Provider Manual

2021

Optum Care Network

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Welcome Letter

Dear Provider,

I am delighted you have chosen to become a participating provider with Optum Care Network of Washington. We view you as our partner in providing affordable, high-quality health care for our members.

Together, we will help people live their best lives. Our goal is to let you as a provider practice medicine first and foremost. Our value-based model lets you focus on patients and care for your wellbeing as well as theirs.

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

This provider manual offers valuable information about the Optum Care Network of Washington and how to work most effectively with us. It will serve as a user-friendly reference guide and educational resource for both you and your staff.

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

The Optum Care Network of Washington staff will work collaboratively with you to create a positive experience for you, your staff, and our enrollees. Please feel free to contact them as needed.

We welcome your comments and suggestions regarding this manual.

Sincerely,
Tiffany Sullivan
President
Optum Care Network of Washington

Provider Manual Overview

This provider manual is an extension of your participation agreement. It includes important information for providers, facilities and practice staff regarding policies, procedures, claims submissions and adjudication requirements, and guidelines used to administer plans. This provider manual replaces and supersedes all previous versions.

As per your participation agreement, all providers and facilities are to comply with CMS and health plan policies and procedures, including, but not limited to those listed herein. Please refer to health plan provider manuals for specific policies and procedures when applicable.

As policies and procedures change, updates will be issued via *e-newsletter* and/or practice alert and will be incorporated into this electronic version of the provider manual.

Any requirements under applicable law, regulation or governmental agency guidance that are not expressly set forth in this provider manual shall be incorporated herein by this reference and shall apply to providers, facilities, health plans and/or company where applicable. Such laws and regulations, if more stringent, take precedence over this provider manual. Providers and facilities are responsible for complying with all applicable laws and regulations.

Delegation Defined

Delegation is the formal process or contract granting an enterprise authority to execute specific functions on behalf of an organization; in the case of Optum Care Network (OCN), it refers to health plans. Ultimately, the health plan is the responsible party. As the delegating party, the health plan must remain apprised of the delegate's actions, ensuring adherence to compliance standards.

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

Please contact your Practice Advocate if you have additional questions.

Contact Information

OCN Main Number General Information	8 a.m.–5 p.m., Monday–Friday Phone 877-836-6806 Fax 888-205-1128
OCN Resources	https://professionals.optumcare.com/resources-clinicians.html
Website Address	https://www.optumcare.com/state-networks/locations/washington.html
Provider Portal	https://professionals.optumcare.com/portal-login.html
Customer Service Eligibility, claims/auth status, General billing question Prior Authorization Intake	8 a.m.–5 p.m., Monday–Friday Phone 877-836-6806 Fax 888-205-1128 Fax 855-402-1684
Claims Payer ID Claims Mailing Address Claims Issue Escalation (Please first contact the Service Center)	 **LIFE1** PO Box 30788, Salt Lake City, UT 84130-0788 opshelp@optum.com
Health Care Coordination Pre-authorization, hospital pre-notification, emergent admission, case management	8 a.m.–5 p.m., Monday–Friday Phone 877-836-6806 Fax 253-627-4708
OCN Directory Searches (Provider, Facilities)	http://www.optum.com/pnw
Credentialing	Phone 253-682-4809 Fax 253-573-9511 credentialing@optumpnw.com
Practice Support Advocates	providersupport@optumpnw.com
Network Development	networkdevelopment@optumpnw.com
Address (For claims mailing see address in 'Claims' section)	Send general information to: 17930 International Blvd, Suite 1000 SeaTac, WA 98188

Practice Engagement

Summary

Each OCN provider group is assigned a Practice Advocate. Your Practice Advocate, together with their network medical director partner, work to help you succeed in 5-Star quality, patient experience, risk adjustment, care management, affordability, contracting, and growth.

Practice Advocate Responsibilities

- Primary Single Point of Contact with Clinic
  - Partners with clinic leadership to strive for optimal performance in quality, accurate risk adjustment, and affordability initiatives to improve long-term clinical outcomes while lowering the total cost of care
  - Assess and coordinate training needs
  - Lead and schedule meetings with clinics
  - Ensures clinic has all data and analytics to ensure success in patient care delivery
  - Communicates incentive program elements and achievements
  - Resolves and escalates concerns
- Performance
  - Delivery of monthly strategic packets
  - Attestation point of care tool delivery and tracking
  - Dashboard performance and incentive reporting
  - Coordinate MA marketing and growth
  - Care management service coordination
  - Updates clinics on new wrap around services
- Training/Education
  - Primary Care Provider (PCP), staff, and clinic administrator education on risk adjustment, quality, and affordability
  - Event coordination
  - New provider onboarding and orientation
  - Portal training
  - Claims issues/processes
- Member Focus
  - Member eligibility issues/resolution
  - Wraparound services utilization, education, and tracking
  - Data and analytics

Credentialing

Credentialing refers to the process performed by OCN to verify and confirm that an applicant meets the established policy standards and qualifications for consideration in the OCN Network. There are currently no fees charged for credentialing. Upon completion of the credentialing process, each applicant is presented to the Credentials Committee, which is comprised of physicians of various specialties, for review and recommendation. A complete copy of the OCN credentials program manual may be provided upon request.

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

Health Plan/Carrier	Providers/Facilities Credentialed
Humana	All Providers All Facilities
Premera	All Providers Ambulatory Surgery Centers Effective 5/1/2020 will include all Facilities
UnitedHealthcare	All Providers All Facilities

Providers Joining Your Practice

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

Types of Providers Credentialed

OCN credentials the following provider types:

- MD
- DO
- DPM
- ARNP
- PA-C
- CNM
- RNFA
- OD
- PhD
- SUDP
- PharmD
- PsyD
- LMHC
- LMFT
- LSW

Facilities Adding Location(s)

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

Types of Facilities Credentialed

- Ambulatory Surgery Centers
- Behavioral Health (facility)
- Birthing Centers
- Chemical Dependency Treatment Centers
- Durable Medical Equipment
- Home Health
- Home Infusion Therapy
- Hospitals
- Independent Diagnostic Testing Facility
- Laboratories
- Radiology (except therapeutic/interventional radiologists who are credentialed individually)

- Physical, Occupational or Speech Therapies
- Skilled Nursing Facilities
- Urgent Care Centers

Sub-Delegation of Credentialing

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

Recredentialing

The recredentialing cycle occurs every three (3) years for providers and facilities. Non-response or failure to return a completed recredentialing application(s) and supporting documentation may be considered a voluntary termination of participation unless otherwise determined by the Chief Medical Officer and/or Credentials Committee.

Exceptions to this may include active military assignment, maternity/paternity leave or sabbatical. Contact OCN credentialing for additional information.

Corrective Action

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

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

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

The OCN credentialing program manual may be available upon request for additional details regarding corrective action, suspensions, terminations, and appeals.

Provider/Facility Rights

Providers and facilities have the right to review information submitted in support of their credentialing application. However, this is limited to information obtained from any outside primary source such as malpractice insurance carriers, state license boards, and/or National Practitioner Data Bank (NPDB).

Providers and facilities have the right to correct erroneous information in the event credentialing information received from other sources conflicts with information provided by the provider or facility.

Provider and facilities have the right to appeal a decision made by the Chief Medical Officer and/or the OCN Credentials Committee.

For detailed information regarding your rights, you may request a copy of the OCN credentialing program manual.

Changes to Your Practice/Facility

All changes to your practice or facility should be provided to OCN in accordance with the terms of your Participation Agreement or as soon as reasonably possible. This includes, but is not limited to:

- Change in address
- Change in ownership
- Change in Tax Identification Number (TIN)
- Additions
- Deletions
- Terminations
- Changes to licensure (actual or threatened) resulting in loss, suspension, or material limitation of a provider's license
- Changes to staff membership or clinical privileges at any hospital
- Changes to formal disciplinary action, if any
- Change to any malpractice action filed against or decided adversely to provider

All changes should be sent to credentialing@optumpnw.com for processing. OCN credentialing will notify health plans on a monthly basis for those plans which OCN has a delegated credentialing agreement in place.

If a provider terminates from your practice, your provider agreement requires notification to OCN via email to credentialing@optumpnw.com within 30 days of departure. You are required to inform OCN via e-mail to whom patients should be re-assigned to. For more information on this topic, please refer to the Patient Re-assignment section below.

Termination of Participation

Providers/facilities are contractually required to provide adequate notice of termination of network participation as this may impact patient care and your credentialing status with the health plans. Upon termination with the OCN Network, your credentialing will revert to being performed directly with the health plans. Clinics should plan accordingly to ensure no disruption in services for patients. Please refer to your provider or facility agreement.

Closing your Practice

Closing your practice due to retirement or business considerations is a complex undertaking. OCN would like to support you in locating resources for your transition and identifying actions needed. The process can be very different for primary care providers and specialists. Please utilize your resources with OCN by contacting your Practice Advocates to assist in planning the logistics. The table below provides a start in preparing for such a change.

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

Contracting

OCN's Provider and Facility Participation Agreements allow OCN to contract with health plans as an arranger of care. Please refer to your agreement for specifics. Please refer to the Credentialing section to determine eligibility to participate.

OCN holds the following contracts:

- Humana Medicare Advantage (HMO and PPO)
- Premera Medicare Advantage
- AARP Medicare Advantage (through UnitedHealthcare)

This list is subject to change. Providers/facilities must also hold a direct contract with the health plan for participation and/or reimbursement purposes. Please refer to the Claims section, the Credentialing and Contracting Crosswalk in the appendix or contact your Practice Advocate for details.

For OCN attributed members, your OCN participation agreement will supersede your direct health plan agreement.

Delegation by Plan

Please see appendix for the Delegation by Plan matrix.

Claims

OCN is delegated to adjudicate and pay claims for some health plans. Providers and facilities are responsible for verifying patient eligibility, benefits and obtaining referrals/authorizations, if applicable, prior to services being rendered. Please refer to the table below.

Medicare Advantage Plans	Submit to	Claims Submission Information

United Healthcare HMO - MA
• AARP Medicare AdvantageComplete
  ○ Plan 1 (HMO-MAPD Plan)
  ○ Plan 2 (HMO-MAPD Plan)
  ○ Plan 3 (HMO-MAPD Plan)
  ○ Walgreens (HMO-MAPD Plan)
	OCN	Electronic Claims: **Payer ID# LIFE1**
		Clearing House: Optum 360
		Paper Claims: PO Box 30788
		Salt Lake City, UT
		84130-0788

Humana HMO • Gold Plus HMO (HMO-MAPD Plan)	OCN	Electronic Claims: **Payer ID# LIFE1** Clearing House: Optum 360 Paper Claims: PO Box 30788 Salt Lake City, UT 84130-0788
Humana PPO • HumanaChoice PPO (PPO-MAPD Plan) • Humana Honor PPO (PPO-MA only Plan)	Humana	Electronic Claims: **Payer ID# 61101** Clearing House: Availity Paper Claims: PO Box 14601 Lexington, KY 40512
Premera Blue Cross HMO • Medicare Advantage (HMO-MAPD Plan) • Medicare Advantage Classic (HMO–MAPD Plan) • Medicare Advantage Classic Plus (HMO-MAPD Plan) • Medicare Advantage Core (HMO-MAPD Plan) • Medicare Advantage Core Plus (HMO-MAPD Plan) • Alpine (HMO-MA Only Plan) • Peak + Rx (HMO-MAPD Plan) • Sound + Rx (HMO-MAPD Plan) • Charter + Rx (HMO-MAPD Plan)	OCN	Electronic Claims: **Payer ID# LIFE1** Clearing House: Optum 360 Paper Claims: PO Box 30788 Salt Lake City, UT 84130-0788
D-SNP Plans	**Submit to**	**Claims Submission Information**
United Healthcare • Dual Complete (HMO D-SNP Plan)	UHC	Electronic Claims: **Payer ID# 95959** Paper Claims: See back of patient's ID card
Humana • Gold Plus SNP-DE (HMO D-SNP Plan)	OCN	Electronic Claims: **Payer ID# LIFE1** Clearing House: Optum 360 Paper Claims: PO Box 30788 Salt Lake City, UT 84130-0788

Claims Submission

Claims should be submitted electronically to **LIFE1.** Paper claims, though not preferred, can be mailed to:

OCN Paper Claims
PO Box 30788
Salt Lake City, UT 84130-0788

OCN Electronic Claims
Payor ID#: LIFE1
Clearinghouse: Optum 360

Reimbursement

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

- Patient's eligibility at the time of the service.

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

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

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

Electronic Funds Transfer

OCN supports claims payments via electronic remittance advice (ERA) and electronic funds transfer (EFT) via InstaMed. ERA/EFT is a convenient, paperless, and secure way to receive claim payments. Funds are deposited directly into your designated bank account and include the TRN Reassociation Trace Number, in accordance with CAQH CORE Phase III Operating Rules for HIPAA standard transactions.

If you have not already set up your InstaMed account, please go to https://register.instamed.com/eraeft to register or contact InstaMed Customer Service via telephone or email.

Tool Free Telephone:

(866) INSTAMED or (866) 467-8263

Email:

support@instamed.com

Help Portal:

https://help.instamed.com/providers/s/

Training Tools:

https://www.instamed.com/support/providers

Charging Members

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

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

Clinical Claims Review

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

Releasing a Patient from your Practice

Please refer to health plan specific provider manuals for releasing a patient from your practice.

Patient Re-Assignment

Optum Care Network manages patients assigned to primary care providers (PCPs) for Humana Medicare Advantage HMO, AARP Medicare Advantage HMO through UnitedHealthcare (UHC MA), and Premera Medicare Advantage HMO. In some cases, patients may be assigned to your practice in error. When this occurs, the health plan must be notified, and assignment must be corrected in their system(s). Patients who have not been seen by your practice, but have been assigned to you should not be re-assigned to another primary care provider unless that patient has initiated the process. *See also Population Health.*

For Humana patients:

- Patients can call Humana customer service number on the back of their ID card to request a different PCP, or
- Complete a PCP change form and fax to Humana. *See Appendix.*

For UHC MA patients:

- Patients should call the UHC customer service number on the back of their ID card to request a different PCP.

For Premera MA patients:

- Patients should call the Premera customer service number on the back of their ID card to request a different PCP.

Compliance

Medicare Compliance Expectations and Training

The Centers for Medicare and Medicaid Services (CMS) requires Medicare Advantage (MA) organizations and Part D plan sponsors to annually communicate specific compliance and Fraud, Waste and Abuse (FWA) requirements to their “first tier, downstream and related entities” (FDRs). FDRs include contracted physicians, health care professionals, facilities, and ancillary providers, as well as delegates, contractors, and related parties.

As a delegate that performs administrative or health care services, CMS and other federal or state regulators require that you and your employees meet certain FWA and general compliance requirements. You are expected to have an effective compliance program, which includes training and education to address Code of Conduct, Health Insurance Portability and Privacy (HIPPA), FWA and compliance knowledge. Optum Care Network requires that you and your employees be sufficiently trained to identify, prevent and report incidents of non-compliance and FWA. This includes temporary workers and

volunteers, the CEO, senior administrators, or managers, and subdelegates who are involved in or responsible for the administration or delivery of MA or Part D benefits or services.
We have general compliance training and FWA resources available at: https://www.unitedhealthgroup.com/suppliers/compliance-program/general-compliance.html.

What you need to do for FWA and general compliance training:

- Provide FWA and general compliance training to your employees and contractors who work on MA and Part D programs. Administer FWA and general compliance training annually and within 90 days of hire for new employees.
- All contracted payers will send out an annual compliance review in which OCN compliance will be required to review and affirm that all compliance areas are met. There may be times OCN compliance will need proof of general compliance training, therefore be prepared to provide an annual attestation that includes:
    - Establishment of a Code of Conduct and Compliance Policies and Procedures, or adoption of the Optum documents
    - Proof of established new hire and annual compliance training requirements
- Confirmation there are no offshore arrangements that are not reported to Optum nor without a completed CMS attestation.

Reporting Misconduct

If you identify compliance issues and/or potential fraud, waste or abuse, please report it to us immediately so we can investigate and respond appropriately. Please see the Reporting Misconduct section of the UnitedHealth Group Code of Conduct.

Part of our compliance program is to have open communication with our partners, providers, and teammates to ensure compliance with our code of conduct, policies and relevant laws. We all have a responsibility to report issues or ask questions. Please contact compliance to report suspected violations of our code of conduct, suspected fraud, waste, or abuse activities or to ask general compliance questions:

- Email compliance at: compliance@optum.com
- File a confidential report with our compliance Hotline:
    - 1-800-455-4521 or at https://secure.ethicspoint.com/domain/media/en/gui/13549/report.html

Reports may be made anonymously, where permitted by law at https://www.unitedhealthgroup.com/who-we-are/our-culture/ethics-integrity.html. Optum Care Network expressly prohibits retaliation if a report is made in good faith.

HIPAA Compliance

Federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) regulations apply to covered entities and business associates, defined as health plans, health care clearinghouses, and health care providers who conduct certain electronic transactions.

HIPAA is a set of statutes designed to improve the efficiency and effectiveness of the U.S. health care system:

- Title I: Establishes rules to "improve the portability and continuity of health insurance coverage" for workers when they change employers.
- Title II: Establishes rules to prevent health care fraud and abuse. Its "Administrative Simplification" section sets standards for enabling the electronic exchange of health information, and includes provisions establishing rules for protecting the privacy and security of personal health information:

- Privacy Rule: protects the privacy of individually identifiable personal health information
- Security Rule: defines national security standards for protecting electronic data that contain protected health information (PHI)
- Enforcement Rule: Empowers the Secretary of the U.S. Department of Health and Human Services (HHS) to impose civil money penalties on entities that violate HIPAA rules
- Breach Notification Rule: Requires HIPAA covered entities and their business associates to notify affected individuals, the HHS Secretary and (in certain circumstances) the media following any breaches of unsecured PHI

HIPAA Violation Reporting

It is the policy of Optum Care Network to notify health plans, where required, when there has been a breach in a HIPAA regulation. To report a potential HIPAA privacy violation or breach:

- Email: privacy@optum.com
- Call: compliance hotline 1-800-455-4521 (Anonymous reporting available)
  - Web: https://secure.ethicspoint.com/domain/media/en/gui/13549/report.html (Anonymous reporting available)

Exclusion Checks

You must review federal exclusion lists (HHS-OIG and GSA) and state exclusion lists, as applicable, prior to hiring/contracting with employees (including temporary workers and volunteers), the CEO, senior administrators, or managers, and any subdelegates who are involved in or responsible for the administration or delivery of MA plan sponsor and Part D benefits or services to make sure that none are excluded from participating in federal health care programs. You must continue to review the federal and state exclusion lists on a monthly basis thereafter. For more information or access to the publicly accessible excluded party online databases, please see the following links:

- Health and Human Services — office of the Inspector General OIG List of Excluded Individuals and Entities (LEIE) at oig.hhs.gov
- General Services Administration (GSA) System for Award Management at SAM.gov

What you need to do for exclusion checks:

- Review applicable exclusion lists as outlined above and maintain a record of exclusion checks for 10 years. Documentation of the exclusion checks may be requested by Optum Care Network, plan sponsors or CMS to verify that checks were completed.

Preclusion List Policy

CMS has a preclusion list effective for claims with dates of service on or after January 1, 2020. The Preclusion List applies to both MA plans as well as Part D plans. The preclusion list includes a list of prescribers and individuals or entities who:

- Are revoked from Medicare, are under an active re-enrollment bar and CMS has determined that the underlying conduct that led to the revocation is detrimental to the best interests of the Medicare program; or
- Have engaged in behavior for which CMS could have revoked the prescriber, individual or entity to the extent possible if they had been enrolled in Medicare and that the underlying conduct that would have led to the revocation is detrimental to the best interests of the Medicare program.
- Have been convicted of a felony under federal or state law within the previous 10 years and that CMS deems detrimental to the best interests of the Medicare program. Care providers receive a letter from CMS notifying them of their placement on the Preclusion List. They can appeal with CMS before the preclusion is effective. There is no opportunity to appeal with Optum Care Network.

CMS updates the preclusion list monthly and notifies MA and Part D plans of the claim rejection date, which is the date on which we reject or deny a care provider’s claims due to precluded status. Once the

claim-rejection date is effective, a precluded care provider's claims will no longer be paid, pharmacy claims will be rejected, and the care provider will be terminated from the Optum Care Network. Additionally, the precluded care provider must hold Medicare beneficiaries harmless from financial liability for services provided on or after the claim rejection.

Marketing Compliance

For the purposes of this provider manual, "marketing" includes any information, whether oral or written, that is intended to promote or educate current or prospective Medicare beneficiaries about any Medicare plans, products, or services.

All contracted practices and facilities are required to comply with all current CMS regulations regarding marketing. As of January 2019, CMS has clarified that providers may interact with their patients regarding plan options when relevant to the course of treatment or at the patient's request. A summary of the rules are as follows, however please refer to https://www.cms.gov/Regulations-and-Guidance/Regulations-and-Guidance.html for the most current and in-force information.

Guide Updates

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

Population Health

OCN has developed programs and resources in concert with health plans to support your practice around population health management. These programs and resources include, but are not limited to, complex care management, quality, risk adjustment programs, clinical education, patient engagement, affordability, social determinants of health, and Electronic Medical Record (EMR) optimization.

There are the following four guiding principles of the OCN population health program:

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

Quality & Risk Adjustment

OCN is committed to supporting our partners in delivering the highest quality of care. To that end, providers may be given the tools and resources to identify quality care gaps, understand best practices, outreach/engagement of patients to close quality care gaps, and tactical support for meeting requirements in accordance with Medicare's quality standards.

All contracted providers are required to allow OCN access to patient charts, for OCN-attributed patients, as part of supporting quality initiatives and clinical documentation accuracy. As an essential part of ensuring all data is captured and reported to health plans, OCN performs chart reviews through remote EMR access, fax, and onsite access to your practice. Data for only your OCN attributed patients is reviewed and processed. The chart abstraction and review process can capture documentation to close care gaps and potential coding trends, which contribute to incentive payment measurements under the Quality Incentive Program.

What does this mean to your practice?

- OCN will deploy chart abstractors to facilitate the capture of clinical documentation to close quality care gaps; or
- OCN will work with your practice to collect records either directly via fax or EMR, or through a third party to facilitate accurate capture of quality care gaps and conditions.
- Practice Advocates will work with practices to provide education, consultation, and materials to help our providers improve their systems and processes to impact highest quality of care.

Risk Adjustment Factor

Risk Adjustment Factor (RAF) is a numeric measurement based on health conditions a patient has (specifically those that fall within a CMS-assigned Hierarchical Condition Category or HCC), as well as demographic factors such as Medicaid status, gender, age/disabled status and whether the patient lives in an institution (for 90 days or longer) or not.

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

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

Coding and Documentation Ongoing Education

As more of our work and payment structures are measured by data, it is increasingly important that we educate and prepare ourselves and our systems to capture the complexity of the care that we provide. To support clinical documentation and an accurate picture of each patient's health and RAF, OCN provides ongoing education for clinicians and staff as well as regular feedback through reporting and analytics.

OCN has a team to help each clinic stay up to date, so that they can provide the most accurate coding and documentation of each patient's clinical status. Our educators will help providers with diagnostic coding issues, medical record review, documentation standards, and education opportunities that support this ever-changing work in healthcare. Additionally, OCN will provide ongoing education and information with industry coding changes as they relate to risk adjustment. OCN's goal is to help promote the highest quality of care to our patients.

What does this mean to your practice?

- OCN will provide clinical documentation education and resources to providers and clinic staff to support on-going development of Risk Adjustment coding and Quality metric recognition coding (CPT Category II).
- Our educators can evaluate documentation and coding behavior and identify recommendations for improvement.
- We will provide consultation and education to help our network partners improve their systems and processes to ensure complete, accurate, and compliant Risk Adjustment and Quality reporting.

Opportunities and Services

- We will perform reviews of medical documentation to ensure that all offices capture chronic HCC (hierarchical condition categories) that would affect the risk adjustment reimbursement, and any subsequent shared savings.
- OCN also analyzes data from inpatient hospitalizations, diagnostic testing, outpatient procedures and services, home health care services, durable medical equipment, rehabilitative therapies, and pharmacy reviews for the possibility of chronic codes that have not been addressed in the calendar year.
- OCN will prepare feedback and training materials to educate providers and their staff on any audit outcomes and will help with accurate documentation procedures.
- OCN will communicate with providers and staff coding and documentation trends and help implement correct diagnosis reporting.
- OCN will perform routine audits of documentation and coding in accordance with compliance policies and procedures and communicate the results to the offices.
- We will follow up with written and verbal education regarding coding and compliance to physicians, clinical staff, and non-clinical staff. You will also be able to request OCN educators to come to your clinics and help with any coding or documenting issues.
- OCN educators will remain apprised of the latest guidelines and relay that information to the clinics and staff. We will provide any updates of new codes or coding issues. OCN will send emails with webinars, coding materials, and any other education needed.

Provider Attestations

In order to submit accurate documentation and coding, OCN provides a point of care tool for primary care providers, including:

- A living (continuously refreshed) presentation that displays suspected relevant gaps in care that have not been addressed in the current calendar year.
  - Gaps in care include historical chronic conditions, suspected conditions, screenings, and quality measures.
  - Providers determine which are valid and address the gap.
  - Serves as a guide to be used at each face-to-face encounter.
- Sources of data on an attestation:
  - Diagnoses, procedures, and results reported in prior years.
  - Diagnoses and results found by nurses or coders (or, in some cases, M.D.) performing a chart review.
  - Data inferred from labs tests, medication fills, and CMS Return files.

EMR Optimization

OCN has a full-time EMR optimization specialist who can assist your practice in utilizing your system more efficiently to compliantly enhance data collection and reporting opportunities. For more information, contact your Practice Advocate.

Utilization Management

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

However, OCN is not delegated for Utilization Management for all plans. Please refer to the table below.

Health Plan	UM Managed by	Contact Information
UHC – Medicare Advantage (HMO) • AARP Medicare Complete ○ Plan 1 ○ Plan 2 ○ Plan 3	OCN	Phone: 877-836-6806 Fax: 855-402-1684
UHC – Medicare Advantage (Dual) • Medicare Solutions Dual Complete	UHC	Phone: 877-842-3210
Humana – Medicare Advantage (HMO) • Gold Plus HMO-MAPD Plan	OCN	Phone: 877-836-6806 Fax: 855-402-1684
Humana – Medicare Advantage (PPO) • HumanaChoice PPO	Humana	www.Humana.com Phone: 800-457-4708
Humana – Medicare Advantage (MMP) • Gold Plus – SNP-DE	OCN	www.Humana.com Phone: 800-457-4708
Premera – Medicare Advantage (HMO) • Medicare Advantage (HMO-MAPD Plan) • Medicare Advantage Classic (HMO–MAPD Plan) • Medicare Advantage Classic Plus (HMO-MAPD Plan) • Soundpath Health Alpine (HMO-MA Only Plan) • Soundpath Health Peak + Rx (HMO-MAPD Plan) • Soundpath Health Sound + Rx (HMO-MAPD Plan) • Soundpath Health Charter + Rx (HMO-MAPD Plan)	OCN	Phone: 877-836-6806 Fax: 855-402-1684

Referrals / Pre-Authorizations

As a managed care network, patients assigned to us are required to use providers/facilities from within our network for care. Keeping services in-network works to minimize some administrative burden and keep costs contained. We have a diverse group of specialists and facilities within our network, but are continuously working to grow and expand our reach in the community.

If your patient requires a specialist or facility that is **not** within the OCN Network, then we recommend that the specialist/facility is contracted with the patient's health plan. If the specialist/facility is not contacted with the plan, prior authorization is required. The OCN and health plan prior authorization lists are subject to change. Updates to the lists will be provided to the network as needed. The most current prior authorization list can also be found on the OCN provider portal at: https://professionals.optumcare.com/portal-login.html.

In-Network (Office Visits) (Tier 1):

OCN PCP to OCN specialist referrals do **not** require precertification
OCN specialist to OCN specialist do **not** require precertification

Out of Network Referral (Tier 2)**:** Requires prior authorization from OCN

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

Physical Therapy

Please note that an authorization is not required for Humana MA HMO or United Healthcare MA and Community Plan (and Premera Medicare Advantage after 5/1/2020). However, there is a 24-visit limit for United Healthcare Community Plan (Medicaid) members.

Women's Health

A referral from a PCP is not required for covered women's health care services when the services are provided by a women's health care provider. However, the member must self-refer within her contracted plan's network. Female-related diagnosis, urinary tract infections and disorders of the breast will be allowed under women's self-referral for women on an OCN plan.

If you have further questions, please contact your Practice Advocate. If a provider falls outside of both tiers and you believe their inclusion in the network would be beneficial, please alert network development at OCN and we will research the opportunity.

Please refer to the appendix for sample forms and additional information. Please see instructions on how to access Tapestry link to request authorization electronically via our provider portal logon https://professionals.optumcare.com/portal-login.html.

Care Management

OCN's Care Management team consists of registered nurses, licensed mental health counselors, social workers, and LPN care coordinators. Primary care offices can refer patients with complex care needs by referral, but we also capture members in need of services from utilization management, pre-authorization trends, transitions of care (i.e., Hospital to Skilled Nursing), and members can also self-refer.

Care Management has oversight of the following programs:

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

For additional information, please contact your Practice Advocate.

Behavioral Health

OCN manages behavioral health authorizations and adjudicates claims for Humana MA HMO line of business only. Please refer to Behavioral Health Plan Resources in the appendix for additional information.

Beginning in early 2021, additional behavioral health services will be available to network members. This will include comprehensive substance use disorder treatment, treatment services for severely mentally ill patients, mental health counseling and peer support. More information about these services and how to refer patients will be provided. Please contact Regional Manager of Behavioral Health and Community Partnerships, Melissa Haney MA, LMFT, CCM mhaney@npnwa.net 253-207-4346 for more information.

Identifying OCN Members/Patients

Health plans assign patients based on PCP selection. In most cases, an identifier can be found on the patient's health plan identification card listing OCN as the "Provider Group" or by Payer ID (LIFE1). Please refer to the health plan identification card samples in the appendix. Additionally, providers and facilities should verify eligibility using the health plan's portal.

Portal Access

Summary

The Optum Care Provider Center (OCPC) will be a secure, internet-based, customized experience for providers to care for their patients and our members. A one-stop shop that has claims and member insights, prior authorizations, quality, risk adjustment and affordability performance data. Providers will have enhanced decision-making tools to improve care and lower costs.

The OCPC will provide access to the following:

- Eligibility Status
- Claims Status
- Prior Authorization Status
- Prior Authorization Submission
- Attestation Review and Submission
- Secure Messaging with Optum Care Network Teams

User Access

To access the OCPC, providers will need to perform the following steps:

Navigate to the portal website, located at https://professionals.optumcare.com/portal-login.html. (This is the same site you will use to logon once your registration is processed.)

- Complete the fields under the 'Provider Registration – New User' section. (The request will then be reviewed by an OCN system administrator.)
- Once account registration is approved, an e-mail will be sent to the provider with login information and instructions.
- Logon to OCPC and finalize setup.

Providers who had accessed the Northwest Physicians Network OneHealthPort platform prior to 01/01/2021 may access OCPC via the Optum link in OneHealthPort.

Frequently Asked Questions

How do I check the status of a claim, authorization, or member eligibility?

Log on to https://professionals.optumcare.com/portal-login.html for claims status, authorizations, and member eligibility. If you are unable to locate the claim or authorization, please contact OCN's contact center at 877-836-6806 Monday through Friday 8 a.m. – 5 p.m.

Does OCN pay claims using Electronic Funds Transfer (EFT)?

Yes, OCN utilizes InstaMed for electronic funds transfer (EFT) and electronic remittance advice (ERA). Funds are deposited directly into your designated bank account and include the TRN Reassociation

Trace Number, in accordance with CAQH CORE Phase III Operating Rules for HIPAA standard. To register, please go to www.instamed.com/eraeft. (*For additional InstaMed information, please see the Electronic Funds Transfer section above.)*

How do I check if my provider(s) or facility are currently credentialed/ contracted with OCN?

Please go to http://www.optum.com/pnw. If you are unable to locate the provider(s) or facility and you believe that you are/should be listed in the directory, please contact OCN's contact center at 877-836-6806, Monday through Friday 8 a.m. – 5 p.m., so that they may further research for you.

How do I submit a prior authorization?

Complete an authorization request form (available electronically on OCN's website) with all member information, specialist and/or facility information and requested service information, including diagnosis (ICD0-10-CM), service or procedure (CPT or HCPCS) being requested. Alternative care (acupuncture, chiropractic, massage and naturopathic) may not be a benefit under the member's plan and may require prior authorization from OCN or the health plan network.

All completed request forms can be faxed to 855-402-1684 for outpatient authorizations, 253-627-4708 for inpatient authorizations, or submitted electronically via the OCPC. *(For additional information on OCPC, please see the Portal Access section above.)*

Please allow two days before calling or resubmitting referral requests.

Appendix

Care Network – Washington

We have created this reference guide to provide you with information about the Prior Authorization Protocols. You can verify whether a prior authorization is required, or initiate a request online or by phone.

- Go to OneHealthPort.com or http://www.optum.com/pnw.
- Call 1-877-836-6806 from 8 a.m. to 5 p.m. PST.
- Fax 1-855-402-1684

Note: The following Prior Authorization List is effective as of January 1, 2021.

Procedure and Services	CPT or HCPCS Codes				
Bone Growth Stimulator	20974	20975	20979		
Breast Reconstruction - Non-Mastectomy	11920	19324	19342	19366	19371
	11921	19325	19350	19367	19380
	11922	19328	19357	19368	19396
	19316	19330	19361	19369	L8600
	19318	19340	19364	19370	
Cancer Supportive Care	J0897	J2505	Q5101	Q5110	Q5120
	J1442	J2820	Q5108	Q5111	
Cardiology	33206	33224	33240	93350	93456
	33207	33225	33249	93351	93457
	33208	33227	33262	93452	93458
	33212	33228	33263	93453	93459
	33213	33229	33264	93454	93460
	33214	33230	33270	93455	93461
	33221	33231			
Cardiovascular	75710	75716	93653		

Procedure and Services	CPT or HCPCS Codes				
Chemotherapy	J0640	J9060	J9202	J9264	J9351
	J0641	J9065	J9203	J9266	J9352
	J0642	J9070	J9204	J9267	J9354
	J9000	J9098	J9205	J9268	J9355
	J9015	J9100	J9206	J9269	J9356
	J9017	J9118	J9207	J9270	J9357
	J9019	J9119	J9208	J9271	J9358
	J9020	J9120	J9209	J9280	J9360
	J9022	J9130	J9210	J9285	J9370
	J9023	J9145	J9211	J9293	J9371
	J9025	J9150	J9212	J9295	J9390
	J9027	J9151	J9213	J9299	J9395
	J9030	J9153	J9214	J9301	J9400
	J9032	J9155	J9215	J9302	J9600
	J9033	J9160	J9216	J9303	J9999
	J9034	J9165	J9217	J9305	Q2017
	J9035	J9171	J9218	J9306	Q2043
	J9036	J9173	J9225	J9307	Q2049
	J9039	J9175	J9226	J9308	Q2050
	J9040	J9176	J9228	J9309	Q5107
	J9041	J9177	J9229	J9311	Q5112
	J9042	J9178	J9230	J9312	Q5113
	J9043	J9179	J9245	J9313	Q5114
	J9044	J9181	J9246	J9315	Q5115
	J9045	J9185	J9250	J9320	Q5116
	J9047	J9190	J9260	J9325	Q5117
	J9050	J9198	J9261	J9328	Q5118
	J9055	J9200	J9262	J9330	Q5119
	J9057	J9201	J9263	J9340	
Cochlear Implants & Other Auditory Implants	69714	69718	L8614	L8690	L8692
	69715	69930	L8619	L8691	

Procedure and Services	CPT or HCPCS Codes				
Cosmetic & Reconstructive Cosmetic procedures that change or improve physical appearance without significantly improving or restoring physiological function	11960	21172	21255	28344	67902
	11971	21175	21256	30540	67903
	15820	21179	21260	30545	67904
	15821	21180	21261	30560	67906
	15822	21181	21263	30620	67908
	15823	21182	21267	31295	67909
	15830	21183	21268	31296	67912
	15847	21184	21275	31297	67950
	17106	21230	21299	31298	67961
	17107	21235	21740	67900	67966
	17108	21248	21742	67901	Q2026
	17999	21249	21743		
Durable Medical Equipment (DME) – Regardless of Cost Power mobility/accessories devices and lymphedema pumps require prior authorization regardless of cost	K0861	K0870	K0880	K0891	E1239
	K0862	K0871	K0884	K0898	E2310
	K0863	K0877	K0885	E0466	E2311
	K0864	K0878	K0886	E1230	E2321
	K0869	K0879	K0890		

Procedure and Services	CPT or HCPCS Codes				
Durable Medical Equipment (DME) >$1000 Rental or purchase cost will exceed $1000 over 12-month period	E0170	E0740	E1030	E1235	E1634
	E0193	E0746	E1035	E1236	E1635
	E0194	E0761	E1036	E1237	E1636
	E0246	E0764	E1037	E1238	E1637
	E0277	E0770	E1050	E1270	E1639
	E0300	E0782	E1070	E1280	E1699
	E0302	E0783	E1084	E1295	E1812
	E0304	E0784	E1085	E1296	K0020
	E0316	E0785	E1086	E1297	K0037
	E0328	E0786	E1087	E1298	K0039
	E0329	E0830	E1089	E1310	K0044
	E0350	E0970	E1100	E1399	K0046
	E0373	E0983	E1110	E1500	K0047
	E0459	E0984	E1161	E1510	K0050
	E0462	E0986	E1170	E1520	K0051
	E0465	E0988	E1171	E1530	K0056
	E0483	E1002	E1172	E1540	K0065
	E0603	E1003	E1180	E1550	K0072
	E0616	E1004	E1190	E1560	K0073
	E0617	E1005	E1195	E1575	K0098
	E0618	E1006	E1200	E1580	K0105
	E0635	E1007	E1222	E1590	K0108
	E0636	E1008	E1224	E1592	K0455
	E0639	E1009	E1227	E1594	K0609
	E0640	E1010	E1228	E1600	K0730
	E0692	E1011	E1229	E1615	K0743
	E0693	E1017	E1231	E1620	K0744
	E0694	E1018	E1232	E1625	K0745
	E0700	E1020	E1233	E1630	K0746
	E0710	E1029	E1234	E1632	

Procedure and Services	CPT or HCPCS Codes				
Gender Dysphoria	14000	15782	53425	55866	57296
	14001	15783	53430	55970	57335
	14041	15788	54125	55980	57426
	15734	15789	54400	56625	58661
	15738	15792	54401	56800	58720
	15750	15793	54405	56805	58940
	15757	19303	54408	57106	64856
	15758	21899	54520	57110	64892
	15775	31599	54660	57291	64896
	15776	31899	54690	57292	92507
	15780	53410	55175	57295	92508
	15781	53420	55180		
Hysterectomy – IP and OP	58150	58541	58544	58553	58571
	58152	58542	58550	58554	58572
	58180	58543	58552	58570	58573
Hysterectomy – IP Only	58260	58267	58280	58291	58293
	58262	58270	58290	58292	58294
	58263	58275			
Injectable	A9513	J0584	J1303	J7320	J7327
	A9590	J0791	J1442	J7321	J7329
	A9606	J0881	J1447	J7322	J7331
	A9699	J0885	J1745	J7323	J7332
	C9061	J0896	J2326	J7324	J7333
	J0222	J1300	J3398	J7326	Q5121
	J0223	J1301	J3399		
Inpatient Admissions-Post Acute services	Acute Care Hospitals Acute Inpatient Rehabilitation Critical Access Hospitals Long-term Acute Care Hospitals Skilled Nursing Facilities				
Non-Emergency Transport - Air	A0430	A0431	A0435	A0436	
Orthognathic Surgery	21120	21142	21154	21195	21240
	21121	21143	21155	21196	21242
	21122	21145	21159	21198	21244
	21123	21146	21160	21199	21245
	21125	21147	21188	21206	21246
	21127	21150	21193	21210	21247
	21141	21151	21194	21215	

Procedure and Services	CPT or HCPCS Codes				
Orthopedic Spinal and Joint Surgeries	22100	22610	23470	29915	63081
	22101	22612	23472	29916	63085
	22102	22630	24360	63001	63087
	22110	22633	24361	63003	63090
	22112	22800	24362	63005	63101
	22114	22802	24363	63011	63102
	22206	22804	27120	63012	63170
	22207	22808	27122	63015	63172
	22210	22810	27125	63016	63173
	22212	22812	27130	63017	63180
	22214	22818	27132	63020	63182
	22220	22819	27134	63030	63185
	22222	22830	27137	63040	63190
	22224	22849	27138	63042	63191
	22532	22850	27412	63045	63194
	22533	22852	27445	63046	63195
	22548	22855	27446	63047	63196
	22551	22856	27447	63050	63197
	22554	22861	27486	63051	63198
	22556	22864	27487	63055	63199
	22558	22865	29866	63056	63200
	22590	22867	29867	63064	0200T
	22595	22869	29868	63075	0201T
	22600	22899	29914	63077	J7330

Out of Network Services

A recommendation from a network physician or health care provider to a hospital, physician or other health care provider who is not contracted with Optum Care Network

Procedure and Services	CPT or HCPCS Codes				
Orthotics - greater than $1000	L0112	L0810	L2005	L3160	L3720
	L0140	L0820	L2010	L3201	L3764
	L0150	L0830	L2020	L3202	L3765
	L0170	L0859	L2030	L3203	L3766
	L0200	L0999	L2034	L3204	L3891
	L0220	L1000	L2036	L3206	L3900
	L0452	L1001	L2037	L3207	L3901
	L0462	L1005	L2038	L3208	L3904
	L0464	L1200	L2040	L3209	L3921
	L0466	L1300	L2050	L3211	L3956
	L0468	L1310	L2060	L3212	L3961
	L0480	L1499	L2070	L3213	L3967
	L0482	L1630	L2080	L3214	L3971
	L0484	L1640	L2090	L3215	L3973
	L0486	L1680	L2126	L3250	L3975
	L0622	L1685	L2136	L3251	L3976
	L0623	L1700	L2232	L3252	L3977
	L0624	L1710	L2320	L3253	L3978
	L0629	L1720	L2387	L3254	L4000
	L0631	L1730	L2520	L3255	L4030
	L0632	L1755	L2525	L3257	L4040
	L0634	L1834	L2526	L3265	L4045
	L0636	L1844	L2627	L3320	L4050
	L0638	L1904	L2628	L3485	L4055
	L0700	L1920	L2800	L3649	L4631
	L0710	L2000	L2861	L3674	
Potentially Unproven (including experimental/investigational and/or linked services)	28890	64405	64744	95965	95966
	36514	64722	66180		
Private Duty Nursing	T1000				

Procedure and Services	CPT or HCPCS Codes				
Prosthetics - greater than $1000	L5010	L5610	L5930	L6500	L6925
	L5020	L5611	L5960	L6550	L6930
	L5050	L5613	L5961	L6570	L6935
	L5060	L5614	L5966	L6580	L6940
	L5100	L5616	L5968	L6582	L6945
	L5105	L5639	L5973	L6584	L6950
	L5150	L5643	L5979	L6586	L6955
	L5160	L5649	L5980	L6588	L6960
	L5200	L5651	L5981	L6590	L6965
	L5210	L5681	L5987	L6621	L6970
	L5220	L5683	L5988	L6624	L6975
	L5230	L5700	L5990	L6638	L7007
	L5250	L5701	L6000	L6646	L7008
	L5270	L5702	L6010	L6648	L7009
	L5280	L5703	L6020	L6693	L7040
	L5301	L5707	L6026	L6696	L7045
	L5312	L5724	L6050	L6697	L7170
	L5321	L5726	L6055	L6707	L7180
	L5331	L5728	L6100	L6709	L7181
	L5341	L5780	L6110	L6712	L7185
	L5400	L5781	L6120	L6713	L7186
	L5420	L5782	L6130	L6714	L7190
	L5500	L5795	L6200	L6715	L7191
	L5505	L5814	L6205	L6721	L7499
	L5510	L5818	L6250	L6722	L8035
	L5520	L5822	L6300	L6880	L8039
	L5530	L5824	L6310	L6881	L8041
	L5535	L5826	L6320	L6882	L8042
	L5540	L5828	L6350	L6883	L8043
	L5560	L5830	L6360	L6884	L8044
	L5570	L5840	L6370	L6885	L8049
	L5580	L5845	L6380	L6895	L8499
	L5585	L5848	L6382	L6900	L8505
	L5590	L5856	L6384	L6905	L8604
	L5595	L5857	L6400	L6910	L8609
	L5600	L5858	L6450	L6920	L8699
Radiation Therapies (IMRT, SRS, SBRT)	G0251	G6015	77373	G0251	G0340
	77385	77371	G0173	G0339	G6016
	77386	77372			
PET/SPECT	78459	78609	78814	78072	78469
	78491	78811	78815	78451	78494
	78492	78812	78816	78452	78803
	78608	78813	78071		

Procedure and Services	CPT or HCPCS Codes				
Radiology	76376	78202	78299	78483	78660
	76377	78215	78300	78496	78699
	78012	78216	78305	78499	78700
	78013	78226	78306	78579	78701
	78014	78227	78315	78580	78707
	78015	78230	78399	78582	78708
	78016	78231	78428	78597	78709
	78018	78232	78445	78598	78740
	78070	78258	78453	78599	78761
	78075	78261	78454	78600	78799
	78099	78262	78456	78601	78800
	78102	78264	78457	78605	78801
	78103	78265	78458	78606	78802
	78104	78266	78466	78610	78804
	78185	78278	78468	78630	78830
	78195	78282	78472	78635	78831
	78199	78290	78473	78645	78832
	78201	78291	78481	78650	78999
Septoplasty/Rhinoplasty	30400	30420	30435	30460	30462
	30410	30430	30450		
Stimulators	61850	61867	61886	E0747	E0749
Bone, Spinal and Vagus	61863	61868	64555	E0748	E0760
	61864				
Sleep Apnea Procedures	21685	41512	41530	41599	42145
Transplants	32850	38208	44135	47145	50370
	32851	38209	44136	47146	50380
	32852	38210	44137	47147	50547
	32853	38212	44715	48551	0537T
	32854	38213	44720	48552	0538T
	32855	38214	44721	48554	0539T
	32856	38215	47133	50300	0540T
	33930	38232	47135	50320	Q2041
	33933	38240	47140	50323	Q2042
	33935	38241	47141	50325	S2060
	33940	38242	47142	50340	S2061
	33944	44132	47143	50360	S2152
	33945	44133	47144	50365	
Vein Procedures	36473	36478	37718	37722	37780
	36475	37700			
	33927	33928	33929	33975	

Prior Authorization Request Form

Prior Authorization Request

***YOU MUST SUBMIT CLINICAL DOCUMENTATION TO SUPPORT YOUR REQUEST**

PLEASE NOTE – AUTHORIZATIONS MAY BE REQUESTED ONLINE VIA ONEHEALTHPORT

DATE: ______________ **Phone: 1-877-836-6806** **Fax: 1-855-402-1684**	☐ Humana HMO Medicare Advantage ☐ Premera HMO Medicare Advantage ☐ UnitedHealthcare AARP West Medicare Advantage ☐ UnitedHealthcare Community & State (Apple Health)

☐ ***Routine*** ☐ ***Urgent*** ☐ ***Post-Service***

***Urgent** is defined as a medical or behavioral health condition manifesting itself by acute symptoms of sufficient severity such that if services are not received within 24 hours of the request the person's situation is likely to deteriorate to the point that emergent services are necessary.*

Patient Name:	Member ID:
DOB:	Phone Number:

***If referring Out of Network, please provide documentation to support medical necessity**

Requesting Provider:	Servicing Provider:
Phone:	Phone:
Fax:	Fax:

☐ ***Inpatient*** ☐ ***Outpatient***

Diagnosis and ICD-10 code(s):	Date of Service:
CPT Code(s):	
Facility Information:	
Comments:	

PLEASE NOTE**: This Authorization does not ensure payment of services. All claims are subject to normal policy limitations, current eligibility, and plan requirements. **AUTHORIZATION LETTERS WILL BE FAXED TO PCP & SERVICING PROVIDER UPON PROCESSING.

Submit Claims to: Optum Care Network
Electronic ID: Life1
Clearinghouse: Optum 360

PAYMENT SUBJECT TO CURRENT ELIGIBILITY AT THE TIME OF SERVICE

Effective 1/2021

Medicare ID Card Samples

United Healthcare MA-HMO

AARP Medicare Advantage
UnitedHealthcare

Health Plan (99999): 999-99999-99
Member ID: 9999999-99 Group Number: XXXXX
Member:
Member Sample
PLAN CODE: XXX
[UHC Dental Benefits]
Payer ID: LIFE1
PCP Name:
SAMPLE, PROVIDER
PCP Phone: (999) 999-9999
OPTUM CARE NETWORK
Copay: PCP $XX ER $XX
Spec $XX
MedicareRx Prescription Drug Coverage
RxBIN: XXXXX
RxPCN: XXXX
RxGrp: XXXX
MARKET PLAN NAME
H9999-999-999

Customer Service Hours: 8 am - 8 pm 7 days/week Printed: xx/xx/xxxx

For Members
Website: www.myAARPMedicare.com
Customer Service: 1-999-999-9999 TTY 711
NurseLine: 1-999-999-9999 TTY 711
Behavioral Health: 1-999-999-9999 TTY 711
[Dental: 1-999-999-9999 TTY 711]
For Providers www.OptumCare.com 1-877-836-6806
Medical Claim Address: P.O. Box 30788, Salt Lake City, UT 84130-0788
Provider Authorization: 1-877-836-6806
[UHC Dental Providers: www.UHCdental.com 1-999-999-9999]
WEST Renew Active OPTUM
For Pharmacists 1-999-999-9999
Pharmacy Claims OptumRx P.O. Box 999999 Healthcare, US 99999-9999

Humana MA- HMO

Humana.
HUMANA GOLD PLUS (HMO)
A Medicare Health Plan with Prescription Drug Coverage
Dental Included CARD ISSUED: 1/1/21
SALLY A SAMPLE
Member Hxxxxxxxx
Plan (80840) 9140461101
RxBIN: 015581
RxPCN: 03200000
RxGRP: Y0610
Copayments
OFFICE VISIT: $10
SPECIALIST: $50
HOSPITAL EMERGENCY: $90
MedicareRx Prescription Drug Coverage
CMS H5619 114

Member/Provider Service: 1-800-457-4708
If you use a TTY, call 711
Pharmacist/Physician Rx Inquiries: 1-800-865-8715
IPA/Center Name: OPTUM CARE NETWORK
Primary Physician: PCP NAME
Claims, PAYER ID LIFE1, PO BOX 30788, SALT LAKE CITY, UT 84130
Please visit us at **Humana.com** (For Dentists - ***Humana.com/sb***)
Additional Benefits: DEN838 VIS734 HER937
EyeMed Vision: 1-888-289-0595

Premera MA – HMO

PREMERA
BLUE CROSS
An Independent Licensee of the Blue Cross Blue Shield Association
<Name of specific plan>
Enrollee Name
FIRST M LASTNAME JR
Plan <HXXXX XXX>
Medical Network
Medicare Advantage
Enrollee ID
Prefix PC
ZNP 123456789 00
Health Plan (80840) <0000000000>
Group Number
12345
RXBIN: 004336
RXPCN: MEDDADV
RXGRP: RX8718
RXID: 12345678900
Issued:
MM/YYYY
<DENTAL, VISION, HEARING>
MEDICARE ADVANTAGE HMO
MedicareRx Prescription Drug Coverage

Members: www.premera.com/MA
OCN EDI Payer ID: LIFE1
Premera Blue Cross
An Independent Licensee of the Blue Cross Blue Shield Association
Use of this card is subject to terms of applicable contracts, conditions and use agreements.
Providers outside of WA, local plan.
Mail Provider claims to:
Optum Care Network
PO Box 30788
Salt Lake City, UT 84130-0788
PCP Name:
<first/last name>
OCN
Customer Service: 888-850-8526
TTY/TDD: 711
Mental health/substance abuse treatment: 844-884-1855
Dental Inquiries: 888-850-8526
Vision/Hearing Inquiries: 888-850-8526
24/7 Nurseline: 855-339-8123
Medical Authorizations: 877-836-6806
Dental Provider Service: 855-612-7477
Pharmacist Call: 866-693-4620

Humana MAPD HMO D-SNP

Humana.
HUMANA GOLD PLUS (HMO D-SNP)
A Medicare Health Plan with Prescription Drug Coverage
Dental Included CARD ISSUED: MM/DD/YYYY
MEMBER NAME
Member ID: HXXXXXXXX
Plan (80840) 9140461101
RxBIN: XXXXXX
RxPCN: XXXXXXXX
RxGRP: XXXXX
MedicareRx Prescription Drug Coverage
CMS XXXXX XXX

Member/Provider Service: 1-800-457-4708
If you use a TTY, call 711
Pharmacist/Physician Rx Inquiries: 1-800-865-8715
IPA/Center Name: XXXXXXX
Primary Physician: XXXXXXXXXXXXXX
Claims, PO Box 14601, Lexington, KY 40512-4601
Please visit us at **Humana.com** (For Dentists- ***Humana.com/sb***)
Additional Benefits: DENXXX VISXXX HERXXX
EyeMed Vision: XXX-XXX-XXXX

Delegation by Plan

Functional Areas	Humana MA HMO	Premera MA HMO	AARP MA HMO (UHC)
Utilization Management	x	x	x
Disease Management	x		x
Case Management	x	x	x
Case Management for Transplants			
Care Transitions	x	x	x
Concurrent Review Management	x	x	x
Correspondence	x	x	x
ER Notification Outreach	x	x	x
Claims	x	x	x
Credentialing	Providers; All Facility Types	Providers and ASCs only	Providers; All Facility Types
Quality/MRA	x	x	x
Behavioral Health/Substance Use	x		
DSNP	x	x	

Behavioral Health – Plan Resources

United Healthcare Medicare Advantage
https://provider.liveandworkwell.com/content/laww/providersearch/en/home.html?siteId=10275&lang=1
Enter patient zip code, on Provider Listing Page, select "Medicare"
Behavioral Health Claims and Authorizations 866-673-6315

Humana Medicare Advantage
Behavioral Health provider assistance **1-866-900-5021 - Non-patient facing number.** 8 a.m. – 6 p.m., Eastern time. Patients may call the number on the back of their Humana member ID card.
Behavioral Health Claims and Authorizations - **OCN Utilization Management**

Premera Medicare Advantage
Find a Behavioral Health provider https://www.premera.com/visitor/find-a-doctor or call the "mental health" phone number on the back of the member's card

Behavioral Health Claims and Authorizations 1-800-711-4577