines.
- Uses of non-FDA-approved procedure/drug/services are considered investigational and are non-covered services.

CPT Plus:

The most current year of CPT Plus is used to administer and adjudicate claims. Standard CPT Guidelines are followed in the processing of all claims.

CPT Plus is used for the following reasons:

- Educational sections to identify coding fundamentals, CPT coding and billing issues
- Revised on a yearly basis
- Provides a listing of terms, identifying codes for reporting medical services and procedures performed by physicians
- Describes medical, surgical and diagnostic services in a uniform language

The benefits of using CPT Plus:

- Has a color coded format to identify:
    - Separate procedures
    - Unlisted codes
    - Non-specific codes
    - Correct Coding Initiative (CCI) to identify services included in a primary procedure
- Identifies codes added or deleted each year
    - Codes billed must reflect the code effective for the date of service billed.
- Provides clear criteria for the Evaluation and Management Codes (E&M)
    - Sets standards for provider
    - Advises supporting documentation needed when billing E&M codes

As a reminder Optum can request additional "relevant records" to support higher levels of care than those services authorized.

Coordination with Other Payors

Benefits will be coordinated with other carriers when Optum is notified the enrollee has other insurance. Please refer to provider's individual contract for information on Coordination of Benefits (COB).

Other Billing and Payment Criteria

Services provided to any enrollee must meet the contractual requirements, or a denial may be issued. These requirements include, but are not limited to:

- Referral or prior authorization
- Submission of invoice

All standard elements as required to process a claim (see section on claim submission found in the downstream provider notification).

All payments and co-payments are subject to the benefit information as defined by the enrollee's employer group specific benefit plan. Claims payment is always dependent on member eligibility status for date of service.

Should provider bill less than agreed upon contractual amounts, payment will be made in the amount of the provider's allowable billed charge.

Anesthesia:

- Anesthesia is processed following the American Society of Anesthesiologists (ASA) guidelines.
    - One (1) unit = fifteen (15) minutes up to four (4) hours
    - After four (4) hours – One (1) unit = ten (10) minutes
    - Obstetrical anesthesia units are reimbursed in accordance with the provider contract; see Exhibit B of the provider's contract.
    - 5010 EDI transactions must be reported in minutes. Should the procedure code have minutes in the description then units are still acceptable.

Immunizations and Injectable Medications:

- Are not separately payable services unless clearly specified in the provider contract
- If provided during the course of a routine office visit, then the visit will be compensated by either monthly capitation payments or contracted fee schedule
- Must include the appropriate National Drug Code (NDC) number and the corresponding quantity for each NDC unit dispensed
- Must include the appropriate HCPC/CPT code and corresponding quantity for each HCPC/CPT unit dispensed
- All immunizations should be given in accordance with the ACIP. Adult immunizations should be given in accordance with USPSTF (United States Preventive Services Task Force) and the benefit plan of the individual member. Any immunization outside of these will require prior authorization and are subject to member benefit and health plan guidelines.

Do Not Bill Events:

Provider shall not be compensated for Services directly related to any Do Not Bill Event (as defined below) occurring in connection with Covered Services provided to a Member pursuant to this Agreement. Provider shall waive Member Cost Share associated with and hold Members harmless from any liability for all Services directly related to any DNBE. Provider shall report DNBEs and submit Claims for Services directly related to DNBEs as set forth in the Provider Manual. In accordance with the terms of this Agreement, a Payor is entitled to deny payment and seek recovery of overpayments with respect to Claims for Services directly related to any DNBE. The Parties shall work together in good faith to identify and report to each other any DNBEs and to, on a case-by-case basis, mutually agree upon adjustments to compensation to reflect a waiver of payment for Services, Including Member Cost Share, provided to a Member that are directly related to any such DNBE.

"Do Not Bill Event" or "DNBE" shall mean the following (as further described in the Provider Manual):

a. At any Location (Including an acute care hospital), the following surgical errors and hospital acquired condition (HAC):

i. Wrong Surgery or invasive procedure on patient;

ii. Surgery or invasive procedure on wrong patient;

iii. Surgery or invasive procedure on wrong body part; and

iv. If not present prior to provision of Services, removal (if medically indicated) of foreign object retained after surgery or other procedure.

b. At any Location that is an acute care hospital, the following HACs if not present upon admission:

i. Air embolism;

ii. Blood incompatibility;

iii. Pressure ulcer (stage three or four);

iv. Falls and trauma;

v. Catheter associated urinary tract infection;

vi. Vascular catheter associated infection;

vii. Manifestation of poor glycemic control;

viii. Surgical site infection following coronary artery bypass graft;

ix. Surgical site infection following orthopedic procedures or bariatric surgery for obesity;

x. Deep vein thrombosis or pulmonary embolism following orthopedic procedures; and

xi. Any new Medicare fee-for-service HAC later added by CMS.

Services shall be deemed directly related to a DNBE if the Services constitute the DNBE, or are to treat the DNBE and are medically necessary.

Claim Forms:

Hospital and Facility vendors are required to bill on a UB04 claim form. Professional providers are required to bill on a CMS Form 1500. Claims from ambulatory surgery centers may be submitted on a UB04. Electronic claims are accepted. Please refer to the section on electronic billing for guidelines.

DRG/APC Reimbursements:

- DRG/APC reimbursement is derived off of Encoder Plus software selecting option Medicare HMO Claim; Encoder Plus is published by Micro-dyn Medical Systems, Inc.

Coding:

- Appropriate codes must be submitted by using those published in the AMA's CPT Level I, HCPCs Level II and III, ICD-10 -CM
- Revenue codes for the date of services rendered

Fee Schedules:

Reimbursement is based on the current Medicare Fee Schedule for the appropriate geographical area unless otherwise stated in the provider's contract.

- https://med.noridianmedicare.com/web/jeb/fees-news/fee-schedules

Global Period

Services rendered within the pre and post global period are included in the global rate. Global period is the time period set aside before and after a surgical procedure is performed. This includes the initial visit and any follow up visits.

- Procedure specific global periods are published in the Federal Register (http://www.gpoaccess.gov/fr/index.html) and can be located at the following:
    - CMS claims manual – section 40: www.cms.gov
    - Novitas Solutions – CMS contractor: www.novitas-solutions.com
- The standards listed in the AMA's (American Medical Association) CPT surgery section are followed for surgical global packages

Modifiers:

Industry standard modifiers, as published by the American Medical Association, are acceptable for billing. The Correct Coding Initiative (CCI) guidelines for claims payment and use of modifiers are used when adjudicating claims.

- CPT defines the standard, acceptable modifiers to be used for professional claims
- HCPCS also includes acceptable modifiers for services not defined by CPT
- Optum accepts modifiers published by CPT and HCPCS

Multiple Procedures:

Multiple surgeries performed by the same physician on the same patient during the same operative session are reimbursed in accordance to Medicare guidelines (100% of the contracted rate for the highest valued procedure, 50% of the contracted rate for the secondary procedure), unless otherwise stated in Provider's contract.

Unbundling and Up Coding:

- CCI edits are followed for identification of unbundled and up coded services. Optum uses Claim Editing System (CES) software to evaluate claims for unbundling and up coding.
- For more information on the proprietary CES software, you may visit the website at:
    - http://www.optum.com/health-plans/operations/payment-integrity/pre-payment.html

Optum reserves the right to rebundle claims according to guidelines established by CMS.

The above information represents the standard claim processing policies approved and used by PMNI and utilized by Optum to administer claims for its contracted IPAs. Please refer to the provider's contract for any negotiated modification to these policies.

Submission Time Frames:

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

Submitter:

- Timely filing limit is 90 days or per the provider contract. A claim submitted after this timeframe may be denied. Please see Provider Dispute section of this manual for the necessary supporting documentation needed for POTF (Proof of Timely Filing) when filing a dispute.

Optum:

- Acknowledgement of electronic claims and disputes (see PDR section of this manual) – two (2) working days
- Acknowledgement of paper claims and disputes (see PDR section of this manual) – fifteen (15) working days
- Clean claims paid or denied within – forty five (45) working days of receipt

*Timeframes stated above are per state and federal regulations.

Helpful Hints:

Things to remember when billing and submitting claims:

- EDI submission is Optum's preferred method of claims submission. It's fast, easy and cost effective.
- Always verify the member's eligibility with the health plan at the time of service.
- Submit the most current information; this will increase the chance of accurate payment.
- Provide accurate data and complete all required fields on the claim.
- If the provider has time limits for claims submission in the contract, be sure to know what they are and submit claims accordingly.
- Know the contract(s) – be sure all billing staff is familiar with current billing and contract information.
- To verify and view claim status go to www.nammnet.com . If provider/staff member is not a current Optum Provider Portal user, contact provider's local IPA PSR to set up an account.
- Contact Customer Service at (800) 956-8000 and have a current TAX ID available when making claims status inquiries.

CMS UB04 Required Fields

In order to insure accurate and timely claim payment certain fields on the standard CMS UB04 claim submission form are mandatory.

Form Locator	Name	Requirement Code	Instructions for Completing
1	Provider Name, Address/Telephone #	**A = Required**	Enter the provider's name, address, city, zip code and telephone number
2	Unassigned Data Field	**O = Optional**	Not required
3a	Patient Control Number	**O = Optional**	The provider may enter a patient control number in this field for accounting purposes.
3b	Medical record number	**A = Required**	This number must be entered for accounting purposes
4	Type of Bill	**A = Required**	Listed below are the valid bill types accepted: Inpatient Hospital – 11, 112, 113, 114, 117, 118 Home Health – 331, 332, 333, 334, 337, 338 Hospice – 813, 817, 818, 823, 827, 828 LTC and Assisted Living – 212, 213, 214, 216, 217, 218 Outpatient – 131, 137, 138 PPEC – 891, 897, 898 0XX7 – Replacement of Prior Claim – this TOB is used when a specific claim needs to be restated in its entirety, except for the identifying information. The original bill is considered null and void, and the information on this bill completely replaces the previous claim. *Previous claim number must be entered in Fld 64 0XX8 – Void/Cancel of a Prior Claim – this code indicates that this claim eliminates and cancels a previously submitted claim. *Previous claim number must be entered in FLD 64
5	Federal Tax ID	**A = Required**	Required
6	Statement Covers	**A = Required**	Required Field. Enter the beginning and ending dates of the period included on this bill

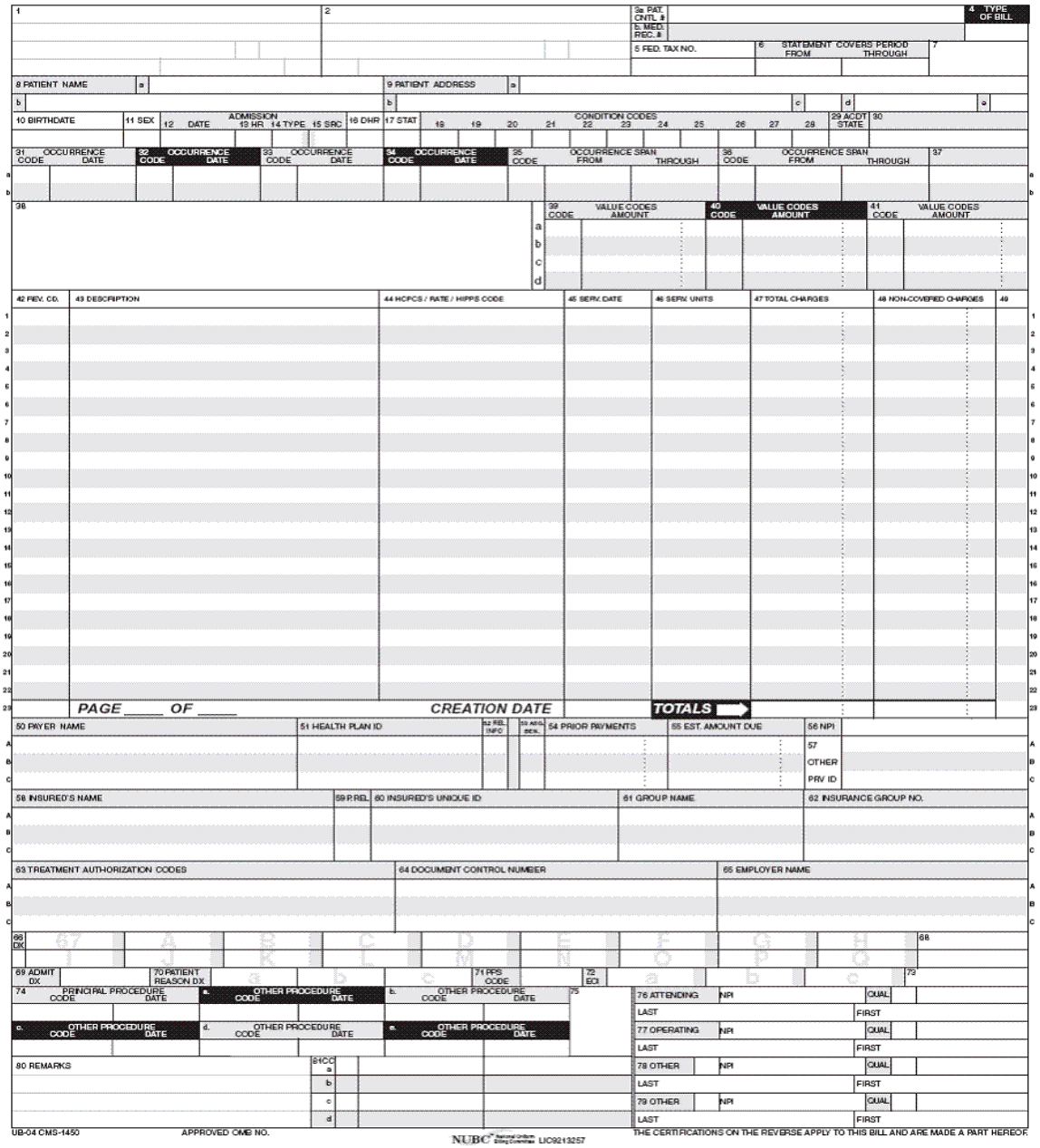
7	Unassigned Data Field	**O = Optional**	Not required
8a	Patient ID number	**A = Required**	Enter the client's medical insurance plan identification number
8b	Patient Name	**A = Required**	Enter the client's last/first name exactly as it appears on the medical insurance card
9	Patient Address	**O = Optional**	Enter the client's full mailing address
10	Patient Date of Birth	**O = Optional**	Enter the client's date of birth
11	Patient Sex	**O = Optional**	Enter M for male or F for female
12	Admission Date	**R = Required based on provider type and specific policy**	Required if Inpatient and LTC. Enter the date of admission for inpatient services.
13	Admission Hour	**R = Required based on provider type and specific policy**	Required for Inpatient and LTC. Enter the national code that corresponds to the hour during which the client was admitted for inpatient care

14	Type of Admission	**R = Required based on provider type and specific policy**	Required for Inpatient and LTC. Enter the national code indicating the priority of this admission
15	Source of Admission	**A = Required**	Required
16	Discharge Hour (DHR)	**R = Required based on provider type and specific policy**	Required for Inpatient. Enter the hour that the client was discharged from inpatient care.
17	Patient Status	**R = Required based on provider type and specific policy**	Required for Inpatient, ITC and Hospice. Enter the code indicating the status as of the statement covers through date.
18-28	Condition Codes	**O = Optional**	The code(s) used to identify conditions relating to this bill that may affect payer processing
29	ACDT State	**O = Optional**	Not required
30	Unassigned Data Field	**O = Optional**	Not required
31-34	Occurrence Codes & Dates	**O = Optional**	Refer to the UB04 National Billing Data Element specifications Manual for the code and associated date defining a significant event relating to this bill.
35	Occurrence Span Codes & Dates	**O = Optional**	Code must be 70-99 or MO – Z9
36	Occurrence Span Codes & Dates	**O = Optional**	Not required
37	Unassigned Data Field	**O = Optional**	Not required
38	Responsible Party Name	**O = Optional**	The provider must use this field to enter the name, address, county and telephone number of the responsible party
39-41	Value Codes Amounts	**R = Required based on Provider type and specific policy**	Inpatient and Hospice covered days = 80. LTC Non-covered days = 81. Co-insurance Days = 82. Lifetime Reserve Days = 83 Value Codes 80-83 must be whole numbers
42	Revenue Codes	**A = Required**	Hospital: Enter the revenue code that corresponds to the revenue description in Form Locator 43. The last entry on the claim detail lines should be 0001 for total charges. PPEC: Use the revenue code that appears on the approved prior authorization letter for covered services.
43	Revenue Description	**A = Required**	Enter a narrative description of the related revenue categories (FL42) included on this bill.
44	HCPCS Rates/Codes	**A = Required**	For inpatient and nursing home claims, record any applicable accommodation rate in this field. For outpatient claims, record any applicable HCPCS codes in this field

45	Service Date	**R = Required**	Enter the date of service provided in MM/DD/YY format. Each date of service must be billed with procedure codes. EXCEPTIONS: Multiple-day service codes, codes requiring an RR modifier
46	Units of Service	**A = Required**	Enter the Quantitative measure of services by revenue category provided to the client including such items as number of accommodation days or special treatment. The cumulative units for accommodation revenue codes 0100-0210, as shown in Form Locator 46, must be equal to units billed in Form Locator 39-41
47	Total Charges	**A = Required**	Enter the total charges pertaining to the related revenue code for the current billing periods as entered in the statement covers period.
48	Non-covered Charges	**O = Optional**	Non-covered charges may be entered in Form Locator 48
49	Unassigned Data Field	**O =Optional**	Not required
50	Payer	**R = Required based on provider type and specific policy**	Required if other insurance had paid. Enter the name of the payer and the NEIC. The EOB or remittance from the third party carrier must be attached to the claim before payment can be made.
51	Health Plan ID	**R = Required based on provider type and specific policy**	Enter the Health Plan ID for primary, secondary and tertiary insurance (NEIC). Must be 5 characters.
52	Release of Information Certification Indicator	**O = Optional**	Not required
53	Assignment of Benefits Certification Indicator	**O = Optional**	Not required
54	Prior Payment	**R = Required based on provider type and specific policy**	Required if a commercial insurance carrier made payment. Indicate the amount paid by the other insurance carrier. Do not indicate Medicare payments in this field
55	Estimated Amount Due	**O = Optional**	Not required
56	NPI	**A = Required**	Enter the 10 digit NPI or A-typical number.
57	Other Provider ID	**O = Optional**	Not required
58	Insured's Name	**R = Required based on provider type and specific policy**	Required if a commercial insurance carrier made a payment
59	Patients Relationship to Insured	**R = Required based on provider type and specific policy**	Enter the appropriate code as referenced in the UB04 National Uniform Billing Data Element Specifications Manual indicating the relationship of the client to the identified insured.
60	Insured's Unique ID	**O = Optional**	Not required
61	Insurance Group Name	**R = Required based on provider type and specific policy**	Required if other insurance has paid. Enter the insured's group plan name if another payer insures the client.

62	Insurance Group Name	**R = Required based on provider type and specific policy**	Required if other insurance has paid. Enter the insured's group plan number if another payer insures the client
63	Treatment Authorization Code	**O = Optional**	Inpatient Rehabilitation hospitals and Specialty hospitals must obtain prior authorization for all services provided
64	Document Control Number	**A = Required**	Required when type of bill (Field 4) indicates a replacement or void. Previous claim number that is being replaced or voided must be entered in this field. If billing electronically, the following elements must be present when sending a replacement or requesting to void a claim; otherwise claim will reject. *Payer Claim Control Number : [Loop2300; REF02] *Claim Frequency Code: [Loop2300; CLM05-3] * '7' – Replacement * '8' - Void
65	Employer Name	**O = Optional**	Not required
66	DX	**O = Optional**	Not required
67 a-q	Other Diagnosis Codes	**A = Required**	Enter the ICD-10 diagnosis codes corresponding to additional conditions that co-exist at the time of admission, or develop subsequently, and which have an effect on the treatment received or length of stay.
68	Unassigned Data Field	**O = Optional**	Not required
69	Admitting Diagnosis	**R = Required based on provider type and specific policy**	Required for Inpatient and LTC. Enter the ICD-10 diagnosis code corresponding to the diagnosis of the client's condition that prompted admission to the hospital.
70	Patient Reason Diagnosis	**O = Optional**	Not required
71	PPS Code	**O = Optional**	Not required
72	ECI	**O = Optional**	Enter the External Cause of Injury Code
73	Unassigned Data Field	**O = Optional**	Not required
74	Principal Procedure Code	**R = Required based on provider type and specific policy**	If applicable enter the primary procedure code and date on which the procedure was performed during the billing period as shown in the client's medical record. Refer to the UB04 National Uniform Billing Data Element Specifications Manual if necessary
74 a-e	Other procedure Codes	**O = Optional**	Required if a principal procedure code and dates have been entered in FL 74
75	Unassigned Data Field	**O = Optional**	Not required
76	Attending Physician	**A = Required**	Enter the 10 digit NPI number and first and last name for the physician attending client
77	Operating Physician	**R = Required based on provider type and specific policy**	Required if field 74 has been completed. Enter the 10 digit NPI number and first and last name for the operating physician
78-79	Other	**O = Optional**	Not required
80	Remarks	**O = Optional**	This field may be used to include information relative to processing the claim.
81 a-d	Qual/Code/Value	**O = Optional**	Not required

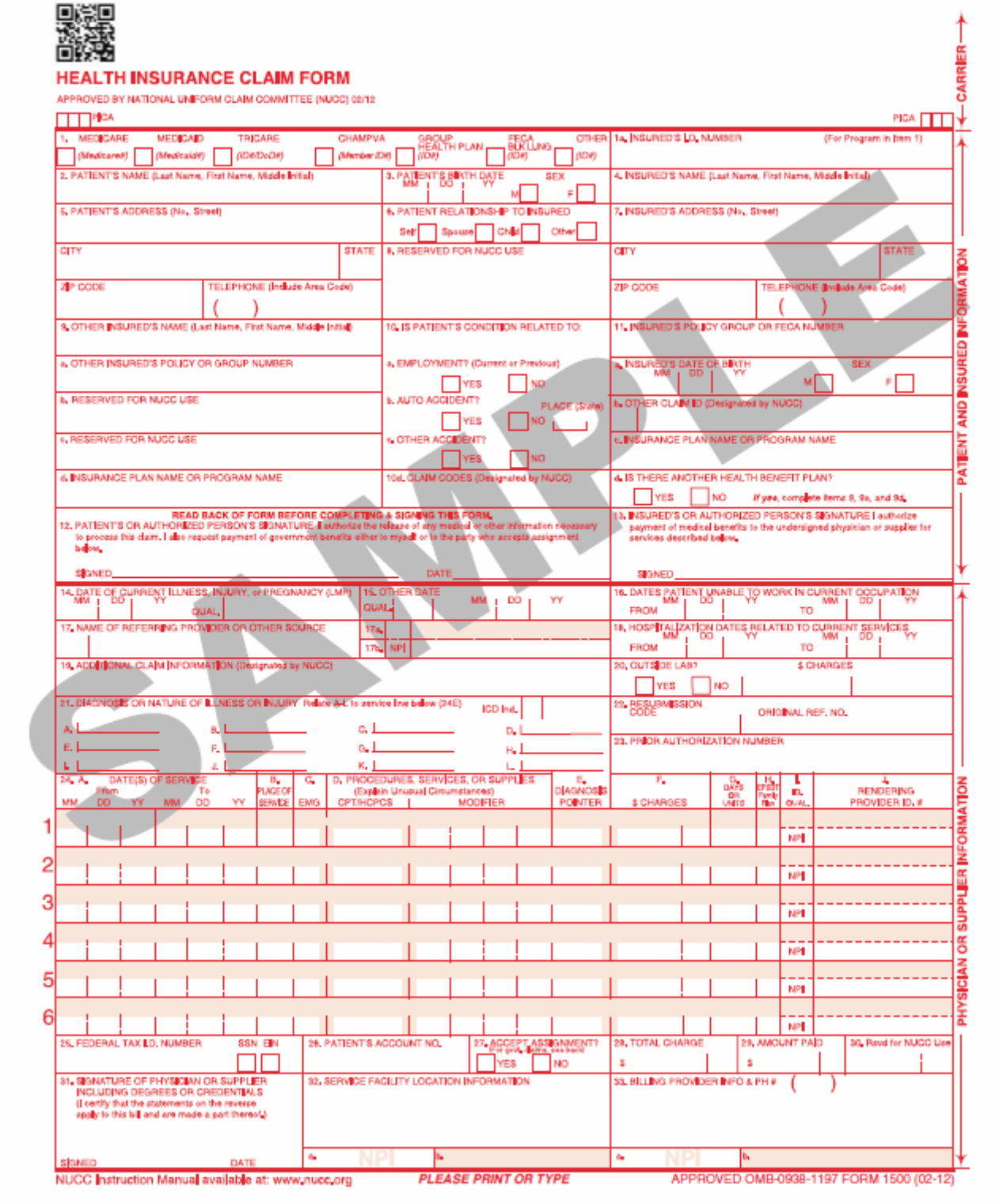
CMS UB04 Claim Submission Form



CMS 1500 Required Fields

In order to ensure accurate and timely claim payment, certain fields on the standard CMS 1500 claim submission form are mandatory.

1	Required-Identify if member is Medicare or Group Health (commercial member)
	1a). Required-Insured ID number
2	Required-Patient full name (may be different from Insured (subscriber)
3	Required-Patient date of birth (not subscriber)
4	Required-Insured (subscriber) may be different from the patient)
5	Required-Patient address (may be different from subscriber)
6	Not required-relationship to patient
7	Not required but beneficial
8	Not-required-patient status (helpful)
9	Other insured (beneficial for identification of COB)
	9a; 9b; 9c; 9d only required if possible COB
10	Please identify if Employment or Accident related
11	Required-Signature of patient or responsible
	11a; 11b; 11c; 11d; Not required
12	Required
13	Required if patient cannot sign
14	Required (date of current illness or accident)
15	Beneficial/not required
16	Required only if worker's comp related
17	Required: Name of referring physician for this visit or episode of care and NPI
18	Required if in-patient services
19	N/A
20	N/A
21	Required: List all diagnoses related to current episode of care
22	Required if replacement of prior claim or void/cancel of prior claim *When submitting a claim, enter the appropriate bill frequency code left justified in the left hand side of the field labeled Resubmission Code. Bill frequency code: 7 – Replacement of prior claim; 8 – Void/Cancel of prior claim. List the original claim number for resubmitted claims in the area titled Original Reference. *If billing electronically, the following elements must be present when sending a replacement or requesting to void a claim; otherwise claim will reject. Payer Claim Control Number: [Loop2300; REF02]. Claim Frequency Code: [Loop2300; CLM05-3]. '7' – Replacement; '8' – Void.
23	Required if service requires prior authorization
24	All fields are mandatory and must be specific:
	• Date of service and the place where performed are required • Procedure codes are to be current to year submitted or year rendered • Unit value if type of service is measured or paid by units • Specify charge if different on each line (each procedure)
25	Tax ID number must be Tax ID in contract (if par provider)
26	N/A
27	Required for Medicare members
28	Required: Total billed charges
29	Required: Co-pay of member
30	Required: State balance due
31	Required: Provider signature
32	Specify facility where service rendered including the nine digit zip code and NPI
33	All information is required as identified in contract including NPI and the nine digit zip code



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.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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.

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 MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

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)

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

SAMPLE

Provider Dispute Process

The Provider Dispute Resolution Department's goal is to provide affiliated physicians and providers with readily accessible information that works to expedite interaction with our organization and will assist providers in their managed care and business operations.

AB 1455

AB1455 was established to set requirements for prompt payment of provider claims by Health Plans. It is known as the California Code of Regulations 1300.71.38 – Fast, Fair and Cost Effective Dispute Resolution Mechanism; this regulation pertains to the provider dispute process and is provided for informational purposes.

The following information, as required by AB 1455, is electronically attached in this section. To view or download the information provided, go to https://www.nammcal.com/resources/provider-dispute-resolution.html

- **Downstream Provider Notice**
  Also see the Claims Submission/Provider Dispute Resolution section in the provider's contract.
- **Claims Payment Practices**
  https://www.nammcal.com/resources/provider-dispute-resolution.html – click on download for claims payment practices
- **Dispute Form**
  https://www.nammcal.com/resources/provider-dispute-resolution.html – click on download for dispute form

Optum provides this information required by AB 1455 on behalf of our affiliated entity **PrimeCare Medical Network, Inc.** and as the Management Services Organization (MSO) for the physician organizations listed at the beginning of this manual.

Definition of a Provider Dispute

A provider dispute is a provider's written notice to the IPA and/or the member's applicable health plan challenging, appealing or requesting reconsideration of claim (or a bundled group of substantially similar multiple claims that are individually numbered) that has been denied, adjusted or contested or seeking resolution of a billing determination or other contract dispute (or bundled group of substantially similar multiple billing or other contractual disputes that are individually numbered) 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 Identification Number
- Provider's contact information

- Should the provider dispute concern a claim or reimbursement of an **over payment** of a claim from IPA to Provider the following must be provided:
  - ✓ Clear identification of the disputed item, such as the claim(s) number
  - ✓ Date of service
  - ✓ Clear explanation of the basis upon which the provider believes the payment amount should be

- Should the provider dispute not concern a claim:
  - ✓ Clear explanation of the issue
  - ✓ Provider's position on such issue

Should the provider dispute concern a member or group of members:

- ✓ Name and identification number(s) of the member or members
- ✓ Clear explanation of the disputed item, including the date of service and provider's position on the dispute
- ✓ Member's written authorization for provider to represent said members

Submitting a Provider Dispute Resolution (PDR)

Optum's preferred method of PDR submission is electronically via https://www.nammnet.com/SecurePortal/Dashboard.aspx . If provider is unable to submit the PDR electronically, contact provider's local PSR.

Advantages of submitting electronically:

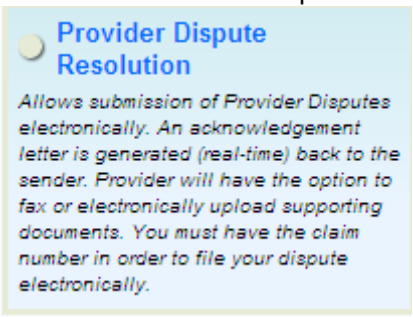
- Cost Savings – no longer need to purchase postage stamps or make a trip to the post office to mail out a dispute. There is no additional cost or fee for the provider as it is included in the Optum Provider Portal account.
- Time Savings – no waiting to see of the PDR was received. When submitting electronically the user will receive an acknowledgement email the moment after the "Submit" button is clicked.

How to Submit a PDR

Electronically:

- Login to https://www.nammnet.com/SecurePortal/Dashboard.aspx
- Click on the "Secure Portal" link

- Enter username and password, then click "OK"
- Click on the "Provider Dispute Resolution" box



- Enter the claim number and select the provider type, then click on "Search"
- Continue to enter information regarding the PDR, including attachments as needed

- Click "Submit" when finished

Mail:

- All mailed provider disputed must be sent to:
  PrimeCare Medical Network, Inc.
  <<Name of Appropriate IPA>>
  Provider Dispute Resolution Department
  P.O. Box 6902
  Rancho Cucamonga, CA 91729

Things to Remember When Submitting a Provider Dispute:

- Provider dispute forms must be completed in full and included with the dispute
  - To download a copy of the form:
- https://www.nammcal.com/resources/provider-dispute-resolution.html
- All required information must be included. Disputes that are missing information will be returned to the submitter.
- Commercial disputes must be submitted within three hundred sixty five (365) calendar days from the last date of action of the group or provider.
- Medicare Provider disputes must be submitted within one hundred twenty (120) calendar days from the last date of action of the group or provider.
- Multiple disputes that are substantially similar may be files in batches as a single dispute utilizing the PDR form and including the Multiple (Like) Claim form:
- https://www.nammcal.com/resources/provider-dispute-resolution.html
- Be specific when completing the description of the dispute and the "Expected Outcome"

Time Frames:

PDRs

- Acknowledgement: Per AB 1455, disputes are required to be acknowledged when received. Below are the standard time frames that Optum has adopted:
  - Electronic PDR:
    - Dispute is acknowledged immediately after submission and an acknowledgement letter is sent instantly to the submitter as a confirmation
  - Paper PDR:
    - Once the dispute is received, it is acknowledged within fifteen (15) working days from the date of receipt via mail
  - Resolution:
    - Commercial contracted and non-contracted disputes and Senior contracted disputes are to be resolved within forty five (45) working days. CMS PDR's must be resolved in 30 calendar days. A written determination stating the pertinent facts and explaining the reason for the determination will be issued to provider.

Other information and fee schedules are available for electronic viewing at the listed links below:

Claims Payment Policies – https://www.nammcal.com/resources/provider-dispute-resolution.html

- Optum Provider Portal – Claim information for providers
- Fee Schedules:
- Medicare Fee Schedule & other related information:
  www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/index.html
- DMEPOS Fee Schedule:
  www.cms.gov/Medicare/Medicare-Fee-for-SErvice-Payment/DMEPOSFeeSched/index.html
- GPO Access – Global Period Federal Register:
  www.gpo.gov/fdsys/browse/collection.action?collectionCode=FR
- Claim Editing System – CES – For more information on CES:
  https://www.optum.com/solutions/care-operations/claims-administration/payment-integrity/claims-contract-editing-cpl.html

*** All inquiries regarding the status of a provider dispute or questions about filing a provider dispute must be directed to the Provider Dispute Resolution Unit for the Group. The PDR department can be reached at (800) 956-8000.**

Authorization Portal/Customer Service

Authorization Portal is Optum's preferred method of contact for its customers. If provider does not have an Authorization Portal account established, contact provider's local Provider Services Representative (PSR) for assistance.

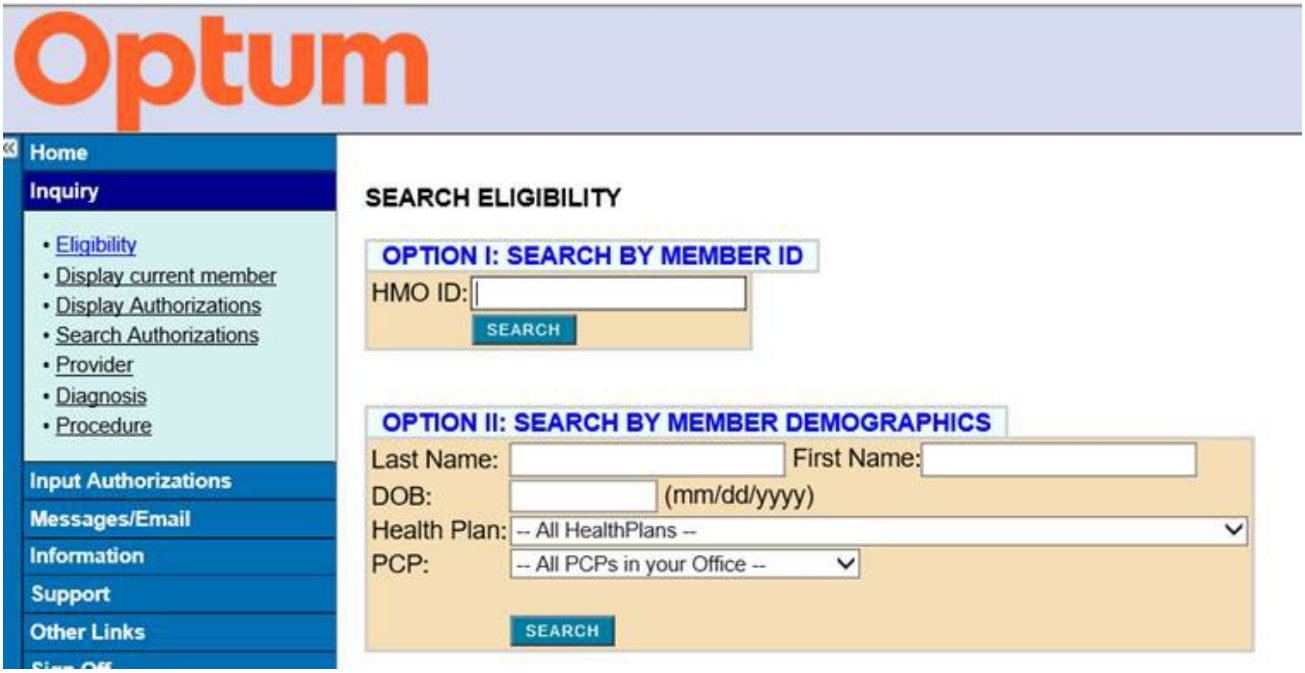
For faster service regarding claims or authorization inquiries, access Authorization Portal on the secure provider portal at www.nammnet.com

Experience the benefits of using the Authorization Portal:

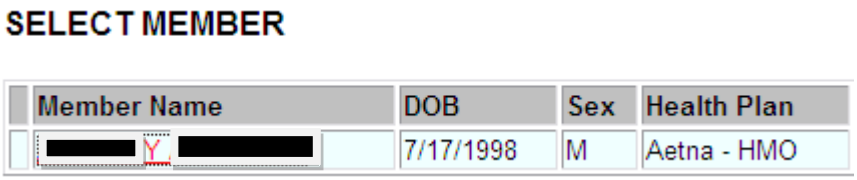
- No wasted time on the phone, holding for information
- Quick and easy accessibility to view claim and authorization information electronically
- Ability to view multiple inquiries
- No additional cost/fee for this feature
- Communication via email to the Customer Service or Utilization Management staff

Authorization Portal Access

Access claim or authorization information in the Authorization Portal by following these easy navigation steps:



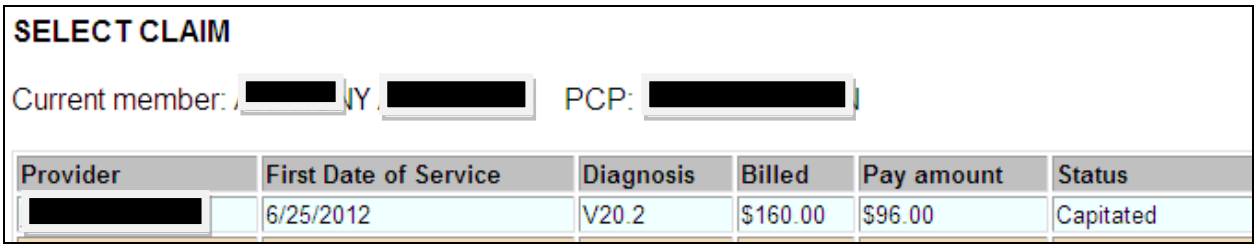
Enter the member's name or member ID (if available) and click on the "Search" button



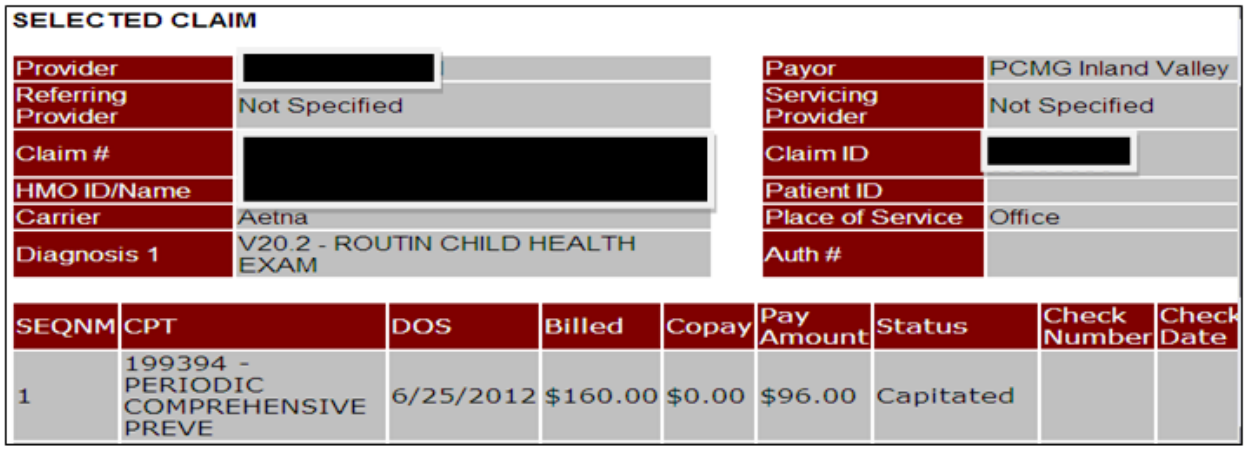
1. Validate/verify the member's information compared to the selection list
2. Select the member by clicking on the appropriate member's name
3. Click on the appropriate link to view Claims or Authorizations

Viewing Claims

To view claims:

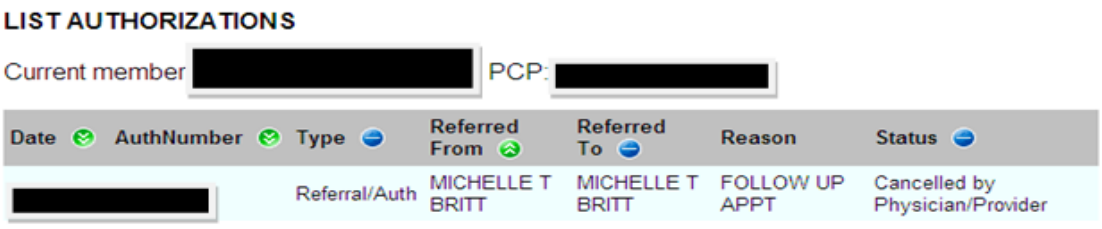


1. Locate and select the claim that is related to the Date of Service (DOS) in question
2. Click on the correct DOS link
3. View the provided claim information.
4. Questions regarding the claim viewed can be emailed to Customer Service by clicking on the "Message about This Claim" link and completing the electronic form.

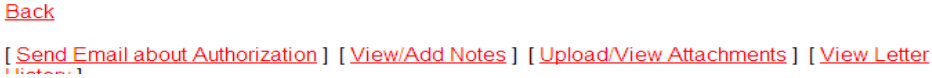


Viewing Authorizations

To view authorizations:



1. Locate the date of service that is related to the authorization in question
2. Click on the red date link



3. View the authorization information
4. Questions, requests for code changes, date extensions or anything regarding the authorization viewed can be emailed to Utilization Management by clicking on the "Send Email about Authorization" link and completing the electronic form

- Hint, type UM in the Last Name field of the message "To" field and you will see all IPA UM Departments listed

All emails submitted via the Authorization Portal are answered between 24 and 48 hours

If at any time provider or staff experience issues with the Authorization Portal account, be sure to contact provider's local PSR for assistance.

Things to remember before contacting Customer Service:

- Optum has 45 working days (60 calendar days) to process claims
- Optum is unable to provide eligibility or benefits. Provider must contact the health plan directly. Use the following links to verify eligibility online directly with the health plan:
  - Aetna – www.aetna.com/healthcare-professionals
  - Alignment Health Plan (Medicare only) - www.alignmenthealthplan.com
  - Blue Cross– www.anthem.com/ca/home-providers
  - Blue Shield – www.blueshieldca.com/provider
  - Brand New Day - https://aerial.carecoordination.medecision.com/ucipa/physician/LoginDefault.aspx
  - Central Health Plan (Medicare only) - www.centralhealthplan.com
  - Cigna – www.cignaforhcp.cigna.com
  - Health Net – www.healthnet.com/portal/provider
  - Humana – www.humana.com/providers
  - IEHP - https://ww3.iehp.org/en/providers/
  - Inter Valley Health Plan - https://www.ivhp.com/MemberEligibility
  - United Healthcare – www.uhcwest.com – select provider
  - Scan – www.scanhealthplan.com – select CA under provider Tools
  - Scripps – www.scrippshealthplan.com
  - Sharp – www.sharphealthplan.com – select provider tab
- Have provider's current Tax ID number ready when contacting Customer Service

If provider is unable to locate the correct information in the Authorization Portal, contact Customer Service at (800) 956-8000

The Customer Service Department can assist providers with claims and authorizations inquiries during the following hours:

- Monday - Thursday – 8:00 AM to 5:00 PM
- Friday – 8:00 AM to 4:30 PM

*If provider is not satisfied with, or does not agree with how the claim was processed, provider has the option of filing an electronic Provider Dispute Resolution at www.nammnet.com. To learn more about Provider Dispute Resolution, see the Provider Dispute Resolution section in this Manual.

Medical Management

General Information

Optum's Medical Management Department consists of Utilization Management, Case Management and Quality Improvement.

The following documents are provided as an overview only of Optum's Quality Improvement and Utilization Management programs. These sections provide some of the common tools needed for the Provider's daily practices.

Optum is proud to provide affiliated physicians with convenient electronic access to Health Improvement Resource Materials. The resource materials consist of a listing of our QI/UM Administrative Policies and Procedures, PCP Guidelines, Disease Management Guidelines and Preventive Health Guidelines. This information is contained in the Optum Provider Portal.

Optum's Attestation Statement

Utilization Management decision making is based only on appropriateness of care and service and existence of coverage. Practitioners or other individuals are not rewarded for issuing denials of coverage. Financial incentives for UM decision makers do not encourage decisions that result in underutilization. Decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual are not made based upon the likelihood that the individual will support the denial of benefits.

Utilization review criteria, based on reasonable medical evidence and acceptable medical standards of practice (i.e. MCG, applicable health plan or CMS guidelines, Hayes criteria and internal guidelines) are used to make decisions pertaining to the utilization of services. Review criteria is used in conjunction with the application of professional medical judgment, which considers the needs of the individual patient and characteristics of the local delivery system.

Upon request from a member, a member's representative, the general public, or a physician, the relevant criteria used to support the UM decision making process may be released. Members are instructed in their adverse determination letters that they may call the UM or Customer Service department to make the request. Physicians may contact the PSR at the IPA to obtain UM Policy or Criteria used in making medical decisions. See page 8 for IPA contact information. The materials provided to provider are guidelines used by UM to authorize, modify, or deny care for persons with similar illnesses or conditions. Specific care treatment may vary depending on individual need and the benefits covered under the health plan contract.

Quality Improvement

Introduction to Quality Improvement (QI)

Included in this section are a few of the most important documents that, as a result of many regulatory requirements, the provider will need while working with managed care members. It is important that the provider and office staff take the time to review the information and guidelines contained within this section.

A. Provided in this manual is a copy of the **Member Bill of Rights** in both English and Spanish. By regulation, this document must be posted in the provider's office in a prominent location for review by members. Many providers choose to place the document in a Plexiglas in their waiting rooms.

B. This section contains an updated sample of the Commercial grievance form along with the Medicare Advantage Appointment of Representatives form. Providers are required to have both of these forms available in their office for members to file a grievance (complaint). The member can complete these forms and mail them to their Health Plan or they may call their Health Plan directly to file a grievance. Additionally, for senior members, the Appointment of Representative form can be used if a Medicare member would like to appoint a person, including a physician, to file a grievance, request a coverage determination, or request an appeal on his or her behalf. Copies of these forms can also be found on the secured provider portal at: https://www.nammnet.com/P4PPortal/MemberGrievance.aspx

C. We have included an excerpt from the policy regarding Medical Records. As a contracted managed care provider, patient records will be subject to audit on a periodic basis, based on these medical standards. Standards require that the medical records include documentation of the patient's principal language spoken. These audit scores will be reflected in the provider's credentialing file.

D. The next document references the currently accepted appointment access criteria. Periodic measurements of access compliance are performed throughout the year. Results of these audits are reviewed closely by the managed care plans with which we contract. Access concerns are also measured through patient satisfaction surveys performed annually.

E. Preventive Health Guidelines have been adopted from Blue Shield and are included for use in the provider's office. These guidelines can be found at the end of this manual beginning on page 94, along with recent changes for women's health coverage. US Preventive Services Task Force guidelines are utilized by Optum and can be found at: www.uspreventiveservicestaskforce.org

F. Clinical Quality Improvement Programs

   a. Pay for Performance (P4P) is a Health Plan incentive program for Commercial membership that rewards the IPAs and Medical Groups that provide quality patient care and service. The program is based on preventive and chronic care clinical measures, member satisfaction, IT integration total cost of care and appropriate resource use. Optum currently requires that the Provider group has EHR systems certified for Meaningful Use.

   b. 5 STAR is a CMS (Medicare) rating of IPA and Health Plans with improved group performance on measures translating to a higher payment.

c. A summary of the P4P and 5 STAR measures has been included, see next page. We use Cozeva as our quality registry. Contact your IPA Provider Service Representative for access and training to the Cozeva registry.

G. Medicare Risk Adjustment, see page 101.

H. Page 113 outlines current requirements in the HIPAA privacy regulations.

STAR / AMP Measurement Set

★ **2021 STAR / AMP Measurement Set** ★

STAR PROGRAM

Cut points[1] valid until October 2022

STAR is a CMS Program to award health plans for their performance in multiple domains and utilizes measures set forth by HEDIS

Measure	1 STAR	2 STAR	3 STAR	4 STAR	5 STAR
Breast Cancer Screening (BCS)*	<42%	≥42% - <61%	≥61 % - <69%	≥69 % - <76%	≥76 %
	-	-	-	-	-
Care of Adult-Medication Review (SNP)	<48%	≥48% - <71%	≥71% - <84%	≥84% - <95%	≥95%
Care of Adult-Pain Assessment (SNP	<55%	≥55% - <76%	≥76% - <87%	≥87% - <96%	≥96%
Colorectal Cancer Screening (COL)*	<49%	≥49% - <62%	≥62% - <71%	≥71% - <80%	≥80%
Controlling Blood Pressure: Hypertensive Pts (CBP)**	<58%	≥58% - <70%	≥70% - <79%	≥79% - <87%	≥87%
Diabetes Care: Kidney Disease (NEPHSCR)*	<82%	≥82% - <88%	≥88% - <94%	≥94% - <97%	≥97%
Diabetes Care: Blood Sugar Controlled ≤9% (HbA1c)*	<41%	≥41% - <60%	≥60% - <72%	≥72% - <81%	≥81%
Diabetes Care: Eye Exam (CDCEye) *	<52%	≥52 % - <62%	≥62 % - <71 %	≥71 % - <79%	≥79%
Med Adherence: Cholesterol (Statins) (PDCS)*	<78%	≥78% - <83%	≥83% - <87%	≥87% - <91%	≥91%
Med Adherence: Diabetes Meds (PDCD)*	<80%	≥80% - <85%	≥85% - <87%	≥87% - <91%	≥91%
Med Adherence: Hypertension (RAS antagonists) (PDCA)*	<74%	≥74% - <82%	≥82% - <87%	≥87% - <90%	≥90%
Transitions of Care: Medication Reconciliation Post-Discharge (MRP)	<39%	≥39% - <56%	≥56% - <69%	≥69% - <82%	≥82%
Osteoporosis Management (OMW)*	<27%	≥27% - <40%	≥40% - <50%	≥50% - <68%	≥68%
Statin Therapy for patients with Cardiovascular (SPC)*	<76%	≥76% - <81%	≥81% - <84%	≥84% - <89%	≥89%
Statin Use in Persons with Diabetes (SUPD)*	<76%	≥76% - <80%	≥80% - <84%	≥84% - <88%	≥88%

Additional STAR Measures

- Pneumonia Vaccine (CAHPS-survey)
- Annual Flu Vaccine (CAHPS-survey)
- Reducing the Risk of Falling (HOS-survey)
- Monitoring Physical Activity (HOS-survey)
- Improving Bladder Control (HOS-survey)
- Improving or Maintaining Physical Health (HOS-survey)
- Improving or Maintaining Mental Health (HOS-survey)
- Plan All-Cause Readmissions (HEDIS-survey)

* **AMP *and* STAR measure**

** **Thresholds are UHC predicted cut points published 10/2021**

1 **Cut Points are from "Medicare Health & Drug Plan Quality and Performance Ratings 2022 Part C & D Technical Notes released on 10/7/2021**

NEW!

Transition of Care will include the following:

1. Notification of Inpatient Admission within 2 days
2. Receipt of discharge information within 2 days
3. Patient Engagement After Inpatient Discharge within 30 days
4. Medication Reconciliation within 30 days of discharge

November 2021

2021 STAR / AMP Measurement Set

AMP PROGRAM

Align. Measure. Perform (AMP) is a CA initiative (previously P4P) that was created to measure Physician Organization (PO) performance using a common set of measures

2021 Measurement Year / 2022 Reporting Year

Cardiovascular

1. Controlling High Blood Pressure (CBP)*
2. Med Adherence: Hypertension (RAS antagonists) (PDCA)*
3. Med Adherence: Cholesterol (Statins) (PDCS)*
4. Statin Therapy for Patients with Cardiovascular Disease (SPC)*

Musculoskeletal

1. Osteoporosis Management in Woman Who Had a Fracture (OMW)*

Diabetes

1. Diabetes Care—HbA1c Poor Control (9.0%) (HbA1c)*
2. Diabetes Care—HbA1c Control (<8.0%) (HbAc8)
3. Diabetes Care—Eye Exam (CDCEye)*
4. Diabetes Care—Nephropathy Monitoring (NEPHSCR)*
5. Diabetes Care—BP Control (<140/90) (CBPD)
6. Diabetes Care—Optimal Diabetes Care Combination Rate (ODC)
7. Med Adherence: Diabetes Meds (PDCD)*
8. Statin Therapy for Patients with Diabetes (SPD)
9. Statin Use in Persons with Diabetes (SUPD)*

Prevention

1. Childhood Immunization Status: Combination 10 (CIS)
2. Adolescent Immunizations: Combination 2 (IMA)
3. Chlamydia Screening in Woman (CHL)
4. Cervical Cancer Screening (CCS)
5. Cervical Cancer Overscreening (CCO)
6. Breast Cancer Screening (BCS)*
7. Colorectal Cancer Screening (COL)*

Respiratory

1. Asthma Medication Ratio (AMR)
2. Appropriate Testing for Children with Pharyngitis (CWP)
3. Avoidance of Antibiotic Treatment of Adults with Acute Bronchitis (AAB)

Behavioral Health and Substance Use

1. Use of Opioids at High Dosage (HDO)
2. Concurrent Use of Opioids and Benzodiazepines (COB)

Reference Key:
HEDIS – Healthcare Effectiveness Data and Information Set is standard measure set tool created by the National Committee for Quality Assurance (NCQA) for health plans
CAHPS – Consumer Assessment of Healthcare Providers and Systems
HOS – Health Outcomes Survey
PQA – Pharmacy Quality Alliance

* **AMP *and* STAR measure**

Please contact your QI Nurse for any questions

Survey Measures
1. Provider Communication
2. Access to Care
3. Care Coordination
4. Office Staff
5. Health Promotion

November 2021

Grievance Form

Grievance Form for California Managed Care Members

Attention Medicare Advantage members – do not complete this form. Request the "California Medicare + Choice Plan Member Appeal and Grievance Form"

You have the right to file a grievance about any of your medical care or service. If you want to file a grievance, please use this form. There is a process you need to follow to file a grievance. Your health plan must, by law, give you an answer within 30 days. If you have any questions, please feel free to call your doctor's office or health plan at the phone numbers on the back of this form. You may also call the phone numbers on your health identification (ID) card. If you think that waiting for an answer from your health plan will hurt your health, call and ask for an "Expedited Review."

Please print or type the following information:

_____

Member Name (Last, first, middle initial)

_____ _____

Address Home Phone number (include area code)

_____ _____

City, State, Zip Work Phone number (include area code)

_____ _____

Name of Employer or Group Enrollment or Member ID #

_____

Date of Birth

If someone other than the member is filing this grievance, please provide the following information:

Name: _____ Daytime Telephone # _____

Relationship to Member: _____

Address: _____

City: _____ State: _____ Zip: _____

Write what your grievance is about. Give dates, times, people's names, places, etc. that are involved.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Please attach copies of anything that may help us understand your grievance.

Y If you attach other pages, please check this box.

Please sign and MAIL or FAX, if applicable, to your health plan (see the page with health plan contact information)

Date_____ **Member Signature**: _____

Date _____ **Signature of Representative** _____

NOTICE TO THE MEMBER OR YOUR REPRESENTATIVE:

The California **D**epartment of **M**anaged **H**ealth **C**are (DMHC) oversees health care plans. If you do not agree with your health plan, you should file a grievance with your health plan before calling the DMHC. You can still take other action that may be available to you. If you need help with a grievance in an emergency, or your plan has not given you an answer on your grievance for more than thirty (30) days, you may call the DMHC for help. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for an IMR, it means that someone outside of your health plan will look at a medical decision made about your care. They will look at whether the care or service is needed. These decisions may be about care or service asked for by your doctor. They also may be about whether your health plan should pay for special treatments, or who should pay for emergency health services you get. You may call DMHC free of charge at **1-888 466–2219**. If you have problems with your hearing or speech, you may call the TDD line at **1-877-688-9891**. The DMHC has an Internet Web site **(http: --//www.hmohelp.ca.gov).** The Web site also has this form and information on how to use it.

Federal Employees: If you are a Federal Employee, you have additional rights through the

Office of Personnel Management (OPM) instead of the DMHC. Please reference your Federal Employees Health Benefits (FEHB) Program Brochure, which states that you may ask OPM to review the denial after you ask your health plan to reconsider the initial denial or refusal. OPM will determine if your health plan correctly applied the terms of its contract when it denied your claim or request for service. Send your request for review to: Office of Personnel Management, Office of Insurance Programs Contracts Division IV, P.O. Box 436, Washington, D.C. 20044

Employees of Self-Insured Companies: You may have the right to bring a civil action under Section 502(a) of the Employee Retirement Income Security Act (ERISA) if you are enrolled with your health plan through an employer who is subject to ERISA. First, be sure that all required reviews of your claim appeal have been completed and your claim has not been approved. Then consult with your employer's benefit plan administrator to determine if your employer's benefit plan is governed by ERISA. Additionally, you and your health plan may have other voluntary alternative dispute resolution options, such as mediation.

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Washington, D.C. 20044

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You may have the right to bring a civil action under Section 502(a) of the Employee Retirement Income Security Act (ERISA) if you are enrolled with your Health Plan through an employer who is subject to ERISA. First, be sure that all required reviews of your claim appeal have been completed and your claim has not been approved. Then consult with your employer's benefit plan administrator to determine if your employer's benefit plan is governed by ERISA. Additionally, you and your Health Plan may have other voluntary alternative dispute resolution options, such as mediation.

California Managed Care Member Health Plan Grievance Addresses

Please send grievance letters to the appropriate Health Plan at:

Aetna Health of California Attn: Commercial Grievance & Appeals, P.O. Box 10169, Van Nuys, CA. 91410 Member Services: 800-756-7039, 877-665-6736 (72 Hr. Expedited), TDD-TTY: (800) 628-3323 Fax 818-932-6566 (72 Hr. Expedited)
Alignment Health Plan Attn: Appeals and Grievances, 110 W. Town and Country Road, Suite 1600 Orange, CA 92868 Member Services: 866-634-2247 Internet Website: www.alignmenthealthplan.com
Anthem Blue Cross of California Attn: Grievance & Appeal Mgt. Dept., P.O. Box 4310, Woodland Hills, CA 91365-4310 "Call Cust. Serv. at the # on the front of your ID card." for Oral-Exp. Appeals (varies by group ID) 7 a.m. – 12 p.m., M-F, PST; 8 a.m. – 4 p.m., Sat., Fax 818-234-2767 or 3824
Blue Shield of California Attn: Member Services, P.O. Box 272540, Chico, CA 95927-2540 Member Services Phone: 800-424-6521, option 3, Spanish 800-424-6521 TDD-TTY: call 800-241-1823 (Oral req.), Internet website: http://www.mylifepath.com
Brand New Day Attn: Appeals and Grievance Department, P.O. Box 93122, Long Beach, CA 90809 Email: complaints@universalcare.com Phone: 866-255-4795, TTY 771; Fax: 657-400-1217

Central Health Plan Attn: Grievance & Appeal Mgt. Dept., 1540 Bridgegate Drive Diamond Bar, CA 91765 Email: appealsandgrievances@centralhealthplan.com (Preferred) Grievance & Appeal Mgt. Dept. Fax: 626-388-2372 Member Services Phone: 866-314-2427
CIGNA HealthCare (California) Attn: Grievance & Appeal Mgt. Dept., 400 N. Brand Blvd., Glendale, CA 91203-2311 Member Services Phone: 800-832-3211, Option 1; Member Srvs., TDD-TTY: 877-688-9891
Health Net (California) Attn: Appeals & Grievances Dept., P.O. Box 10348, Van Nuys, CA 91410-0348 Member Services Phone: 800-522-0088; Fax: 818-676-7200; Expedited Fax 818-676-7504 TDD-TTY: Commercial – 800-995-0852; Medi-Cal – 800-952-8349
Humana Health Plan of California, Inc. Attn: Grievance & Appeals Department, P.O. Box 14165, Lexington, KY 40512-4165 Telephone: 1-800- 867-6601 Toll Free: 1-800- 457-4708 (Member Services)
IEHP P.O. Box 19026, San Bernardino, CA 92423-9026 Toll Free: 1-877-273-IEHP (4347) (Member Services) TTY/TDD: 1-800-718-4347 Fax: 1-909-890-5748
Inter Valley Health Plan Attn: Grievance & Appeals, Inter Valley Health Plan, 300 South Park Avenue, Pomona, CA 91769-6002 Phone: 909-623-6333 or 800-251-8191; TTY Devices: Dial 711. Fax: 909-620-8092
SCAN Health Plan Attn: Grievance and Appeals Department, P.O. Box 22644 Long Beach, CA 90801-5644 Toll Free: 1-(800) 559-3500 (Member Services) TTY: 1-(800) 735-2929 Fax to: 1-(562) 989-0958
Scripps Health Plan Attention: Appeals & Grievances 4S-300, 10790 Rancho Bernardo Road San Diego, CA 92127 TTY: 1-844-337-3700
Sharp Health Plan Attn: Appeals and Grievances, 4305 University Ave., Suite 200, San Diego, CA 92105 Telephone: 1-800-359-2002 (Member Services) Fax: 1-619-740-8572
UnitedHealthcare of California Attn: Appeals Dept.-Exp. Mbr. Apls., PO Box 6107,MS CA124-0160, Cypress, CA 90630 Member Services Phone: Standard: 800-624-8822, Fax 800-704-3420, TDD-TTY: 800-442-8833. Expedited 888-277-4232, FAX 800-346-0930, TDD-TTY 800-422-8833

Medicare Advantage Members' Rights

Filing an Appeal

To exercise appeal rights, file appeals in writing within sixty (60) calendar days after the date of the original denial notice. Your plan can give you more time if you have a good reason for missing the deadline.

You or someone you name to act for you (your **authorized representative**) may file an appeal. You may name a relative, friend, advocate, attorney, doctor or someone else to act for you. Others not previously mentioned may already be authorized under State Law to act for you.

You can call us at: (800) 282-5366 to learn how to name your authorized representative. If you have a hearing or speech impairment, please call us at TTY/TDD (800) 628-3323.

Important Information about Your Appeal Rights

There are Two Kinds of Appeals You Can File:

Standard (30 days) – You can ask for a standard appeal. Your plan must give you a decision no later than 30 days after it gets your appeal. (Your plan may extend this time by up to 14 days if you request an extension, or if it needs additional information and the extension benefits you.)

Fast (72-hour preview) – You can ask for a fast appeal if you or your doctor believe that your health could be seriously harmed by waiting too long for a decision. Your plan must decide on a fast appeal no later than 72 hours after it gets your appeal. (Your plan may extend this time by up to 14 days if you request an extension, or if your plan needs additional information and the extension benefits you.)

- ✓ If any doctor asks for fast appeal for you, or supports you in asking for one, and the doctor indicates that waiting for 30 days could seriously harm your health, your plan will automatically give you a fast appeal.
- ✓ If you ask for a fast appeal without support from a doctor, your plan will decide if your health requires a fast appeal. If your plan does not give you a fast appeal, your plan will decide your appeal within 30 days.

What Do I Include With My Appeal?

You should include: your name, address, Member ID number, reason for appealing, and any evidence you wish to attach. You may send in supporting medical records, doctors' letters, or other information that explains why your plan should provide the service.
Call our doctor if you need this information to help you with your appeal. You may send in this information or present this information in person if you wish.

How Do I File An Appeal?

For Standard Appeal: You or your authorized representative should mail or deliver your written appeal to your Health Plan at the address indicated on the California Medicare Advantage Plan Member Appeal & Grievance Form.

For a Fast Appeal: You or authorized representative should contact us by telephone or fax using the plan contact information indicated on the California Medicare Advantage Plan Member Appeal & Grievance Form.

What Happens Next? If you appeal, your plan will review our decision. After your plan reviews our decision, if any of the services you requested are still denied, Medicare will provide you with a new and impartial review of your case by a reviewer outside of your Medicare Advantage Organization. If you disagree with that decision, you will have further appeal rights. You will be notified of those appeal rights if this happens.

Other Resources To Help You:
Medicare Rights Center
Toll Free: 1-888-HMO-9050
TTY/TDD:

Elder Care Locator
Toll Free: 1-800-677-1116
1-800-MEDICARE (1-800-633-4227)
TTY/TDD: 1-877-486-2048

OMB Approval No. 0938-NEW Form No. HCFA-10003-NDMC
(June 2001)

Appointment of Representation Form

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved OMB No.0938-0950

Appointment of Representative

Name of Party	Medicare Number (beneficiary as party) or National Provider Identifier (provider or supplier as party)

Section 1: Appointment of Representative

To be completed by the party seeking representation (i.e., the Medicare beneficiary, the provider or the supplier):

I appoint this individual, _____, to act as my representative in connection with my claim or asserted right under Title XVIII of the Social Security Act (the Act) and related provisions of Title XI of the Act. I authorize this individual to make any request; to present or to elicit evidence; to obtain appeals information; and to receive any notice in connection with my claim, appeal, grievance or request wholly in my stead. I understand that personal medical information related to my request may be disclosed to the representative indicated below.

Signature of Party Seeking Representation		Date
Street Address		Phone Number (with Area Code)
City	State	Zip Code
Email Address (optional)		

Section 2: Acceptance of Appointment

To be completed by the representative:

I, _____, hereby accept the above appointment. I certify that I have not been disqualified, suspended, or prohibited from practice before the Department of Health and Human Services (HHS); that I am not, as a current or former employee of the United States, disqualified from acting as the party's representative; and that I recognize that any fee may be subject to review and approval by the Secretary.

I am a / an _____

(Professional status or relationship to the party, e.g. attorney, relative, etc.)

Signature of Representative		Date
Street Address		Phone Number (with Area Code)
City	State	Zip Code
Email Address (optional)		

Section 3: Waiver of Fee for Representation

Instructions: This section must be completed if the representative is required to, or chooses to, waive their fee for representation. (Note that providers or suppliers that are representing a beneficiary and furnished the items or services may not charge a fee for representation and **must** complete this section.)

I waive my right to charge and collect a fee for representing _____ before the Secretary of HHS.

Signature	Date

Section 4: Waiver of Payment for Items or Services at Issue

Instructions: Providers or suppliers serving as a representative for a beneficiary to whom they provided items or services must complete this section if the appeal involves a question of liability under section 1879(a)(2) of the Act. (Section 1879(a)(2) generally addresses whether a provider/supplier or beneficiary did not know, or could not reasonably be expected to know, that the items or services at issue would not be covered by Medicare.) I waive my right to collect payment from the beneficiary for the items or services at issue in this appeal if a determination of liability under §1879(a)(2) of the Act is at issue.

Signature	Date

Charging of Fees for Representing Beneficiaries before the Secretary of HHS

An attorney, or other representative for a beneficiary, who wishes to charge a fee for services rendered in connection with an appeal before the Secretary of HHS (i.e., an Administrative Law Judge (ALJ) hearing or attorney adjudicator review by the Office of Medicare Hearings and Appeals (OMHA), Medicare Appeals Council review, or a proceeding before OMHA or the Medicare Appeals Council as a result of a remand from federal district court) is required to obtain approval of the fee in accordance with 42 CFR 405.910(f).

The form, "Petition to Obtain Representative Fee" elicits the information required for a fee petition. It should be completed by the representative and filed with the request for ALJ hearing, OMHA review, or request for Medicare Appeals Council review. Approval of a representative's fee is not required if: (1) the appellant being represented is a provider or supplier; (2) the fee is for services rendered in an official capacity such as that of legal guardian, committee, or similar court appointed representative and the court has approved the fee in question; (3) the fee is for representation of a beneficiary in a proceeding in federal district court; or (4) the fee is for representation of a beneficiary in a redetermination or reconsideration. If the representative wishes to waive a fee, he or she may do so. Section III on the front of this form can be used for that purpose. In some instances, as indicated on the form, the fee **must** be waived for representation

Approval of Fee

The requirement for the approval of fees ensures that a representative will receive fair value for the services performed before HHS on behalf of a beneficiary, and provides the beneficiary with a measure of security that the fees are determined to be reasonable. In approving a requested fee, OMHA or Medicare Appeals Council will consider the nature and type of services rendered, the complexity of the case, the level of skill and competence required in rendition of the services, the amount of time spent on the case, the results achieved, the level of administrative review to which the representative carried the appeal and the amount of the fee requested by the representative.

Conflict of Interest

Sections 203, 205 and 207 of Title XVIII of the United States Code make it a criminal offense for certain officers, employees and former officers and employees of the United States to render certain services in matters affecting the Government or to aid or assist in the prosecution of claims against the United States. Individuals with a conflict of interest are excluded from being representatives of beneficiaries before HHS.

Where to Send This Form

Send this form to the same location where you are sending (or have already sent) your: appeal if you are filing an appeal, grievance or complaint if you are filing a grievance or complaint, or an initial determination or decision if you are requesting an initial determination or decision. If additional help is needed, contact 1-800-MEDICARE (1-800-633-4227) or your Medicare plan. TTY users please call 1-877-486-2048.

You have the right to get Medicare information in an accessible format, like large print, Braille, or audio. You also have the right to file a complaint if you believe you've been discriminated against. Visit https://www.cms.gov/about-cms/agency-Information/aboutwebsite/cmsnondiscriminationnotice.html, or call 1-800-MEDICARE (1-800-633-4227) for more information.

Form CMS-1696 (Rev 08/18)

Medical Records Standards

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

- **Patient Identification**
  Each page in the record must contain the patient name and/or patient ID number.

- **Personal/Biographical Data**
  Each record must have the patient's name, 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 limited-English proficient or hearing impaired persons. Use and/or refusal of interpreters will be documented.

- **Patient Consent**
  To the extent required by applicable law, Providers must represent and warrant that it has received from each Member all legally required consents and authorizations necessary for Provider or Provider's designees to release a Member's health information, including but not limited to pharmacy, dental, vision, mental health, substance abuse, HIV/AIDS, psychotherapy, reproductive, and communicable disease information to other medical providers, contracted IPA, Optum and its Optum affiliates, for purposes of treatment, payment or health care operations as defined by HIPAA and/or applicable state law. Provider shall promptly notify IPA of each patient who does not authorize the release of health information described above.

- **Practitioner Identification**
  All entries will be identified as to the author. It is suggested that this is by full signature (first and last time 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 clearly dated on each unique record documentation

- **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 members over the age of 18 must be noted. Patients will be provided information as to making their own health decisions. Advance directives supplied to the practitioner must be included in the medical record.

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

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

- **Smoking/ETOH/Substance Abuse**
  For patients age 14 and older, there is appropriate notation concerning depression, violence, and the use of cigarettes, alcohol and substances (for patients seen three or more times, there is evidence of substance abuse query). If a member answers "yes" to the alcohol prescreen question, the PO will ensure that the PCP needs to offer the member an expanded, validated alcohol screening questionnaire. If the member is identified as being engaged in risky or hazardous drinking, the PO will ensure the PCP will offer at least one, but may offer up to a maximum of three behavioral counseling interventions for alcohol misuse per year. The PO will ensure that the PCP maintains documentation of the alcohol misuse screening or their members. When a member transfers from one PCP to another, the receiving PCP must obtain the member's prior medical records, including those pertaining to the provision of preventive services. Additional behavior counseling interventions must be authorized when medically necessary. However, medical necessity must be documented by the members PCP.

- **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 member relevant to the particular treatment will be noted.

- **Plan/Treatment**
  Treatment plans are consistent with diagnoses.

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

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

- **Appropriate Use of Consultants**
  Review for under and over-utilization will be noted. For example, repeated visits with a PCP for an unresolved problem might lead to a request for consultations with a specialty physician.

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

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

- **Medication Documentation**
  Current medication is documented, including name, dosage, frequency and route, include refill information. For medications given on site, list the name, dosage, route, site given, and the manufacturer's name and lot number, and member's reaction to medication.

- **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. The CDC and the American Academy of Pediatrics (AAP) recommend that children be screened for developmental delays and disabilities during regular well-child visits at 9, 18, 24 and 30 months. ASD-specific screenings should occur in all children at ages 18 and 24 months because these are critical periods for early social and language development.

- **Member Education**

  Recommendation and instructions given are included.

- **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 (eg. 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 (see policy #02-06-008-01 Amending or Correcting Health Information & Records).

Acceptable Signature Examples

Acceptable Electronic Signature Examples	Acceptable Written Signatures
• Chart 'Accepted By' with Provider's name	• Legible full signature
• 'Electronically signed by' with Provider's name	• Legible first initial and last name
• 'Verified by' with Provider's name	• Illegible signature over a typed or printed name
• 'Reviewed by' with Provider's name	• Illegible signature where the letterhead, addressograph or other information on the page indicates the identity of the signatory. Example: An illegible signature appears on a prescription. The letterhead of the prescription lists 3 physicians' names: One of the names is circled
• 'Approved by' with Provider's name	• Illegible signature NOT over a typed/printed name and NOT on letterhead, but the submitted documentation is accompanied by: 1) a signature log, or 2) an attestation statement
• 'Released by' with Provider's name	• Initials over a typed or printed name
• 'Signed by' with Provider's name	• Initials NOT over a typed/printed name but accompanied by: 1) a signature log, or 2) an attestation statement
• 'Signed before import by' with Provider's name	• Unsigned handwritten note where other entries on the same page in the same handwriting are signed
• 'Signed: John Smith, M.D.' with Provider's name	
• Digitized signature: Handwritten and scanned into the	

computer	
• 'This is an electronically verified report by John Smith, M.D.'	
• 'Authenticated by John Smith, M.D.'	
• 'Authorized by: John Smith, M.D.'	
• 'Digital Signature: John Smith, M.D.'	
• 'Confirmed by' with Provider's name	
• 'Closed by' with Provider's name	
• 'Finalized by' with Provider's name	
• 'Electronically approved by' with Provider's name	
• 'Signature Derived from Controlled Access Password'	

Medi Medi Smoking Cessation

- For Medi-Medi members only, Providers are required to meet the following requirements related to Tobacco Cessation:
  - Initial assessment within 120 days of enrollment
  - Health Education Behavioral Assessment (IHEBA). *The Staying Healthy Assessment (SHA) is DHCS's IHEBA*
  - Shall cover all FDA-approved tobacco cessation medications for adults who use tobacco products. This includes over-the-counter medications with a prescription from the provider. **Medication**:
    - Bupropion SR (Zyban)
    - Varenicline (Chantix)
    - nicotine gum
    - nicotine inhaler
    - nicotine lozenge
    - nicotine nasal spray
    - nicotine patch
  - At least one FDA-approved tobacco cessation medication must be available without prior authorization.
- Shall ensure that providers review the SHA's questions on tobacco with the beneficiary
- Shall ensure that individual, group, and telephone counseling is offered at no cost to beneficiaries who wish to quit smoking, whether or not those beneficiaries opt to use tobacco cessation medications
- Shall ensure beneficiaries receive a minimum of at least four counseling sessions of at least ten minutes. (individual/group/telephone- beneficiary's choice)
- Shall cover tobacco cessation counseling for at least two separate quit attempts per year, without prior authorization, and no mandatory breaks between quit attempts
- Shall ensure providers refer beneficiaries who use tobacco to the California Smokers' Helpline (Helpline) (1-800-NO-BUTTS)
- Ask all pregnant women if they use tobacco or are exposed to tobacco smoke
- Offer at least one face-to-face tobacco cessation counseling session per quit attempt
- Ensure referral to a tobacco cessation quit line, such as the Helpline
- Counseling services must be covered for 60 days after delivery, plus any additional days needed to end the respective month
- Shall use the USPHS "Clinical Practice Guideline, Treating Tobacco Use and Dependence: 2008 Update" for provider training on tobacco cessation treatments
- Trainings shall include:
  - Requirements for comprehensive tobacco cessation services included in this APL.
  - An overview of the "Clinical Practice Guideline, Treating Tobacco Use and Dependence: 2008."

- How to use and adopt the “5 A’s,” the “5 R’s,” or other validated model for treating tobacco use and dependence in the provider’s clinical practice.
- Special requirements for providing services for pregnant tobacco users.
- Informing providers about available online courses in tobacco cessation

- Primary care practices institute a tobacco user identification system, including the use of International Classification of Diseases (ICD)-10 Codes. The full set of ICD-10 codes to record tobacco use can be found at: www.ctri.wisc.edu/documents/icd10.pdf
- At a minimum, tracking for adults shall include results from tobacco questions in the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey
- Tracking treatment utilization of tobacco use may be implemented using any of the following measures:
  - Pharmacy claims data for NRT products.
  - Helpline web-based referral system.
  - Helpline e-referral program.
  - Individual and group counseling outcomes.
  - Current Procedure Terminology codes for tobacco use, such as: 99406; symptomatic; smoking and tobacco use cessation counseling visit, greater than 3 minutes, up to 10 minutes. 99407; symptomatic; smoking and tobacco use cessation counseling visit; greater than 10 minutes.
- Providers must also meet the following requirements related to Alcohol Misuse Screening / Behavioral Counseling Interventions for Alcohol Misuse:
- When a member answers “yes” to the IHEBA alcohol pre-screen question, the PCP offers the member an expanded, validated alcohol screening questionnaire. One of the following screening tools must be used:
  - Alcohol Use Disorder Identification Test (AUDIT) or
  - Alcohol Use Disorder Identification Test—Consumption (AUDIT-C).
  - PO to ensure that PCPs offer behavioral counseling intervention(s) to those members that a provider identifies as having risky or hazardous alcohol use when a member responds affirmatively to the alcohol question in the IHEBA, provides responses on the expanded screening that indicate hazardous use, or when otherwise identified.

Amending or Correcting Health Information and Records

Subject: Amending or Correcting Protected Health Information	**Policy Manual:** Optum Corporate
Effective Date: April 14, 2004	**Policy Number:** 01-11-00-011
Revision Dates:	**Department:** Compliance Title: Vice President of Legal Affairs Signature: On File
Certification Dates: 02/04; 04/05; 03/06; 02/07; 03/08; 03/09; 12/11; 12/12	
Last Revised By: VP of Legal Affairs	**Approval Signature on File:** President

SCOPE

All employees of Optum, PMNI, and its affiliated entities, globally referred to as "the Company" shall follow the procedures set forth in this policy.

PURPOSE

To allow the opportunity for members to request an amendment or correction to the protected health information (PHI) generated by the Company IPAs/Groups. (Examples: Claim or authorization denial letters, authorizations, health education mailings/surveys, etc.)

POLICY

Members who believe information in the Company IPA/Group designated record set is incomplete or incorrect may request an amendment or correction to the information.

PROCEDURE

Upon notification or request from a member to amend or correct information, the following steps should be taken by the Company IPAs/Group department who generated the correspondence:

1. Pull hard copy (i.e., Claim or authorization, denial letter, physician correspondence, etc.)
2. Verify any discrepancies.
3. Correct information in the computer system and/or paperwork as needed.
4. Notify all concerned parties of correction.
5. If no discrepancy is found, notify member and refer member back to the provider or source of the disputed information.

Appointment Access Criteria

Access Type	Standard
PCP and Specialty Access Standards	
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 non-urgent appointments for specialty care	Within 15 business days
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
In-office wait time for scheduled appointments (PCP and Specialist)	Not to exceed 15 minutes
Access to preventive health services	Within 30 days of initial request
Non-urgent appointments for ancillary services for the diagnosis or treatment of injury, illness or other health condition	Within 15 business days of request
Appointment rescheduling	The provider must promptly reschedule the appointment in a manner that is appropriate for the member's health care needs
Appointment Access Standards Behavioral Health	
Access to non-urgent appointment with physician for routine care	Within 10 business days of request
Non-urgent appointments with a non-physician behavioral health care provider	Within 10 business days of request
Access to 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 appointments at a later date if the member prefers not to accept the appointment offered within the same or next business day).
Advance Scheduling	Preventive care services and periodic follow-up care may be scheduled in advance consistent with professionally recognized standards of practice as determined by the treating licensed health care provider

2021 Preventive Health Guidelines

For children ages 0 to 2

Topics you may want to discuss with your doctor

Safety

- Use a checklist to "babyproof" your home.
- Check your home for the presence of lead paint.

Nutrition

- Breastfeeding and iron-enriched formula and food for infants.

Dental health

- Do not put your baby or toddler to bed with a bottle containing juice, milk, or other sugary liquid. Do not prop a bottle in a baby's or toddler's mouth. Clean your baby's gums and teeth daily.
- Use a clean, moist washcloth to wipe gums. Use a soft toothbrush with water only, beginning with eruption of first tooth.
- Age 6 months to preschool: Discuss with your dentist about taking an oral fluoride supplement if water is deficient in fluoride.
- Age 2: Begin brushing child's teeth with pea-size amount of fluoride toothpaste.

Immunizations

Shot number in a series	1	2	3	4
DTaP (diphtheria, tetanus, acellular pertussis)	2	4	6	15–18 months
Flu, annual	For children 6 months and older[2,18]			
Hepatitis A	12–23 months (second dose at least 6 months after first)			
Hepatitis B	0 (birth)	1–2	6–18 months	
Hib (Haemophilus influenzae type b)	2	4	6	12–15 months
IPV (inactivated poliovirus vaccine)	2	4	6–18 months	
Meningococcal Age 2–18 months	For children with risk factors			
MMR (measles, mumps, rubella)	First dose at 12–15 months, second dose at ages 4–6			
Pneumococcal (pneumonia)	2	4	6	12–15 months
Rotarix (rotavirus), or	2	4 months		
RotaTeq (rotavirus)	2	4	6 months	
Varicella (chicken pox)	12–15 months, second dose at ages 4–6			

Screenings/counseling/services

Blood tests	24–48 hours after birth to screen for conditions such as phenylketonuria or hypothyroidism[1]
Fluoride use	Discuss use or prescribe oral supplement for ages 6 months and older. Apply fluoride varnish to primary teeth of infants and children.[24]
Gonococcal ophthalmia	Topical eye medication administered during initial newborn care
Height and weight	Periodically
Newborn Screening Panel	Screening recommended for all disorders listed on the Recommended Uniform Screening Panel (RUSP)[23]
Sickle cell disease screening	Risk assessment and testing if risk identified
Skin Cancer	Behavioral counseling to minimize exposure to ultraviolet radiation for persons ages 6 months to 24 years old at high risk
Tuberculosis	Risk assessment and testing if risk identified

Injury prevention for infants and young children

Decrease risk of SIDS

Sudden infant death syndrome (SIDS) is a leading cause of death for infants. Put infants to sleep on their backs to decrease the risk of SIDS.

Protect your children with car seats

Use the right car seat for your vehicle and for your child's weight. Read the car seat and vehicle manufacturer's instructions about installation and use. Use a rear-facing car seat until your child is at least 1 year old and weighs at least 20 pounds.

Babyproof your home

Take these steps to give your child a safe home environment:

- Keep medicines, cleaning solutions, and other dangerous substances in childproof containers, locked up and out of reach of children.
- Use safety gates across stairways (top and bottom) and guards on windows above the first floor.
- Keep hot-water heater temperatures below 120° F.
- Keep unused electrical outlets covered with plastic guards.
- Consider not placing your baby in a baby walker. If you do, provide constant supervision. Block the access to stairways and to objects that can fall (such as lamps) or cause burns (such as stoves or electric heaters).
- Keep objects and foods that can cause choking away from your child. This includes things like coins, balloons, small toy parts, hot dogs (whole or small bites), peanuts, and hard candy.
- Use fences that go all the way around pools and keep gates to pools locked.

For children ages 3 to 10

Topics you may want to discuss with your doctor

Safety

- Use a checklist to "child-proof" your home.
- Check your home for the presence of lead paint.

Exercise

- Participate in physical activity as a family, such as taking walks or playing at the playground.
- Limit screen time (such as mobile devices, computers, and television) to less than two hours a day.

Nutrition

- Eat a healthy diet. Limit fat and calories. Eat fruits, vegetables, beans, and whole grains every day.

Dental health

- Ask your dentist when and how to floss child's teeth.
- Age 5: Talk to your dentist about dental sealants.

Other topics for discussion

- Well-child visits are a good time to talk to your doctor about any concerns you have with your child's health, growth, or behavior.

Immunizations

DTaP (diphtheria, tetanus, acellular pertussis)	Ages 4–6 (Tdap for age 7 and above)
Flu, annual	Recommended[2,18]
Hepatitis A	For children not previously vaccinated and risk factors are present
Hepatitis B	For children who did not complete the immunization series between 0 and 18 months
IPV (inactivated poliovirus vaccine)	Fourth dose at ages 4–6
MMR (measles, mumps, rubella)	Second dose at ages 4–6
Pneumococcal (pneumonia)	For children with risk factors[4] or an incomplete schedule (ages 2–5)
Varicella (chicken pox)	Second dose at ages 4–6

Screenings/counseling/services

Height, weight, body mass index (BMI), vision, hearing	At annual exam
Fluoride use	Discuss use or prescribe oral supplement for ages 6 months and older. Apply fluoride varnish to primary teeth of infants and children.[24]
Obesity	Screening, counseling, and behavioral interventions for children age 6 and older and offer or refer to comprehensive intensive behavioral intervention to promote improvements in weight status
Skin cancer	Behavioral counseling for minimizing exposure to ultraviolet radiation for persons ages 6 months to 24 years old at high risk
Tobacco use and cessation	Discuss education or brief counseling to prevent initiation of tobacco use amongst school-aged children and adolescents
Tuberculosis	Risk assessment and testing if risk identified

Be aware of your child's recommended weight: Use our online tools to calculate your child's body mass index (BMI) by logging in to **blueshieldca.com** and searching for BMI.

Injury prevention:

For older children

- Children should use a booster seat in the car's back seat until they are at least 8 years old or weigh at least 80 pounds.
- Older children should use car seat belts and sit in the back seat at all times.
- Teach your child traffic safety. Children under 9 years old need supervision when crossing streets.
- Make sure your child wears a helmet while rollerblading or riding a bicycle. Make sure your child uses protective equipment for rollerblading and skateboarding (helmet, wrist, and knee pads).
- Warn your child about the risk of using alcohol and drugs. Many driving and sports-related injuries are caused by the use of alcohol and drugs.

For all ages

- Use smoke and carbon monoxide alarms/detectors in your home. Change the batteries every year, and check once a month to see that they work.
- If you have a gun in your home, make sure that the gun and ammunition are locked up separately and kept out of children's reach.
- Never drive after drinking alcohol or after marijuana use.
- Use car seat belts at all times.
- Post the number for the Poison Control Center – (800) 222-1222 – near your phone. Also, add the Poison Control Center number to your home "Important Information" list. The number is the same in every U.S. location. Do not try to treat poisoning until you have called the Poison Control Center.

For children ages 11 to 19

Topics you may want to discuss with your doctor

Exercise

- Regular physical activity (at least 30 minutes per day starting at age 11) can reduce the risks of coronary heart disease, osteoporosis, obesity, and diabetes.

Nutrition

- Eat a healthy diet. Limit fat and calories. Eat fruits, vegetables, beans, and whole grains every day.
- Optimal calcium intake for adolescents and young adults is estimated to be 1,200 to 1,500 mg/day.

Sexual health

- Sexually transmitted infection (STI)/HIV prevention:[4] practice safer sex (use condoms) or abstinence.
- Avoid unintended pregnancy: use contraception.

Substance use disorder

- Use of alcohol, tobacco (cigarettes, vaping, or chewing), inhalants, and other drugs among adolescents is a major concern for parents. Let the doctor know if you have any concerns about your child.

Dental health

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

Other topics for discussion

- It is a good idea to let your teenager have private time with the doctor to ask any questions he or she may not feel comfortable asking you.

Immunizations

Flu, annual	Recommended[2]
Hepatitis A	For individuals not previously vaccinated and risk factors are present
Hepatitis B	For individuals not previously vaccinated; for individuals with risk factors seeking protection[29]
HPV (human papillomavirus)	Two- or three-dose series depending on age at initial vaccination. Recommended for all adolescents age 11-12 years and through 18 years of age.
Meningococcal	Routine vaccination two-dose series. First dose at ages 11-12, second dose at age 16.
MMR (measles, mumps, rubella)	At pre-adolescent visit (ages 11–12) if missing second dose
Pneumococcal (pneumonia)	For children with risk factors[6]
Tdap booster (tetanus, diphtheria, pertussis)	For children ages 11–12 who have completed the recommended DTaP immunization series[27]
Varicella (chicken pox)	At pre-adolescent visit (ages 11–12) if missing second dose

Screenings/counseling/services

Alcohol misuse	Screening for unhealthy alcohol use and behavioral counseling as needed
Blood pressure, height, weight, BMI, vision, and hearing	At annual exam
Chlamydia and Gonorrhea	Screening for all sexually active women under age 24 and for women at increased risk for infection[11]
Contraception	FDA-approved contraceptive methods for females, education, and counseling[32]
Depression	Screening for all adolescents for major depressive disorder (MDD)
Domestic violence and abuse	Screening for interpersonal and domestic violence for adolescents, women, and women of childbearing age[34]
Drug Misuse	Screening for unhealthy drug use[25]
Healthy diet and physical activity	Behavioral counseling[37]
Hepatitis C	Screening for HCV infection in persons at high risk of infection[30]
HIV	Screening for all adolescents and adults ages 15–65. Recommend preexposure prophylaxis (PrEP) to persons at high risk of HIV acquisition.
Obesity	Screening, counseling, and behavioral interventions and offer or refer to comprehensive intensive behavioral intervention to promote improvements in weight status
Sexually transmitted infections	Behavioral counseling as needed[26]
Skin cancer	Behavioral counseling for minimizing exposure to ultraviolet radiation for adolescents at high risk
Syphilis	Screening for individuals at increased risk for infection[12]
Tobacco use and cessation	Discuss education or brief counseling to prevent initiation of tobacco use among school-aged children and adolescents
Tuberculosis	Risk assessment and testing if risk identified

Promoting your preteen's and adolescent's social and emotional development

Parents need to offer open, positive communication while providing clear and fair rules and consistent guidance. Let your child find his or her own path while staying within the boundaries you have set.

- Be a good role model for handling disagreements – for example, talk calmly when disagreeing.
- Praise him or her for successfully avoiding a confrontation – for example, say, "I'm proud of you for staying calm."
- Supervise the websites and computer games that your child uses.
- Set limits on use of computers, telephones, texting, and TV after a set evening hour to help your child get regular sleep.
- Talk to your child about healthy relationships. Dating abuse does occur among preteens and teens.
- Be a role model for healthy eating and regular physical exercise.

For women ages 20 to 49

Topics you may want to discuss with your doctor

Exercise

- Regular physical activity (at least 30 minutes per day) can reduce the risks of coronary heart disease, osteoporosis, obesity, and diabetes.
- Over 40: Consult physician before starting new vigorous physical activity.

Nutrition

- Know your body mass index (BMI), blood pressure, and cholesterol level. Modify your diet accordingly.
- Eat a healthy diet. Limit fat and calories. Eat fruits, vegetables, beans, and whole grains every day.
- Optimal calcium intake for women between ages 25 and 50 is estimated to be 1,000 mg/day.
- Vitamin D is important for bone and muscle development, function, and preservation.

Sexual health

- Sexually transmitted infection (STI)/HIV prevention,[14] practice safer sex (use condoms) or abstinence.
- Avoid unintended pregnancy: use contraception.

Substance use disorder

- 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.

If you are pregnant, please refer to the "For pregnant women" page for pregnancy-related recommendations.

Immunizations

Flu, annual	Recommended[2]
Hepatitis A	For individuals with risk factors; for individuals seeking protection[3]
Hepatitis B	For individuals with risk factors; for individuals seeking protection[4,29]
HPV (human papillomavirus)	For all women age 26 and younger if not previously immunized. Recommended for all sexually active women age 30 and older in conjunction with cervical cancer screening (Pap smear).
Meningococcal	First-year college students who live in residential housing if not previously immunized and military recruits[8]
MMR (measles, mumps, rubella)	Once, without proof of immunity or if no previous second dose[5]
Pneumococcal (pneumonia)	For individuals with risk factors[7]
Td booster (tetanus, diphtheria)	Recommended once every 10 years[15]
Varicella (chicken pox)	Recommended for adults without evidence of immunity; 2-dose series 4-8 weeks apart[10]

Screenings/counseling/services

Alcohol misuse	Screening for unhealthy alcohol use and behavioral counseling as needed
Blood pressure, height, weight, BMI, vision, and hearing	At well visit, annually
BRCA risk assessment and genetic counseling/testing	Women with a positive result on the risk assessment tool or have a family history of breast, ovarian, tubal, prostate, pancreatic, or peritoneal cancer are recommended to receive genetic counseling and/or genetic testing.[20]
Breast cancer	Recommend mammogram every 1–2 years beginning at age 40
Breast cancer chemoprevention	Recommended for women at high risk for breast cancer and low risk for adverse effects from chemoprevention
Cardiovascular disease	Statin use for primary prevention in adults[35]
Cervical cancer	Recommended screening every 3 years with cervical cytology by Pap tests
Chlamydia and Gonorrhea	Screening for all sexually active women under age 24 and for women at increased risk for infection[11]
Contraception	FDA-approved female contraceptive methods, education, and counseling[32]
Depression	Screening for all adults
Diabetes	Screening for overweight or obese adults ages 40–70[22]
Domestic violence and abuse	Screening for interpersonal and domestic violence for adolescents, women, and women of childbearing age[34]
Drug Misuse	Screening for unhealthy drug use[25]
Healthy diet and physical activity	Behavioral counseling[27]
Hepatitis C	Screening for HCV infection in persons at high risk of infection[30]
HIV	Screening for all adolescents and adults ages 15–65. Recommend preexposure prophylaxis (PrEP) to persons at high risk of HIV acquisition.
Latent tuberculosis infection (LTBI)	Screening for asymptomatic adults at increased risk for infection[33]
Lipid disorder	Screening for individuals at increased risk[9]
Obesity	Screening, counseling, and behavioral interventions and offer or refer to comprehensive intensive behavioral intervention to promote improvements in weight status
Osteoporosis	Screening for women at increased risk
Sexually transmitted infections	Behavioral counseling as needed[24]
Skin cancer	Behavioral counseling for minimizing exposure to ultraviolet radiation for young adults to age 24 at high risk
Syphilis	Screening for pregnant women and individuals at increased risk for infection[12]
Tobacco use and cessation	Screening for tobacco use and cessation intervention

For men ages 20 to 49

Topics you may want to discuss with your doctor

Exercise

- Regular physical activity (at least 30 minutes per day) can reduce the risks of coronary heart disease, osteoporosis, obesity, and diabetes.
- Men over 40: Consult physician before starting new vigorous physical activity.

Nutrition

- Know your body mass index (BMI), blood pressure, and cholesterol level. Modify your diet accordingly.
- Vitamin D is important for bone and muscle development, function, and preservation.

Sexual health

- Sexually transmitted infection (STI)/HIV prevention,[14] practice safer sex (use condoms) or abstinence.

Substance use disorder

- 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.

"Know your numbers." We encourage you to learn your "numbers" at your doctor visit and work toward the optimal goals through exercise and a healthy diet.

Immunizations

Flu, annual	Recommended[2]
Hepatitis A	For individuals with risk factors; for individuals seeking protection[3]
Hepatitis B	For individuals with risk factors; for individuals seeking protection[4,29]
HPV (human papillomavirus)	Recommended for all adults through 26 years of age. 2 or 3-dose series depending on age of initial vaccination
Meningococcal	First-year college students who live in residential housing if not previously immunized and military recruits[8]
MMR (measles, mumps, rubella)	Once, without proof of immunity or if no previous second dose[5]
Pneumococcal (pneumonia)	For individuals with risk factors[9]
Td booster (tetanus, diphtheria)	Recommended once every 10 years[35]
Varicella (chicken pox)	Recommended for adults without evidence of immunity; 2-dose series 4-8 weeks apart[10]

Screenings/counseling/services

Alcohol misuse	Screening for unhealthy alcohol use and behavioral counseling as needed
Blood pressure, height, weight, BMI, vision, and hearing	At annual exam
Cardiovascular disease	Statin use for primary prevention in adults[35]
Depression	Screening for all adults
Diabetes	Screening for overweight or obese adults ages 40–70[22]
Drug Misuse	Screening for unhealthy drug use[25]
Healthy diet and physical activity	Behavioral counseling[27]
Hepatitis C	Screening for HCV infection in persons at high risk of infection[30]
HIV	Screening for all adolescents and adults ages 15–65. Recommend preexposure prophylaxis (PrEP) to persons at high risk of HIV acquisition.
Latent tuberculosis infection (LTBI)	Screening for asymptomatic adults at increased risk for infection[33]
Lipid disorder	Screening for individuals at increased risk[9]
Obesity	Screening, counseling, and behavioral interventions and offer or refer to comprehensive intensive behavioral intervention to promote improvements in weight status
Sexually transmitted infections	Behavioral counseling as needed[26]
Skin cancer	Behavioral counseling for minimizing exposure to ultraviolet radiation for young adults to age 24 at high risk
Syphilis	Routine screening for individuals at increased risk for infection[12]
Tobacco use and cessation	Screening for tobacco use and cessation intervention

Heart health factors	Optimal goals
Total cholesterol	Less than 200 mg/dL
LDL "bad" cholesterol	Less than 100 mg/dL
HDL "good" cholesterol	50 mg/dL or higher
Triglycerides	Less than 150 mg/dL
Blood pressure	Less than 120/80 mmHg
Fasting glucose	Less than 100 mg/dL
Body mass index (BMI)	Less than 25 kg/m2
Exercise	Minimum of 30 minutes most days of the week

For men and women age 50 and older

Topics you may want to discuss with your doctor

Nutrition

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

Sexual health

- Sexually transmitted infection (STI)/HIV prevention:[14] practice safer sex (use condoms) or abstinence.

Substance use disorder

- 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 for discussion

- 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) for those age 65 and older.

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

Immunizations

Flu, annual	Recommended[2]
Hepatitis A	For individuals with risk factors: for individuals seeking protection[3]
Hepatitis B	For individuals with risk factors: for individuals seeking protection[4]
Meningococcal	Booster every five years if risk remains.
MMR (measles, mumps, rubella)	Once, without proof of immunity or if no previous second dose[5]
Pneumococcal (pneumonia)	Recommended for individuals age 65 and older; and individuals under age 65 with risk factors[7]
Td booster (tetanus, diphtheria)	Recommended once every 10 years[15]
Varicella (chickenpox)	Recommended for adults without evidence of immunity; 2-dose series 4–8 weeks apart[10]
Zoster (shingles)	Two doses of RZV for all adults age 50 and older. ZVL may be used as an alternative for adults age 60 and older.

Screenings/counseling/services

AAA (abdominal aortic aneurysm)	For ages 65–75 who have ever smoked, one-time screening for AAA by ultrasonography
Alcohol misuse	Screening for unhealthy alcohol use and behavioral counseling as needed
Aspirin	Use for primary prevention of cardiovascular disease and colorectal cancer for adults who are at increased risk[19]
Blood pressure, height, weight, BMI, vision, and hearing	At annual exam
BRCA risk assessment and genetic counseling/testing	Women with a positive result on the risk assessment tool or have a family history of breast, ovarian, tubal, prostate, pancreatic, or peritoneal cancer are recommended to receive genetic counseling and/or genetic testing.[20]
Breast cancer	Recommend mammogram every 1–2 years beginning at age 40; BRCA/BART testing is covered if medically necessary[20]
Breast cancer chemoprevention	Covered for individuals at high risk for breast cancer and low risk for adverse effects from chemoprevention
Cardiovascular disease	Statin use for primary prevention in adults[35]
Cervical cancer	Every 3 years if cervix present; after age 65, Pap tests can be discontinued if previous tests have been normal
Chlamydia and Gonorrhea	Screening for individuals who are at increased risk for infection[11]
Colorectal cancer	Screening for adults ages 50–75[21]
Depression	Screening for all adults
Diabetes	Screening for overweight or obese adults ages 40–70[22]
Domestic violence and abuse	Screening for interpersonal and domestic violence for adolescents, women, and women of childbearing age[24]
Drug Misuse	Screening for unhealthy drug use[25]
Fall prevention	Recommended exercise interventions for adults ages 65 or older at increased risk[28]
Healthy diet and physical activity	Behavioral counseling[27]
Hepatitis C	Screening for HCV infection in persons at high risk of infection[30]
HIV	Screening for all adolescents and adults ages 15–65. Recommend preexposure prophylaxis (PrEP) to persons at high risk of HIV acquisition.
Latent tuberculosis infection (LTBI)	Screening for asymptomatic adults at increased risk for infection[33]
Lipid disorder	Screening periodically
Lung cancer	Screening for lung cancer in persons with smoking history[31]
Mammography	Biennial mammography recommended for women age 50 and older
Obesity	Screening, counseling, and behavioral interventions and offer or refer to comprehensive intensive behavioral intervention to promote improvements in weight status
Osteoporosis	Routine screening for women age 65 and older and for men age 70 and older – beginning age can be reduced for individuals at increased risk[13]
Sexually transmitted infections	Behavioral counseling as needed[26]
Syphilis	Screening for individuals at increased risk for infection[12]
Tobacco use and cessation	Screening for tobacco use and cessation intervention

For pregnant women

Screenings/counseling/services	
Alcohol misuse	Screening for unhealthy alcohol use and behavioral counseling as needed
Aspirin	Low-dose aspirin use for the prevention of morbidity and mortality from preeclampsia[14]
Asymptomatic bacteriuria	Recommended screening using urine culture in pregnant women.
Breast-feeding counseling	Promote breast-feeding to pregnant or postpartum women. Provide comprehensive lactation support and breast-feeding equipment.
Chlamydia and Gonorrhea	During first prenatal visit and second screening during the third trimester for those at increased risk[11]
Depression	Refer pregnant and postpartum persons who are at increased risk of depression to counseling interventions
Drug Misuse	Screening for unhealthy drug use[25]
Folic acid	Discuss use of 0.4 to 0.8 mg daily
Gestational diabetes	Women between 24- to 28-week gestations and the first prenatal visit for pregnancy. Women identified to be at increased risk for diabetes.
Hepatitis B	First prenatal visit[29]
HIV	First prenatal visit[23]
Preeclampsia	Screening with blood pressure measurements
Rh (D) incompatibility	Recommended repeated Rh(D) antibody testing for all unsensitized Rh(D) – negative women at 24 to 28 weeks' gestation, unless the biological father is known to be Rh(D) – negative
Syphilis	Recommend early screening for infection in all pregnant women[12]
Tdap	One dose of Tdap is recommended during each pregnancy, preferably in the early part of the gestational weeks 27–36
Tobacco use and cessation	Screening for tobacco use and tobacco-cessation intervention

Having a baby? Be aware that while almost all women get the "baby blues" after childbirth, as many as 10% will get postpartum depression. For more information, visit our website, **blueshieldca.com**, or see your healthcare provider.

Recommendations for a healthy pregnancy

Prenatal care

Begin within 14 days of confirming pregnancy.

Dietary supplements

Women of childbearing age should take 0.4 to 0.8 mg of folic acid daily to decrease the risk of fetal brain and spinal cord birth defects. The recommended calcium intake for pregnant or nursing women is 1,000 milligrams daily.

Screenings and diagnostics

Blood pressure and weight check at all visits; urine test; obstetrical history and physical; screenings for asymptomatic bacteriuria; chlamydia; gestational diabetes; Group B streptococcal bacteria; hepatitis B; syphilis; gonorrhea; hematocrit; rubella; varicella; Rh (D) incompatibility; HIV counseling and screening; ultrasonography; screening for alpha fetoprotein; chorionic villus screening (CVS) or amniocentesis (for women age 35 and older); blood tests for certain birth defects; fundal height; fetal heart tones.

Discussion topics at prenatal care visits

Prior vaccinations (including flu shots), history of genital herpes, nutrition, smoking cessation, other medication and drug use, preterm labor risk, domestic abuse, mental health as an initial intervention service after screening for interpersonal and domestic violence, and other medication and drug use.

Postpartum care

To be performed within three to seven weeks following delivery. Postpartum exam to include weight, blood pressure, breast and abdomen exam, or pelvic exam.

Health Resources and Services Administration Supported Women's Preventive Services: Required Health Plan Coverage Guidelines

Non-grandfathered plans and issuers are required to provide coverage without cost sharing consistent with these guidelines in the first plan year (in the individual market, policy year) that begins on or after August 1, 2012.

Type of Preventive Service	HHS Guideline for Health Insurance Coverage	Frequency
Well-woman visits.	Well-woman preventive care visit annually for adult women to obtain the recommended preventive services that are age and developmentally appropriate, including preconception and prenatal care. This well-woman visit should, where appropriate, include other preventive services listed in this set of guidelines, as well as others referenced in section 2713.	Annual, although HHS recognizes that several visits may be needed to obtain all necessary recommended preventive services, depending on a woman's health status, health needs, and other risk factors.* (see note)
Screening for gestational diabetes.	Screening for gestational diabetes.	In pregnant women between 24 and 28 weeks of gestation and at the first prenatal visit for pregnant women identified to be at high risk for diabetes.
Human papillomavirus testing.	High-risk human papillomavirus DNA testing in women with normal cytology results.	Screening should begin at 30 years of age and should occur no more frequently than every 3 years.
Counseling for sexually transmitted infections.	Counseling on sexually transmitted infections for all sexually active women.	Annual.
Counseling and screening for human immune-deficiency virus.	Counseling and screening for human immune-deficiency virus infection for all sexually active women.	Annual.
Contraceptive methods and counseling. ** (see note)	All Food and Drug Administration approved contraceptive methods, sterilization procedures, and patient education and counseling for all women with reproductive capacity.	As prescribed.

Health Resources and Services Administration Supported Women's Preventive Services: Required Health Plan Coverage Guidelines

Breastfeeding support, supplies, and counseling.	Comprehensive lactation support and counseling, by a trained provider during pregnancy and/or in the postpartum period, and costs for renting breastfeeding equipment.	In conjunction with each birth.
Screening and counseling for interpersonal and domestic violence.	Screening and counseling for interpersonal and domestic violence.	Annual

Medicare Risk Adjustment

Optum encourages providers to document patient health information and demographics for appropriate Medicare reimbursement. CMS uses this demographic information reported for one year along with risk adjustment diagnosis codes to determine reimbursement rates for the following year. Compensation rates are based on patient risk scores.

History of Medicare Managed Care

- ✓ 1965 - Medicare program starts
- ✓ 1973 - Congress passes HMO Act
- ✓ 1982 – Congress passes the Tax Equity and Fiscal Responsibility Act (TEFRA). TEFRA established the AAPCC payment system. AAPCC's took FFS expenditures by county and multiplied that by 95%
- ✓ Organized delivery system
- ✓ Discrete PCP sub-groups within an IPA
- ✓ Physician Organized Delivery Systems (PODS)
- ✓ Discrete PCP sub-groups within an IPA
- ✓ 1987 – Congress passes the Balanced Budget Act (BBA)
- ✓ 2000 – Principal Inpatient Diagnostic Code Grouping (PIP-DCG) model implemented. This model only incorporated data from inpatient encounters
- ✓ 2000 – Congress passes the Benefits Improvement and Protections Act of 2000 (BIPA)
- ✓ BIPA mandates that Medicare implement a risk adjusted payment system incorporating ambulatory diagnosis beginning in 2004
- ✓ Medicare selects the DCG/HCC model (known as CMS-HCC)

CMS Hierarchical Condition Categories (HCC) Model

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

Applied Research Works, Inc.
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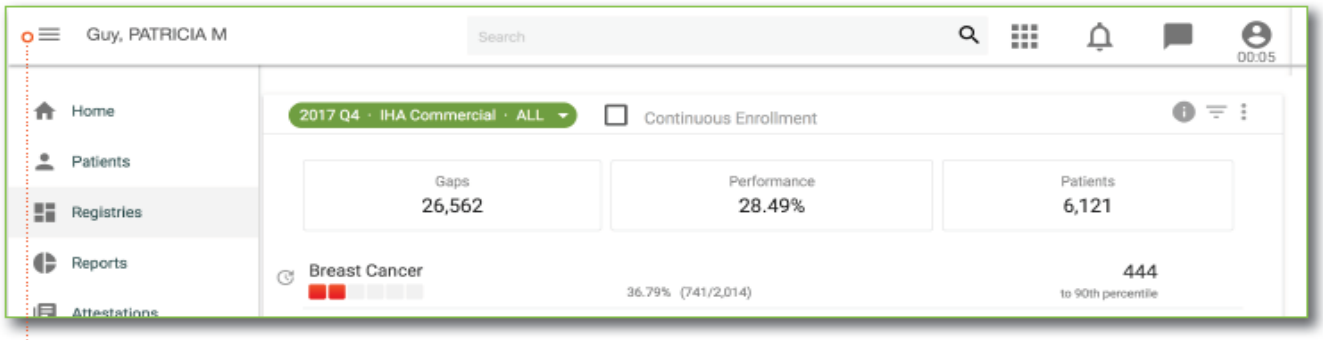
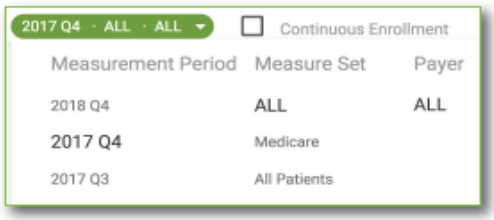
USER GUIDE
Practice

1. OVERVIEW

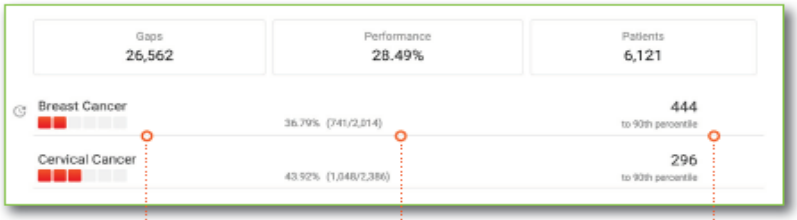


TOGGLE SIDEBAR APP TRAY NOTIFICATIONS SUPPORT CHAT ACCOUNT



REGISTRIES FILTER

- Measurement period: Calendar year
- Measure set: HEDIS, CMS STARS etc.



THRESHOLD PERFORMANCE

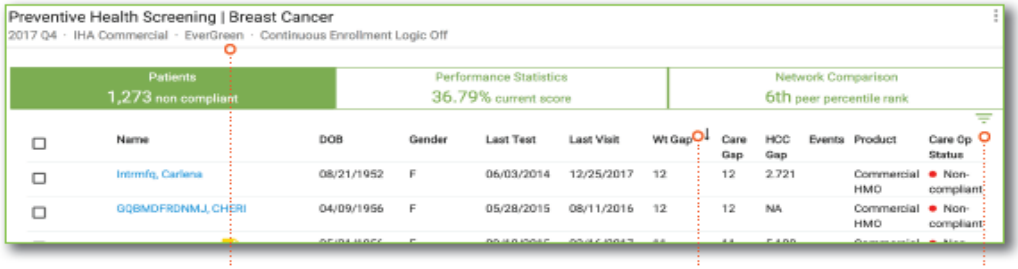
NUMERATOR - Compliant
DENOMINATOR - Eligible

NUMBER TO GOAL

COLOR CODED PERFORMANCE THRESHOLDS

VIEWING PERFORMANCE

The *REGISTRIES* view is your one-stop-shop for viewing performance by patient population. Patients are grouped by *measure-set*. Medicare, Commercial, etc. Color coded chiclets or STARS report performance, by measure.



PATIENTS DUE LIST

Select any measure to view a list of patients due.

Sort, filter, export and print this list to create custom campaign outreach lists.

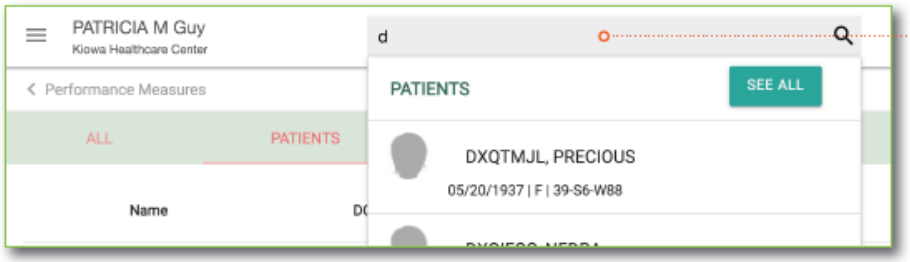
VIEW DETAILS FOR EACH LISTING

SORT MOST COLUMNS

FILTER

For feedback, contact:training@cozeva.com

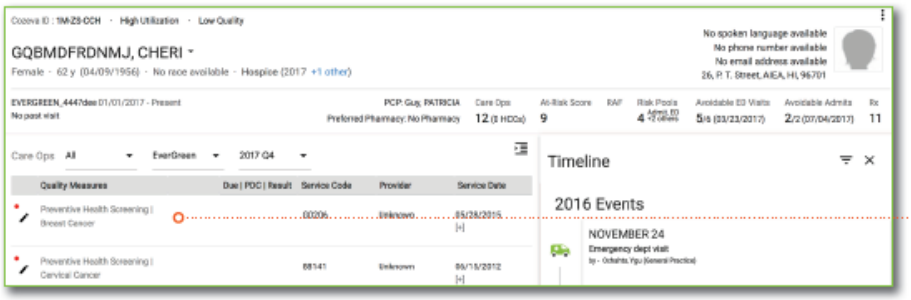
2. PATIENT DASHBOARD



SEARCH FOR PATIENTS

Search by:

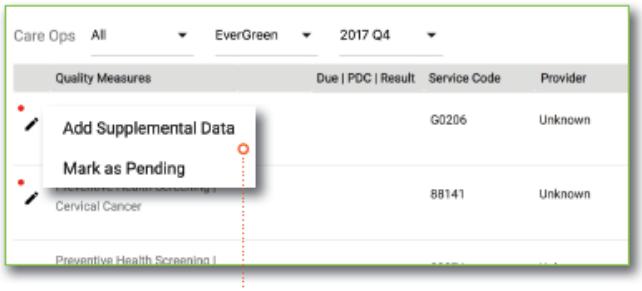
- First name
- Last name
- Date of birth
- MRN



VIEW OPEN CARE GAPS

- Open Care gap
- Pending Care gap
- Satisfied Care gap

3. ATTEST TO COMPLIANCE OR EXCLUSION



ATTEST TO COMPLIANCE OR EXCLUSION VIA THE PENCIL TOOL

SUPPLY CODES AND SERVICE DATE

VIEW RELEVANT CLINICAL HISTORY

ACCESS PATIENT DOCUMENTS

MARK AS PENDING

Temporarily mark as compliant for five weeks if the gap will close through claims. Pending gaps are presented with a hollow dot.

ADD SUPPLEMENTAL DATA

Permanently mark a measure as compliant (or exclude a patient from a measure) if you have proof of service documentation that the service was completed (i.e. lab result, shot records, etc.) but the measure will not be recieved by COZEVA on an in-network claim.

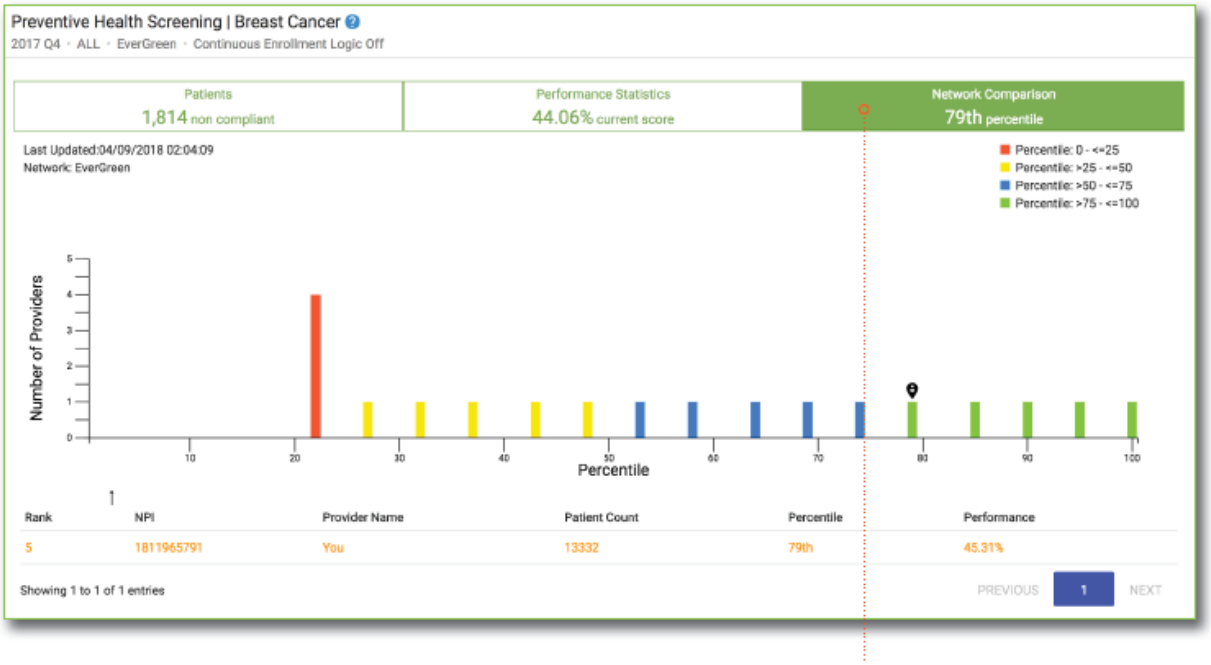
FILL OUT ATTESTATION FORM

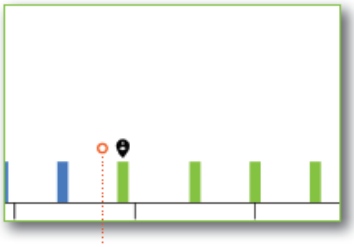
Fill out the attestation form for the patient. Supplemental data forms observe measure set logic- users can only exclude or attest to compliance with codes in the value set.

PROVIDE PROOF OF SERVICE DOCUMENTATION

Upload or associate already uploaded documents with the attestation for review by an administrative user.

4. NETWORK COMPARISON





CURRENT PROVIDER PERFORMANCE

VIEWING PERFORMANCE RELATIVE TO NETWORK

From within most patient due lists, view performance as compared to other providers in the network via the *Network Comparison* tab. The percentile displayed in the ribbon pertains to threshold performance based on the measure.

Select a colored bar to view a list of providers and their corresponding performance. Some organization's *blind* this view in COZEVA- for these builds, provider/practice names are de-identified. Contact your organization's help-desk for questions regarding the *Network Comparison* view.

Rank	NPI	Provider Name	Patient Count	Percentile	Performance
262	9367903377	Veda Kerr	736	72nd	52.54%
263	9118921001	Codi Woodbury	949	72nd	52.52%
264	3354405844	You	3681	72nd	52.49%
265	3980801695	Megan Schmitt	385	72nd	52.17%
266	7194840542	Michaela Seeley	121	72nd	51.85%
267	7756612540	Heidi Kendall	239	72nd	51.72%
267	5418804067	Neomi Naquin	285	72nd	51.72%
269	5338223711	Samella Bolton	626	72nd	51.52%
270	5433517988	Janna Honeycutt	1120	72nd	51.11%

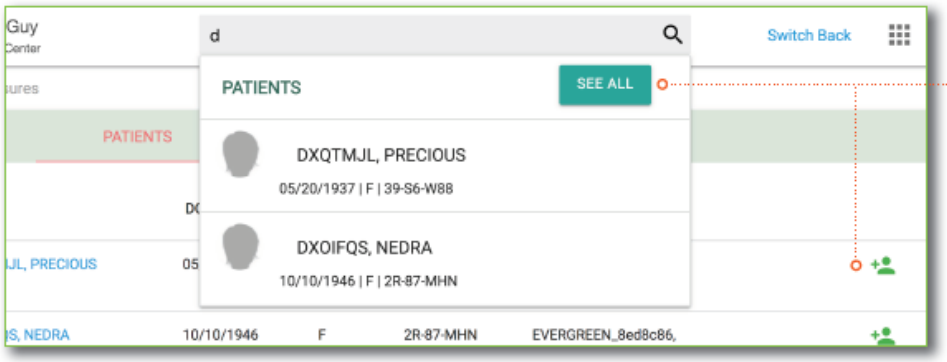
VIEW OTHER PROVIDERS

Select a bar to view providers in that level of performance.

Some organizations will 'blind' this view- these users will see their performance against de-identified provider listings.

For feedback, contact:training@cozeva.com

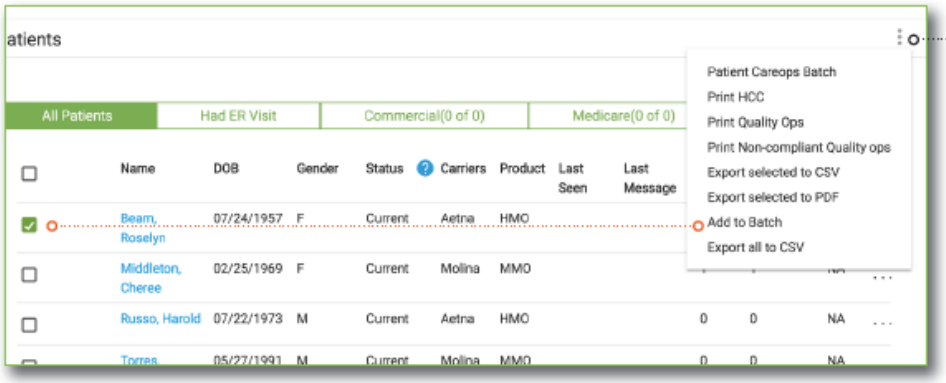
5. CREATE PATIENT BATCHES



ADD PATIENT TO BATCH (OPTION 1)

Pull multiple patient due reports using the batches functionality.

- Search for the patient
- Select SEE ALL
- Select +



ADD PATIENT TO BATCH FROM PATIENT LISTING (OPTION 2)

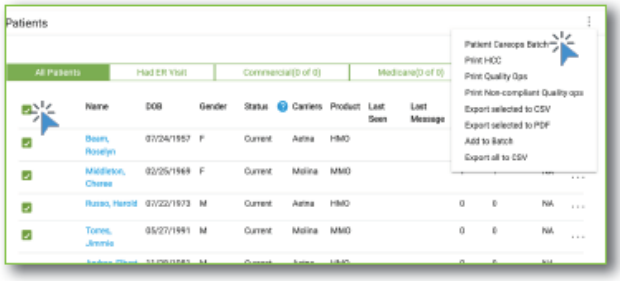
From any patient listing:

- Select patient box
- Select export/print
- Select Add to Batch

Continue adding patients using one of the methods outlined above.

VIEW BATCHED PATIENTS

Access batched patients in the sidebar. Select the Menu ☰ button from the drop down and choose 'Batches.' Batches are provider centric and automatically shared with all other team members. Only one batch per provider or practice is possible.



PRINT AND DELETE BATCHES

Print all patient due reports in a batch by first selecting them all using the top check box, and then selecting 'Print Care ops Batch.' Clear an existing batch using the appropriate selection. Create batches for patients coming in the next day or week for easy integration into your existing workflow.

Why Physician Data Reporting is Critical

- ✓ The model is highly data reliant and only works when complete and accurate diagnosis data is used.
- ✓ 80% of the diagnoses are extracted from physician data.
- ✓ If diagnoses are not documented per the CMS standards, then they do not count.
- ✓ Every January 1st, the beneficiary "becomes well" – if a condition is not documented each year it does not count towards the next year's payment amount.

What has Risk Adjustment Done?

- ✓ Leveled the playing field for enrolling Medicare beneficiaries – no incentive to enroll only "healthy seniors".
- ✓ Good medical management is rewarded.
- ✓ Physicians are no longer penalized for who they service.
- ✓ Moves the system of care to one that is more supportive of the needs of chronically ill patients.

Risk Adjustment is here to Stay

- ✓ It's the law and would take an act of congress to change.
- ✓ It's more equitable.
- ✓ It works.
- ✓ Medicare will refine the model.
- ✓ Embrace it and it can be good for you.

Keys to Success with Risk Adjustment

- ✓ Good coding and documentation practices – the medical record documentation must support the material submitted on the encounter of Annual Health Assessment Form.
- ✓ High reporting levels of encounter data.
- ✓ Member retention.

Coding and Documentation

- ✓ Use the current version of ICD-10CM and code to the highest level of specificity.
- ✓ 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 Health Assessment Description

- ✓ Face to face visit with all seniors.
- ✓ PCP's are reimbursed for each senior member for whom they conduct an Annual Health Assessment and complete the AHA form/Online.
- ✓ The AHA form must be completed in its entirety and submitted to Optum for processing.
- ✓ The form itself will be used to report the encounter.
- ✓ Optum will offer education to MDs and their office staff.

Compliance with IPA Initiatives

- ✓ IPA Executive Committees adopt initiatives during the year to advance Medicare Risk Adjustment efforts. Physicians are required to participate and comply with these initiatives as may be appropriate.

Health Education

The following documents are contained herein:

1. Introduction to the Language Assistance Program (LAP)
2. Introduction to Optum's Diabetic Education Program
3. Optum Diabetes Education Referral Form
4. Health Plan Health Education Programs

Language Assistance Program (LAP)

Health Plans have established a Language Assistance Program (LAP) for commercial members that are limited English proficient (LEP). Health Plans are required to translate certain "vital" documents in threshold languages and make them available to members (eg. Health Plan applications benefit summaries, UM and claims denials, etc.) A limited English proficient enrollee is defined as "an enrollee who has an inability or a limited ability to speak, read, write or understand the English language on a level that permits that individual to interact effectively with health care providers or Health Plan enrollees."

Translation requests will normally come through the Health Plan, but may be received by the Provider offices. Any member requests for translation or interpreter services may be forwarded to the member's Health Plan Member Service department for assistance with coordination.

Diabetic Management Program

Diabetic Education and Management services are available to all Optum members with diabetes. MPMG can refer to "Whittier" and all other IPAs can refer to Optum Health Enhancement. The programs cover the following topics: Healthy eating; management; medication review; physical activity; and behavior modification with goal setting. Please see your PSR for directions on how to submit the diabetic education referral.

We look forward to working with provider's patients to assist them with managing their disease and preventing complications.

MPMG offices may submit the referral to "Whittier" diabetic program; all other IPAs can submit to Optum Health Enhancement, see below.

Referral Type: (DED) Direct Referral LHCP		
Field Name	**What to enter**	**Comments**
Auth Class	Direct Referral	
Member	Member is selected prior to entry	Search Member name and DOB
Patient Requested	Enter as applicable	
Category	Enter applicable Category	Will Default to Routine (Do Not Change)
Referred From	Click "Other from Physician" and select Requesting Physician	PCP requesting
Referred To	Click "Other Physician" and search using "Vendor"	Select Optum Health Enhancement 63OPTUMHEALT
Place of Service	Home	
Estimated Date of Service	Will Default to Date of Entry	
Requested Visits	Number of total requested visits	Will default to 1
Diagnosis 1	Click Diagnosis 1 and choose dx code	Choose additional dx codes if needed by clicking on "Add New Diagnosis"
Procedure 1***	Click Procedure 1 and choose applicable code	99202 – 99205
Requested Units	Defaults to 1	
Requested Services	LHCP Diabetic Education Program	
Notes	Enter applicable Notes	
	Click Submit	

Mammograms

A new state law is in effect that requires physicians to notify women if they have dense breast tissue, which could be associated with a higher risk of breast cancer.

About the New Law

Federal law already mandates that health care providers report mammogram screening results to patients in writing. In California, those letters now must include an extra paragraph if women have dense breast tissue, such notices will encourage women to decide on a course of action with their physician. California is the fifth state in the country to require dense breast tissue notifications.

This bill requires, under specified circumstances, a health facility at which a mammography examination is performed to include in the summary of the written report that is sent to the patient a prescribed notice on breast density.

A health facility at which a mammography examination is performed shall, if a patient is categorized by the facility as having heterogeneously dense breasts or extremely dense breasts, based on the Breast Imaging Reporting and Data System established by the American College of Radiology, include in the summary of the written report that is sent to the patient, as required by federal law, the following notice:

Your mammogram shows that your breast tissue is dense. Dense breast tissue is common and is not abnormal. However, dense breast tissue can make it harder to evaluate the results of your mammogram and may also be associated with an increased risk of breast cancer. This information about the results of your mammogram is given to you to raise your awareness and to inform your conversations with your doctor. Together, you can decide which screening options are right for you. A report of your results was sent to your physician.

Health Plan Education Programs

Health Plan	Description	Phone Number
Aetna	• **Healthy Outlook** ⇨ Diabetes ⇨ Coronary Artery Disease • **Informed Health Line**	(866) 269-4500 (800) 556-1555
Anthem Blue Cross	• **(Future Mom's Program –Prenatal Edu Program)** • **Wellbeing Program /Condition Care** ⇨ Additional Support/Education for those with Chronic Health Conditions ⇨ Diabetes ⇨ Asthma ⇨ CHF/COPD ⇨ Low Back Pain	(800) 769-4896 (800) 522-5560
Blue Shield	• **65+ plus member services** • **24 Hour Nurse Line** • **First Steps Prenatal** • **Depression** • **Preventative Health**	(800) 776-4466 (866) 954-4567 (877) 371-1511
Cigna	• **HealthCare Well Aware** ⇨ Asthma ⇨ Diabetes ⇨ Heart Disease ⇨ Low Back Pain ⇨ COPD	(800) 882-4462
United HealthCare	• **Case Management** ⇨ Taking Charge of Diabetes ⇨ Taking Charge of Depression **VM** ⇨ Taking Charge of Your Heart ⇨ CAD/Stroke QMed • **Case/Disease Management VM**	(866) 352-9898 (800) 915-9159 (800) 513-5131 (800) 915-9159 (877) 840-4085
SCAN	• **Member Services**	(800) 559-3500

Coordination of Benefits (COB) and Third Party Liability (TPL)

Third Party Liability

Third Party Liability (TPL) issues must be processed in accordance with regulatory requirements. Optum has established a TPL management program that has been approved by the health plans. As a result, Optum California is required to be the coordinator of billing and collection of all TPL cases with referred and/or authorized services.

If the patient states that they have had an accident, whether it is by motor vehicle, injury at a grocery store, assault and battery etc., have the member complete the Accident Questionnaire (sample questionnaire to follow).

Other COB (if Optum is not Primary Insurance)

If a member presents current proof of other primary insurance making the IPA the secondary payor, the provider has the right to bill the primary insurance and collect the applicable co-pays from the member. The provider must inform Optum of this status by having the member complete the Coordination of Benefits (COB) Questionnaire (sample questionnaire to follow).

Member's Rights

Contracts between the health plan and the member extend discounts to the members according to Optum's Network rates. Optum entities filing liens are **prohibited** from billing full charges if they are paid at contractually discounted rates (fee-for-service) or are otherwise compensated under a contractual agreement with all considerations of obligations as defined in accordance with applicable state and federal laws, rule and regulations (i.e. HIPAA, FDCPA guidelines including Mini-Miranda Warning, SB1471, Made Whole Rule, common law doctrine, etc).

Benefits will be coordinated with other carriers when Optum is notified that the member has other insurance. Please refer to provider's contract for information on Coordination of Benefits (COB).

Optum will not assume responsibility for services under Worker's Compensation. Always verify if a claim is for a work related injury when treating patients, and obtain specific billing information from the member.

Legal Claims

TPL cases requiring legal involvement or court appearances, motions, declaratory judgments, equitable relief or matters dealing with complaints and legal actions, (especially managing the cases through the court) will be directed to our legal department. Actions and settlements thereafter will follow our company's legal considerations and policies and will no longer be handled under the documented TPL guidelines.

Provider's Responsibilities

Provider compensation, whether it is fee-for-service or capitation, should be considered payment in full. Liens for members will be filed by the TPL Unit in accordance with contractual obligations and regulatory requirements. Any exceptions should be coordinated first with the TPL Unity at Optum in order to avoid duplication or breech in contractual obligations.

Care for all members with a TPL case should be managed with the same considerations as any other member, which includes Primary Care Physician (PCP) authorizations and network referrals.

Applicable co-pays should be collected by providers for any referred and/or authorized services as with any other HMO member, regardless of TPL status. If any members refuse to pay co-pays, have them contact our local TPL Department for education.

The following are examples of internal and external resources responsible for providing operational and technical support as related to the processing of TPL cases. Each is responsible to submit any applicable data to the TPL Unit for further processing in accordance with their desktop operating procedures:

a. Receptionists/Front Office Staff
b. Physicians/Front Office Support Staff
c. Urgent Care Admitting Personnel
d. Utilization Management Department (UM)
e. Claims Department
f. Customer Service Representatives
g. Medical Records Department from our Network of Hospitals

To coordinate these efforts and to learn more on regulatory requirements, contact the TPL Unit at (909) 605-8098.

Worker's Compensation

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

TPL Contact Information

All completed Coordination of Benefits or Accident Questionnaires should be forwarded to:

Optum
TPL Department
3990 Concours, Suite 500
Ontario, CA 91764-7970
Phone: (909) 605-8098
Fax: (909) 605-0535

COB Questionnaire

1. **Are you and/or your dependents insured under any other group health insurance plan or Medi-Cal?**

   Yes _____ Please complete section 2 and 3.

   No _____ Skip to section 3 and sign.

2. **Name and address of other insurance carrier.**

   Insurance Company Name: _____
   Address: _____Phone Number:_____
   City:_____ State:_____ Zip:_____
   Name of insured:_____ Date of Birth:_____
   Effective date of coverage:_____
   Employer Name:_____
   Employer Address:_____

   Name of covered dependents and their relations to the insured.

Name	Relationship
_____	_____
_____	_____
_____	_____
_____	_____

3. **I certify the above information is correct to the best of knowledge and authorize the release of medical information and claims payment records to Optum.**

   _____ _____
   Print Member Name **Print Spouse Name**

   _____ _____
   Signature of Member **Signature of Spouse**

   Date: _____

Accident Questionnaire

Member Name _____ Health Plan _____

Address _____ Health Plan Member _____

Number_____

City/State/Zip Code _____ Date of Accident _____

1. **Briefly describe** accident (e.g., location of accident, date, and how it happened)? _____

_____

_____

2. **ANY** other insurance coverage (e.g., auto, worker's compensation, homeowner's, etc.):

Insurance Company Name: _____

Insurance Address: _____

Insurance Phone Number: _____ Policyholder's Name/Number: _____

Adjuster's Name: _____ Claim Number: _____

3. **Identify** other parties who may be responsible for accident:

Name: _____

Address: _____ Phone Number: _____

Insurance Name: _____ Phone Number: _____

Policyholder's Name: _____ Claim Number: _____

I hereby authorize Optum and/or affiliated entities to release any information concerning my injury which may be needed for the proper handling and processing of my claims, to any third party payor or my own attorney. A Photostat copy of this authorization shall be as valid as the original.

I hereby acknowledge my obligation under my Health Plan Benefits agreement, which requires if I obtain a settlement for medical expenses from a third party payor, I will reimburse Optum and/or the affiliated entity for expenditures made on my behalf in connection with this injury.

I hereby authorize and direct my attorney and, or any third party payor to pay Optum directly any sum due for the expenditures made on my behalf in connection with this injury.

_____ _____

Signature Date

Legislation

Corporate HIPAA Compliance

What is HIPAA?

The Health Insurance Portability and Accountability Act (HIPAA) was passed in 1996 to reform the health insurance market. Aimed at reducing administrative overhead in health care, the ***Administrative Simplification*** sections of the regulations impose requirements for standardized electronic transmission of health care data. These standards are accompanied by privacy and security guidelines to protect patient confidentiality and ensure data integrity. These federal regulations impact the entire health care industry.

What does this mean for Physicians?

Most physician offices are specified as "covered entities" under HIPAA and will be required to comply with the regulations. They will need to review and revise many of their policies and procedures concerning claims submission, medical records maintenance, patient sign-in, physical security, internet/email security, referral/authorization submission, eligibility verification, patient consent, and much more. It is crucial that physicians and their staff began to familiarize themselves about HIPAA and evaluate the impact it will have on their operations.

What is Optum doing?

For the affiliated IPAs, Optum will maintain a full compliance program, including transmission of standardized electronic transaction, increased use of EDI, organization wide privacy and security policies and ongoing monitoring of the regulations. To assist the affiliated physicians, Optum is conducting regular physician updates, providing reference materials and distributing compliance tools, to include checklists and tips, sample forms, policy templates and general HIPAA education. Physicians can contact their IPA PSR for additional information about the HIPAA program, or reference their contract.

SB 137

Open/Closed Panels - Provider shall notify Group in writing, within five (5) business days if:

(a) Provider no longer accepting new patients, or

(b) If Provider previously not accepting new patients is now open to new patients.

If Provider is not accepting new patients but is contacted by a Member seeking to become a new patient, Provider shall direct the Member to the health plan in which the Member is enrolled to find a participating provider who is accepting new patients and to the Department of Managed Health Care to report any inaccuracy with the health plan's provider directory.

Nothing herein waives any obligations in this Agreement, including without limitation: open and closed panel requirements and other notices required in this Agreement, including any changes/updates in status/demographic information.

AB 457 Protection of Patient Choice in Telehealth Provider Act

Payment Parity Provision – PMNI will reimburse covered telehealth services on the same basis and to the same extent that PMNI reimburses the same covered services delivered in-person.

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 January 1, 2021. 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:

a. 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
b. 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.
c. Have been convicted of a felony under federal or state law within the previous 10 years and that CMS deems detrimental to the best interests of the Medicare program.

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

Federal Disaster Policy

Policy and Procedure

Subject: Federal Disaster Policy	Policy Manual: Optum Corporate
Effective Date: April 1, 2013	Policy Number:
Revision Dates:	Department: Title: Signature: On File
Certification Dates:	
Last Revised By: V. Medlen	Approval Signature on File: President

SCOPE

All employees of Optum, PMNI, and its affiliated entities, globally referred to as "the Company" shall follow the procedures set forth in this policy.

PURPOSE

To provide guidance regarding provider access during a Federal Disaster or other Public Health Emergency Declaration.

POLICY

In the event of an emergency disaster declaration or public health emergency the company is committed to providing adequate health care coverage.

PROCEDURE

1. Designate that the emergency/disaster policy begins with declaration of federal/local determination
2. Continues for 30 days from date of original designation
3. Allow for Part A/B and supplement Part C benefits to be furnished at specified non-network facilities (Part A/B benefits must be furnished at Medicare certified facilities).
4. Waive in full requirement for gatekeeper referrals, where applicable
5. Temporarily reduce out of plan approved costs to in-network cost sharing amounts
6. Waive the 30 day notification requirement to members as long as all of the changes benefit the enrollee (such as waiving authorizations and reduction of cost sharing)

To:

From:

Date:

Re: Benefits during Disasters and Catastrophic Events

This notice is being sent to serve notice and provide guidance regarding provider access during a Federal Disaster or other Public Health Emergency Declaration.

In the event of a Presidential emergency declaration, a Presidential (major) disaster declaration, a declaration of emergency or disaster by a Governor, or an announcement of a public health emergency by the Secretary of Health and Human Services – but absent an 1135 waiver by the Secretary –MA plans are expected to:

1. Designate that the emergency/disaster policy begins with declaration of federal/local determination

2. Continues for 30 days from date of original designation

3. Allow for Part A/B and supplement Part C benefits to be furnished at specified non-network facilities (Part A/B benefits must be furnished at Medicare certified facilities).

4. Waive in full requirement for gatekeeper referrals, where applicable

5. Temporarily reduce out of plan approved costs to in-network cost sharing amounts

6. Waive the 30 day notification requirement to members as long as all of the changes benefit the enrollee (such as waiving authorizations and reduction of cost sharing)