



OptumHealth Care Solutions, LLC Provider Operations Manual



Physical Health Edition

Provider Service Web site:
myoptumhealthphysicalhealth.com

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Provider Operations Manual Contents

(Click on the topic to directly view information on each topic)

Welcome To Optum	3
About Optum	3
Terminology.....	4
Provider Resources	6
Online Provider Information and Tools	6
Plan Summaries.....	7
Clinical Appeals Process	8
Patient Satisfaction Data	9
Clinical Support Program	10
Overview	10
Review Process	10
Submission Process.....	11
Response Process.....	12
Reconsiderations	12
Network Tiering Overview	14
Accessing Your Tier Letter	14
Network Tiering Criteria.....	14
Data Sharing Resources.....	15
Claims Process	15
Claims Submission and Status.....	15
Contracted Rate/Fee Schedules.....	16
Payment and Remittance Advice	16
Coordination of Benefits	18
Patient Financial Responsibility	19
Fraud and Abuse	20
Fraud and Abuse	20
Provider Obligations	21
Credentialing and Recredentialing	21
Office Operation Expectations.....	22
Notices & Information Updates.....	26
Medical Records	27
Termination of Participation.....	28
Federal Consolidated Appropriations Act (CAA) for Continuity of Care (COC) regulations.....	29
OptumHealth Physical Health of California (Optum)	30
Language Assistance program	30
Member Grievances	31
Member Grievance Form	36
Insurance Benefit Plans.....	39
Provider Dispute Resolution.....	40

Welcome to Optum®

About Optum

Congratulations, and welcome to OptumHealth Care Solutions, LLC (Optum). Optum is a national leader in providing physical medicine solutions to the health care market.

As an Optum participating provider, you are part of a growing network of health care professionals dedicated to providing consumers with access to quality, affordable health care services. Visit our corporate Web site at optum.com for more information on our scope of services and products.

Through most of our communication to you, we identify ourselves as Optum. This name unites our program with other quality programs and products under the UnitedHealth Group®, parent company. In all legal documentation, to include Optum Provider Agreements, we will identify ourselves as Optum.

Upon acceptance into the Optum network, you should have received a welcome letter with important information to get you started. It identifies the health plans whose enrollees you are able to treat as an in-network Optum provider, and also includes Plan Summaries and fee schedules for each health plan. In addition, the welcome letter provides information about our online provider portal and the process to obtain an exclusive provider login identification number (ID) and password that you can use to:

- Access WebAssist, (the Optum online provider Web site myoptumhealthphysicalhealth.com)
- Submit claims electronically through myoptumhealthphysicalhealth.com
- Submit a Patient Summary Form (PSF) electronically through myoptumhealthphysicalhealth.com

The Optum Plan Summaries provide procedural information specific to each contracted health plan. We encourage you, and your office staff, to carefully review your Optum Provider Agreement, Plan Summaries, and this Provider Operations Manual. Used in conjunction with each other, these documents will give you information you need to effectively interact with Optum.

This Provider Operations Manual contains important information including policies and procedures to be followed when working with Optum, and/or members covered by health plans managed by Optum. These provisions apply to all providers under contract with Optum and/or its affiliated companies.

- California specific language set forth in gray

The obligations of the provider under the Optum Provider Agreement, Plan Summaries, this Provider Operations Manual and other such policies and/or procedures, apply equally to the provider and to the provider's office staff. Please communicate important aspects of these obligations to your staff to help ensure successful participation as a provider in the Optum network.

Terminology

The following terms listed below have been provided for your information. Please reference this list if you have questions as to how these terms should be interpreted in this Provider Operations Manual.

Benefit Contract	The Benefit Contract defines the coverage the member has available and is a document of the health plan that is made accessible to each member by the health plan. Benefit Contracts are also known as Evidence of Coverage (EOC), or may be known as the Summary Plan Descriptions (SPD).
Covered Services	Covered services are the health care services covered by the member’s benefit contract.
Claims Processing	Typically, claims and clinical support services are coupled together for the most effective tracking of the health care episode. Receipt of the claim, or claims data, allows us to develop provider profile information in addition to generating proper payment to the provider for appropriate services. It is important to pay close attention to the Plan Summary to determine the proper procedures for claim processing.
Clinical Submission	Clinical information submitted to Optum at or near the beginning of care or at the extension of care. Summarized data derived from clinical submissions is made available through a variety of data-sharing resources.
Clinical Submission Response	A response supplied to the provider by Optum once an evaluation of the provider’s clinical submission has been made.
Coordination of Benefits (COB)	Coordination of Benefits (COB) is a contract provision that applies when a person is covered under more than one group medical program. It requires that payment of benefits be coordinated by all programs to eliminate over-insurance or duplication of benefits. (The primary plan pays first; the difference is paid by the secondary plan.)
Eligibility Verification/ Benefit Information	<p>Most Plans offer automated forms of eligibility verification through the Internet, the Plan’s Web site or automated telephone systems. These systems are generally the most effective method of obtaining current eligibility information. The Plan Summary identifies eligibility verification options that may be used for each Plan. Regardless of the method of eligibility verification, it is important to verify patient eligibility. (Any reference to ID card includes both a physical or digital card.) Obtaining this coverage information will help you determine the correct clinical submission procedure and will allow you to clearly communicate with the patient regarding the patient’s financial responsibility. For referral-based plans, the provider should verify that the patient has a valid referral, or that the patient is aware of the benefit impact of seeking care without a referral.</p> <p>Please be aware that the Payer will make the final determination of eligibility at the time of claim payment. Eligibility may change retroactively when:</p> <ul style="list-style-type: none"> • The Payer, or Optum, receives information that an individual is no longer eligible; or • The individual’s Benefit Contract has been terminated; or • The individual decides not to purchase continuation coverage; or • The eligibility information received is later determined to be false.

Network Access	This arrangement provides a member with access to a network of participating providers. Network access may be provided to a Plan on a standalone basis; however, it may be combined with additional services to provide a more robust array of services.
Patient Summary Form (PSF)	The PSF is a standardized health record including valid and reliable public domain outcomes-assessment instruments for documenting and submitting data regarding the demographic, diagnostic and historical attributes of all patients treated and the outcomes of treatment.
Payer	The entity or person that has financial responsibility for payment of covered services. Payer may be Optum, Plan or other entity as designated by Optum or Plan.
Plan	As referenced in this Provider Operations Manual, “Plan” refers to the entity that has been authorized by Optum to access its network of providers. A Plan generally has the responsibility for issuance and administration of the member’s benefit contract.
Public Sector	Public Sector includes Medicaid, Medicare, or any other local, state, and federal government-sponsored programs.
Service Level	Defined as the number of passive modality/therapy Current Procedural Terminology (CPT) units.
Support Clinicians	These are licensed peers that perform utilization review (UR) and clinical outreach.
Tier 1 Provider	<p>Providers that meet a minimal patient volume and have clinical decision-making consistently aligned with current evidence and community standards. Tier 1 providers participate in a minimal UR process.</p> <p>Following two consecutive years as a Tier 1 provider, while meeting a minimal patient volume, the provider moves to a no UR process (Tier 1 Advantage). Tier 1 Advantage providers, with minor plan exceptions, are no longer required to submit PSFs.</p>
Tier 2 Provider	Providers that are new to the network, have not met a minimum patient volume or have clinical decision-making not aligned with current evidence and community standards in one or more areas. Tier 2 providers participate in a comprehensive UR process.
Transparency	All contracted providers have 24/7 access to a comprehensive set of administrative, demographic, case mix, and clinical outcomes data key performance indicators. This data is made available to contracted providers via secure web-enabled applications.

Provider Resources

Online Provider Information and Tools

Optum WebAssist, myoptumhealthphysicalhealth.com, is a valuable resource for providers and their administrative support staff. Access to this secure Web site is obtained through your Optum login ID and unique password which you have obtained from our Provider Services Department. If you have misplaced your login ID and/or your password or have any other questions, please contact the Optum Provider Service Department at (800) 873-4575.

The Optum WebAssist feature includes:

<p>Data Submission</p> <ul style="list-style-type: none"> • PSF Submissions • Claim Submission • Patient Status Reports 	<ul style="list-style-type: none"> • Quick and easy access. • A confirmation of receipt. • There is no need to re-enter patient demographic information for returning patients as it is stored electronically. Simply select the patient's name from the "My Patients" list.
<p>Status Checks</p> <ul style="list-style-type: none"> • Clinical Submissions Response • Claims 	<ul style="list-style-type: none"> • It is the same information as provided on your faxed or mailed Clinical Submission Response. • It is a preferred method since you have the ability to print results instantly from your printer. • The Web site is updated frequently giving the most up to date information. • Clinical submissions can generally be viewed on the Web site within two days of receipt. • Claims can generally be viewed on the Web site within five to 10 days of receipt.
<p>Clinical Information and Tools</p>	<ul style="list-style-type: none"> • Provides immediate access to the most current educational materials, clinical Web links, printable patient exercise templates, clinical guidelines, provider newsletters, and articles.
<p>Provider Profiles</p>	<ul style="list-style-type: none"> • Updated monthly. • You may choose a variety of report types to view your data. • You may also choose the time period; annually, semiannually, or quarterly.
<p>Provider Tier Letters</p>	<ul style="list-style-type: none"> • Posted annually, providing access to your most current tier letter. • You have the ability to view and print the letter.
<p>Administrative Resources</p>	<ul style="list-style-type: none"> • Provides real time access to current documents eliminating the wait on mail delivery. • Provider Operations Manual. • Plan Summaries and fee schedules.

Plan Summaries

- How to identify members/enrollees of a specific health plan
- How to verify eligibility
- Malpractice requirements
- Where and when to submit claims
- The form of clinical submission required and the designated process
- Where and when to submit required clinical documentation
- Regional office addresses, telephone and fax numbers
- Where to find online assistance

The following represents a typical Plan Summary format.

		<p>HEALTH PLAN Program Effective Date xx/xx/xxxx</p>	<p>[Specialty] Plan Summary Revision Date: xx/xx/xxxx Valid for the State of xxxxxx</p>
<p><u>Program Description</u></p> <p>This section describes the program you are participating with. This section will also clearly document the malpractice level requirements.</p>		<p><u>Claims Submission</u></p> <p>Describes claims submission instructions</p>	
<p><u>Eligibility/Verification Options</u></p> <p>This section describes the process a provider should use to verify eligibility</p>		<p><u>Claims Inquiry</u></p> <p>Describes instructions for claims status inquiries</p>	
<p><u>Clinical Submission Process</u></p> <p>This section explains the following:</p> <ul style="list-style-type: none"> • Defines submission process • Clearly states the steps to completing a submission <ul style="list-style-type: none"> ◦ Group check ◦ Patient Summary forms (if applicable) ◦ Submission methodology • Compliance of Clinical Submission process 		<p><u>Provider Status Changes</u></p> <p>Instructions for submitting demographic changes and/or TIN Changes</p>	
<p><small>*OptumHealth Care Solutions- Physical Health includes ACN Group, Inc., ACN Group IPA of New York, Inc., Managed Physical Network, Inc., and ACN Group of California, Inc. 080710.V1</small></p>			

Clinical Appeals Process

Optum recognizes that providers may desire a review of a clinical decision made by Optum. To process these requests, we have created a Clinical Appeals Process. Prior to initiating a formal appeal of a clinical decision, the provider may choose to request reconsideration. Issues of a nonclinical nature, such as reimbursement, coding or administrative denials are not handled under the Clinical Appeals Process and should be handled as directed in the "Clinical Support Program" section or the "Claims Process" section of this Provider Operations Manual.

Clinical appeal requests may be made either by telephone or in writing. Written requests are preferred and can be submitted to the attention of the Service Operations Department. Include the following in your request:

- Reference number from initial determination
- Patient name
- A clear statement of the denied services that you are appealing
- The basis for your appeal
- Any additional information that may have a bearing on the decision

A clinical peer not previously involved in the initial determination and not a subordinate to the initial reviewer will conduct the review. If the provider is not satisfied with the results of this review, there are, in many cases, additional appeal procedures available to the provider. This may include a second level appeal request to Optum and/or a review by an independent review organization, if required by state regulations. If Optum upholds its initial determination, the provider will be informed of subsequent appeal rights in our response letter.

The patient has appeal rights as well; the process and timeframes are generally different than those for providers as they vary based upon state regulations and/or the specific health plan's process. The rights and information concerning the process are communicated to the patient at the time of the determination.

Patient Satisfaction Data

There are a variety of market dynamics highlighting the need to make patient satisfaction data regarding health care services more transparent to consumers. In response to consumers' interest, Optum has undertaken a significant initiative to collect patient satisfaction data and make that information available online.

Patient satisfaction data is collected through a survey administered by an independent survey vendor utilizing the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey tool. The survey tool was developed by the Agency for Healthcare Research and Quality (AHRQ) for a multi-year initiative to support and promote the assessment of consumers' experience with health care. The CAHPS survey is utilized nationally and focuses on four key components of the consumer experience in your office: ease of getting an appointment, communication skill of the treating health care provider, courtesy and helpfulness of staff, and an overall rating of the treating health care provider.

As consumers assume greater financial responsibility for their care, it's important for them, when selecting a provider to be able to compare the differences between providers.

Patient satisfaction data may be used in two ways. First, your clinic data is reported back to you for your review through the Optum provider Web site. With this data, you can determine the level of satisfaction among your patients; uncover areas of opportunity based on patient feedback and compare patient satisfaction against other health care professionals. Second, once sufficient data is collected, results may be published on a consumer-facing provider lookup portal.

The following steps describe how to access and learn more about the goals, chosen provider performance measures, measurement methodology, participation in the survey process and use of the patient satisfaction data:

1. Go to myoptumhealthphysicalhealth.com
2. Enter your provider ID & password
3. Click "Tools & Resources"
4. Click "Patient Satisfaction Result" to view any available satisfaction data
5. Click "CAHPS Survey Methodology" to view measurement methodology
6. Click "Patient Satisfaction CAHPS Survey Tutorial" to learn more about the survey process and how to participate

Clinical Support Program

Overview

The Optum Clinical Support Program is a form of utilization review (UR). It is a means to continually improve the quality and affordability of health care services by helping providers incorporate current best clinical evidence into practice. To accomplish this, Optum has developed an integrated set of outreach activities of varying levels of intensity. Provider outreach is performed by experienced professionals of the same specialty. The interaction is based on the degree to which decision-making varies from current best clinical evidence and/or community standards of care. Collectively, these activities are referred to as the Clinical Support Program.

The Clinical Support Program is transparent and collaborative, designed to affect clinical behavior rather than treatment limitations and denials.

Review Process

The Optum UR process is designed to ensure that patients have access to all treatment available to them as described in their Evidence of Coverage (EOC). As specified in the contract a provider signs when voluntarily joining the Optum network, and consistent with information provided to patients in their EOC, Optum network providers participate in a UR process. The UR process requires the treating provider to submit a PSF, which collects demographic and clinical data about the patient.

The treating provider does not document, or request approval for an anticipated number of visits or services. For Tier 2 providers, the feedback provided by Optum in response to a clinical submission is a recovery milestone corresponding to a range of visits within which 80-95% of patients with similar characteristics have typically recovered. As such the recovery milestone is not a “medically necessary” or “approved” number of visits, and does not prevent a patient from accessing benefits available as specified in their EOC. The recovery milestone is simply a point at which it would be appropriate for a provider to document barriers to recovery in patients whose treatment needs are becoming unusual. Decision-making regarding the necessity of individual services within the broader parameters established by the recovery milestone is determined by the treating providers.

In some cases ongoing treatment does not seek to cure the patient’s condition, or is being provided during periods when standardized subjective and objective measures indicate the patient’s condition is not improving with ongoing treatment. In these cases, and consistent with language in the patient’s EOC, Optum may make a determination that a continuation of treatment is not covered by the third party financially responsible for the services. In the rare event of an adverse benefit determination such as this, both the provider and patient are advised of the rationale for the adverse determination and are provided with information regarding how to initiate an appeal of the adverse determination.

Submission Process

The following terms listed below have been provided for your information. Please reference this list if you have questions as to how these terms should be interpreted in this Provider Operations Manual.

<p>Clinical Process Summary</p>	<p>The provider is required to submit a Patient Summary Form (PSF) via the Provider Portal at myoptumhealthphysicalhealth.com when treatment has been initiated or continuing care is expected.</p> <p>Utilization Review Process</p> <ul style="list-style-type: none"> • Optum reviews the clinical information submitted and provides recovery milestone information (dates and/or service levels). • Adverse determinations may occur depending upon the patient’s condition and clinical presentation. Support Clinicians review clinical information and make decisions based upon the clinical presentation. (They do not receive any financial incentive based on the quantity or type of decisions made.) • Submission of the PSF is required for claims payment. <p>CA provider see “Submission Options” below</p>
<p>Clinical Electronic Form Requirements</p>	<p>Please consult your Plan Summary for each health plan’s requirements on the submission process.</p> <p>Forms are available at myoptumhealthphysicalhealth.com.</p>
<p>Clinical Submission Responses</p>	<p>Optum will deliver a response to the provider via the myoptumhealthphysicalhealth portal or by fax or mail in the event the provider has an online waiver. These will be delivered in accordance with the timeframes specified in the state regulatory requirements. The patient will generally also receive a response as well. Review each response closely, paying particular attention to the items noted below.</p>
<p>Responses</p>	<p>Utilization Review Process</p> <ul style="list-style-type: none"> • Explanations regarding any submission deficiencies • Specific number of visits and/or service levels • Date when resubmission is required • Explanations for clinical denials • If an adverse determination is made both the provider and patient will be notified of the adverse determination and will be provided with instructions for initiating an appeal. For additional information see the appeals section of this Provider Operations Manual.

Submission Options

Submit your clinical submissions to Optum electronically at myoptumhealthphysicalhealth.com. It is recommended that forms be submitted within three days of the first date of the requested treatment plan. Please refer to the Plan Summaries for instructions for specific timely filing limits.

Services that are submitted beyond the timeline indicated in the Plan Summary may be denied. Claims associated with these dates of service may not be paid due to late clinical submission. The patient may not be billed for any services denied as a result of a late submission.

In California, participating providers may request telephonic submission of PSF information to (800.428.6337.) for Knox-Keene members. Portal submission is encouraged as it allows for more timely and accurate submission of data.

Secondary Coverage

When we handle secondary coverage, submission of clinical information is not required, unless indicated in the Plan's Coordination of Benefits (COB). We follow all applicable state and federal regulations pertaining to COB.

Response Process

You may view the status of your clinical submission by accessing Optum online:

1. Go to myoptumhealthphysicalhealth.com.
2. Select "Clinical Subs and Claims"
3. Select "Clinical Sub Status"
4. Submissions can then be viewed by authorization date or patient name and date of birth

Submission responses will not be faxed or mailed to the provider unless the provider has previously been approved for an online-submission waiver. Member responses will continue to be mailed to the member. It is the provider's responsibility to ensure that Optum receives the required documentation within the submission time period as indicated on each Plan Summary. In states where regulation requires telephone notification to members for adverse determinations, providers are responsible for calling to inform the patient of the determination the same day the provider receives notification.

Response Follow-up

You may view the status of your clinical submission by accessing us online at myoptumhealthphysicalhealth.com or by contacting Optum. It is the provider's responsibility to ensure that Optum receives the required documentation within the submission time period as indicated on each Plan Summary. If you use mail for submission or response receipt, please allow adequate time for postal delivery prior to contacting us.

In states where regulation requires adverse determination member telephone notification, providers are responsible for calling to inform the patient of our determination, the same day that the provider receives notification.

Patient Status Reports

The Patient Status Report (PSR) is used to document the outcome of treatment. The PSR report should be viewed online each month at myoptumhealthphysicalhealth.com. The PSR contains a list of all the patients whose treatment plans are scheduled to conclude the following month. By the end of each month, the PSR should be completed online at myoptumhealthphysicalhealth.com.

Reconsiderations

If you believe that a determination identified in your Clinical Submission Response is inappropriate, Optum will reconsider the decision if the appropriate additional information is presented. Reconsideration requests are classified as either clinical or administrative.

Clinical Determination

If the determination is clinical in nature, where allowed, the provider may request reconsideration and discuss the case by telephone with the individual who made the initial decision. The Optum Support Clinician will make an autonomous determination based on the merits of current and newly acquired clinical information. Please contact the Support Clinician indicated on your Clinical Submission Response.

If that person is not available, then another Support Clinician will handle the reconsideration request. The Support Clinician will make an autonomous determination based on the merits of the current and newly acquired clinical information. If the adverse determination is not changed upon reconsideration, a first level appeal review may be requested by the provider. Please refer to the "Clinical Appeals Process" section for further information on appeals.

Administrative Determination

Administrative determinations are determinations that are not based upon clinical interpretation. If you believe that Optum has made an administrative error, please contact us promptly via e-mail at myoptumhealthphysicalhealth.com, fax, mail, or telephone, and we will investigate.

If you are not claiming that Optum has made an error, but still desire an administrative reconsideration (such as late submission for unusual reasons), please submit a written request. The request must:

- Be submitted within 30 calendar days of the determination date on the Clinical Submission Response (or Remittance Advice (RA) if a Clinical Submission is not on file); and,
- Be sent to the regional service center, Attention: Reconsideration & Appeals Coordinator; and,
- Include a copy of the applicable Clinical Submission Response; and,
- State why the provider believes his/her request should be granted; and,
- Include pertinent facts, including supporting documentation.

We will provide a written response to your reconsideration request within 30 days.

In California, we will provide a written response to your reconsideration request within 45 business days.

Network Tiering Overview

Variation in clinical decision-making is a well-documented issue and an important factor associated with suboptimal quality and affordability of health care services. Our objective in creating network tiers is to identify, within a network of providers/facilities, the degree to which an individual provider's/facility's decision-making are aligned with current best clinical evidence. The resulting tier designation allows Optum to align outreach activities and administrative requirements to those providers whose decision-making is at variance from current evidence and/or community standards. Optum maintains a two-tiered network environment.

Tier 1 – Providers that meet a minimal patient volume and have clinical decision-making consistently aligned with current evidence and community standards. Tier 1 providers participate in a minimal UR process. Following two consecutive years as a Tier 1 provider, while meeting a minimal patient volume, the provider may move to a no UR process (Tier 1 Advantage Program). Tier 1 Advantage providers, with minor plan exceptions, are no longer required to submit PSFs.

Tier 2 – Providers that are new to the network, have not met a minimum patient volume or have clinical decision-making not aligned with current evidence and community standards in one or more areas. Tier 2 providers participate in a comprehensive UR process.

A provider's tier status may be updated on an annual basis or at anytime in our sole discretion. During the review period, provider/facility performance within the network is reviewed to see if they qualify for a change in Tier status. All decisions related to provider tiers are made in Optum's sole discretion. Nothing in this section shall be considered to confer upon any provider any exception or entitlement related to provider tier decisions that are made in Optum's sole discretion.

Network Tiering Criteria

Criteria used to assign tiers are developed and approved by several committees, each consisting of external providers and subject matter experts from active practice, academic institutions, trade associations and professional licensing bodies. The actual criteria may be viewed online at myoptumhealthphysicalhealth.com on the top of each web page under your "Tier Status". On an annual basis or at anytime in our sole discretion the performance of individual providers or facilities may be compared with these criteria to assign a tier designation. It's important to note that tiering criteria are aggregate indicators of the decision-making applied to the entire group of patients treated during a specified time period. The treatment needs of individual patients vary and treatment provided to any individual patient may exceed any or all of the Tier 1 criteria.

When evaluating tiering criteria, consideration is made regarding characteristics of the treated patient population to ensure case mix does not adversely impact the tier assignments. The standardized record submitted to Optum through the UR process contains extensive data regarding the characteristics of each patient treated by a provider. This data is summarized in the Optum data sharing resources available to both providers and Optum. Additionally, Optum performs a high volume of peer to peer outreach throughout the year to help us understand whether unique attributes of a provider's practice setting or patient population may be impacting their decision-making.

Provider Tier Letters

Chiropractic, physical therapy, and occupational therapy clinical Tier letters are available to view and print at www.myoptumhealthphysicalhealth.com. Tier letters will no longer be sent by US mail to providers, unless an "online-submission waiver" has been previously approved and is on file with Optum. Tier letters may be updated annually or at anytime in our sole discretion, as part of the clinical performance review process. Providers will be notified when their new Tier letters have been posted.

You may view and print your current clinical Tier letter by accessing Optum online:

1. Go to www.myoptumhealthphysicalhealth.com
2. Enter your Optum provider ID & password
3. If you need your provider ID or password, click below the login button
4. Click "Clinical Resources"
5. Click "Your Tier Letter"

Data Sharing Resources

Optum is committed to transparency in the sharing of provider level performance data. The exact same provider level administrative, clinical, case mix and coding data available to Optum is available to network providers 24 hours a day, seven days a week via a secure web-based data-sharing portal at myoptumhealthphysicalhealth.com. Optum providers can access this data to evaluate how their performance compares to same specialty peers treating patients from the same health plan during the same time interval, and to current best clinical evidence.

Claims Process

Claims Submission and Status

Optum understands that prompt and proper processing of your claim is important to you. We are committed to delivering a high level of performance in handling of all your claims; your compliance with the procedures detailed in this Provider Operations Manual will help us continue to maintain this level of performance.

Please consult your individual Plan Summaries for specific information regarding the claims process for each particular patient's Plan. The Plan Summary will provide additional specifics regarding timely filing requirement and claim submission options.

Participating providers are required to submit claims on behalf of the patient; do not ask your patient to submit claims for services rendered by you. The provider must bill for all services provided at his/her usual and customary rates as billed to other insurers or patients.

Each date of service, and each service provided, should be billed as a separate line item. Claims should be submitted to the location indicated on the Plan Summary. For claims that are submitted directly to Optum, the following options apply:

- Electronic Data Interchange (EDI) Claims
- myoptumhealthphysicalhealth.com

Providers submitting claims using EDI or myoptumhealthphysicalhealth.com typically report that:

- Mailing and administrative costs are reduced.
- Claims avoid postal delays, thus they are received more quickly.
- Claims are more complete and accurate since there is no need for data entry and possible keying errors.

Consult your Plan Summary for specific options, or contact your current EDI vendor to determine if you are able to submit claims electronically to Optum or the health plan. If you would like to submit claims via EDI to Optum you can send them via Emdeon® or CaparioSM.

Vendor	Contact Information	Payer IDs*
Emdeon	www.emdeon.com or (877) 469-3263	<ul style="list-style-type: none"> • Managed Physical Network (MPN) - New York State Empire Plan 87726 (Policy Number: 30500), and UnitedHealthcare • All Other 41161
Capario	www.capario.com or (888) 894-7888	<ul style="list-style-type: none"> • Managed Physical Network (MPN) - New York State Empire Plan 87726 (Policy Number: 30500), and UnitedHealthcare • All Other ACN01

*Payer IDs should always be confirmed by referencing the Plan Summary prior to electronic claim submission.

Service/Procedure and Diagnosis Coding

Each claim must include a current, valid International Classification of Diseases (ICD) diagnosis code, and be billed with a valid CPT-4 or Healthcare Common Procedure Coding System (HCPCS) code and, when appropriate, a modifier. Claims with incorrect/incomplete coding may be denied payment.

Claims Returns

Claims may be returned as incomplete or unacceptable for the following reasons:

- Optum is unable to identify the provider as an Optum provider.
- Optum does not manage the patient’s Plan or group.
- The claim should have been sent directly to the Plan or the Payer.
- The claim is missing or contains illegible information causing Optum to be unable to interpret the patient’s identity or Plan coverage, the identity of the provider, and/or the services rendered.
- The claim contains handwritten edits, or uses correction fluid or tape in any of the required fields.

Please be sure to review your claims prior to submission to allow for prompt, accurate processing.

Claims Status

Myoptumhealthphysicalhealth.com can be used to easily check the status of submitted claims. If you are unable to use the Web site, we ask that you use the guidance provided below in determining when to call Optum for a status update. Also, we request that you do not automatically rebill as it delays payment of all claims due to the additional processing required.

Situation	Please wait at least:
Has my electronic submission been received by Optum?	<p>One week</p> <p>Allow time for clearinghouse transfer and loading.</p>
Has my paper claim submission been received by Optum?	<p>Two weeks</p> <p>Allow time for mail delivery, sorting, and data entry.</p>
Has my claim been paid?	<p>Four weeks</p> <p>Allow time for mail delivery, sorting, data entry, adjudication, and postal delivery.</p>

Contracted Rates/Fee Schedules

Payment will be made for Covered Services, provided they have been rendered and billed in accordance with Optum, Plan, and Payer procedures. Payment for such services will be subject to Payer medical and reimbursement policies and paid at the lesser of: (1) provider’s customary charge for the Covered Service, less any applicable patient expenses; or (2) the fee schedule amount for such Covered Service, less any applicable patient expenses. The patient may not be billed for the difference between your customary charge and the fee schedule amount or for any charges disallowed based on Payer reimbursement policies unless the patient has given written consent and acknowledgement prior to delivery of the service.

A separate fee schedule will exist for each Plan and is generally included as part of the Plan Summary mailing. Fee schedules are also available online at myoptumhealthphysicalhealth.com.

Payment and Remittance Advice (RA)

When Optum has been designated as the Payer, a RA will be provided to support the payment and/or denial. The statement will include the detail for each patient and claim that is included in the payment.

To enroll in Electronic Funds Transfer (EFT) or Electronic Remittance Advice (ERA 835) for claims submitted to Optum, visit the Optum Provider Portal for enrollment instructions.

For Plans where Optum is not the designated Payer, payment and RA will be received directly from the Plan or their designated Payer.

Payment Denials

The RA indicates a denial code and a description for each item not paid by Optum or the Payer. Payment denials can be classified into five major categories:

Non-covered services	Services that are not covered per the patient’s benefit contract. The patient can be held financially responsible for non-covered services as long as the patient has given a written consent and acknowledgement prior to delivery of the service.
Lack of coverage	The patient may not have coverage with the specific Plan on the date of service. If no alternate coverage exists, then the patient can be held financially responsible for the services.
Other party has financial responsibility	<p>The following instances may result in this form of denial:</p> <ul style="list-style-type: none"> • Worker’s compensation carrier has primary responsibility. • Automobile insurance carrier has primary responsibility. • Other health coverage is deemed primary and the Plan that was billed only has secondary responsibility. After you receive the primary carriers Explanation of Benefits EOB/RA, then re-submit for processing of secondary benefits. • Optum does not directly handle claims/payment for the patient’s group/plan. Claims should be sent to the Payer listed on the back of the patient’s ID card.
Claim already processed	The claim has already been received. Payment has been made to the provider or the claim has been forwarded to the Payer.
Administrative denials	<p>The most common administrative denials include:</p> <ul style="list-style-type: none"> • Failure to file the claim within specified time limits. • Failure to send the Clinical Submission. • Clinical Submission not submitted for the date of service. • Invalid or missing procedure codes or diagnosis codes. • Billing for service at greater level than justifiable. • Payer’s Reimbursement policy does not allow for reimbursement of services. <p>Patients cannot be billed for services denied due to the failure of the provider or the provider’s staff to follow administrative procedures and requirements of Optum or the Payer.</p>

For more information regarding patient billing, please reference the “Patient Financial Responsibility” section of this Provider Operations Manual.

Payment Adjustment/Reconsiderations

If you believe that an error has been made, contact us immediately online at myoptumhealthphysicalhealth.com. If online access is not available, you may fax or mail us and we will investigate. If you have received an overpayment, you are obligated to notify us and arrange for reimbursement of the overpayment. If Optum identifies that you have been overpaid, we may correct this by either offsetting against future payments due or by obtaining direct reimbursement from you.

For reconsideration of a denial made due to lack of administrative compliance (such as late submission for reasons beyond the control of you or your staff), please submit a written request. The request must:

- Be submitted within 30 calendar days of the RA date; and,
- Be sent Attention: Service Coordinator; and,
- Include a copy of the applicable RA, and,
- State why the provider believes the request should be granted; and,
- Include pertinent facts about the provider's case including supporting documentation.

We will provide a written response to your reconsideration request within 30 days.

In California, we will provide a written response to your reconsideration request within 45 business days.

Coordination of Benefits (COB)

Plans and third party Payers rely on COB to eliminate duplicate payments when a patient has multiple sources of coverage for the health services. Full and accurate completion of the appropriate sections of the Centers for Medicare and Medicaid Services (CMS) 1500 Form is essential to determining payment responsibility. Optum or the Payer will follow applicable COB provisions of each contracted Plan and any state or federal regulations pertaining to COB.

When Optum is not the primary Payer, the provider shall collect payment from the primary Payers, following his/her customary collection procedures. If, after all primary Payers have been pursued, and if any additional benefit is available to the patient, then claims should be filed with Optum (only if Optum is delegated to process claims for the specific Plan).

When Optum is the secondary Payer, it is recommended that claims be submitted within 60 days of the primary Payer's determination of benefits, unless the Plan imposes a different time frame for claim submission. The claims must be billed according to the standard submission procedures and must include a copy of the primary Payer's determination of benefits. The determination of benefits may be either an EOB/RA or other correspondence from the Payer describing payments from the primary Payer.

Patient Financial Responsibility

(Deductibles, Co-insurance and Co-payments)

Patient expenses are amounts that are the patient's responsibility to pay to the provider in accordance with the patient's benefit contract. The most common patient expenses are:

- **Co-payments** – Amount payable by the patient stated as an amount per visit.
- **Deductible** – Amount required to be paid by the patient each year prior to any coverage by the Plan. Only those approved services at the applicable fee schedule will apply towards the patient's deductible.
- **Co-insurance** – Patient responsibility that is outlined in the patient's certificate of coverage (COC). The patient's responsibility will be detailed in the provider RA.
- **Benefit Limits** – Limits on the amount of benefit that will be paid. These limits are stated as a maximum number of visits per day/year or a maximum dollar amount per day/year. After a patient has reached their limit, the patient becomes financially responsible for the care provided.

Other situations for which a Patient can be billed

Beyond the patient expenses detailed above, there are three situations where an Optum provider may bill a patient:

1. If the patient does not have coverage or the coverage was not effective on the date of the service; or
2. For services not covered or excluded by a patient's Plan (as defined by the patient's Benefit Contract), as long as the patient has been informed of the noncovered services and has given written consent/acknowledgement prior to receiving the services; or
3. In those instances when maintenance/elective/custodial care is an exclusion per the patient's Benefit Contract, maintenance care/elective services may be billed as long as the patient has been informed of the maintenance/elective/custodial services and has given written consent/acknowledgement prior to receiving the services.

To be of an acceptable nature, the written acknowledgement must:

- Include acknowledgement of lack of coverage; and
- Include agreement to pay for the services; and
- Specify service types and dates; and
- Be signed and dated, prior to delivery of the service.

A sample form called the "Patient Billing Acknowledgement Form Non-Covered Services" ** can be used to obtain this acknowledgement and is available online at myoptumhealthphysicalhealth.com.

**Not for use in New Jersey

Situations for which a Patient cannot be billed

The patient may not be billed in the following situations:

1. When non-covered services or maintenance/elective/custodial care has been provided to a patient for whom there is no evidence of informed, written consent prior to rendering of the services
2. For services that are determined by the provider, Optum or Payer to be inappropriate or ineffective
3. When information required of the provider relative to Covered Services has not been supplied to Optum via the Clinical Submission process within the required timeframes
4. When the service has been denied payment for failure to follow the administrative procedures of Optum, Plan, or Payer

Fraud and Abuse

Fraudulent and abusive practices result in significant additional health care costs. It is in the best interest of all to identify and eliminate these practices. Allegations of fraud are treated seriously by Optum and will be aggressively investigated. Suspected instances of fraud or abuse against Optum can be reported by contacting the Optum Compliance Department.

Fraud	Abuse
<p>Intentional deception or misrepresentation that the individual knows to be untrue, knowing that the deception results in benefit to themselves or some other person. Fraud may take many forms, some examples of which are:</p> <ul style="list-style-type: none"> • Billing for services not provided • Misrepresenting services or the diagnosis to justify the services/equipment provided • Altering a claim or PSF to obtain a higher level of reimbursement • Soliciting, offering or receiving a kickback or bribe 	<p>Incidents or practices that are inconsistent with accepted sound medical practices, resulting in unnecessary costs, improper payment for services not meeting professionally recognized standards of care, or services that are medically unnecessary. Abusive practices include:</p> <ul style="list-style-type: none"> • Excessive charges • Medically unnecessary services • Improper billing practices • Unbundling of services

Public Sector Specific Requirement

The CMS annual compliance training requirement related to fraud, waste, and abuse awareness applies to all organizations that provide health care or administrative services for Medicare-eligible individuals under the Medicare Advantage program. If your organization provides these services, your organization will need to complete the required compliance training annually.

Providers are responsible for administering and tracking their organization's completion of this training. All employees within your organization who provide health care or administrative services for a Medicare-eligible individual under a Medicare Advantage program must participate in the training. You may choose how to monitor your employees' completion of the training. For your convenience, we have provided a sample training log within the training materials for individuals to sign after completion. Tracking of training must be maintained for 10 years and made available to Optum, CMS or agents of CMS upon request to verify the training occurred.

To access the fraud, waste, and abuse training visit us online at myoptumhealthphysicalhealth.com. Please select the last option "CMS Fraud, Waste & Abuse Provider Training" under the "Tools & Resources" menu.

Provider Obligations

Credentialing and Recredentialing

Credentialing is a process of verification of training, experience, licensure, and subsequent review of the information gathered to assess the provider's ability and qualifications for providing quality care to the members of Optum clients. Optum operates its credentialing program in accordance with the National Committee for Quality Assurance (NCQA) and any applicable federal or state regulatory standards. The provider must complete the credentialing process and receive an effective participation date before being considered a participating network provider.

Applicants that are denied participation will receive a letter of denial stating the reason for denial. Denied applicants may be given the right to appeal. In order to be considered, all appeals must be received by Optum within 30 days of the date of the denial notice. Certain states have conferred additional appeal rights; such rights will be conveyed to the provider in the letter of denial. Appeal requests will be reviewed by a Credentialing Appeals Committee comprised of separate and distinct membership from the committee that made the initial decision. If a provider is denied, they must wait 24 months to reapply to the network.

Recredentialing in the majority of states is completed every 36 months per NCQA standards. Recredentialing may be performed more frequently depending on state law or client requirements. The process includes re-verification, review, and approval by the Optum Credentialing Risk Management (CRM) Committee. To initiate the process, the provider will receive notification that they must complete the recredentialing process. Recredentialing includes review of:

- Malpractice (professional liability) insurance coverage and associated claims
- License to ensure continued unencumbered (free from restriction and/or probation) licensure
- Sanctions
- Provider performance such as complaints
- Information included in the application

Upon completion of the preliminary review and credentials verification, the file will be presented to the Optum CRM Committee. Committee members withdraw from any matter involving a close personal or professional association with a reviewed applicant; or when the member is in professional competition in the community of the reviewed applicant.

Participating providers who successfully pass the recredentialing process will receive a letter of acknowledgement of successful recredentialing.

If the provider fails to return the application, does not provide necessary information, or does not respond to requests for information, the provider's participation will be terminated. If reconsideration of this termination for failure to complete the application process is desired, the provider will have 30 days from the date of the termination notice to submit all missing documentation. If the application is denied or participation is terminated by the CRM Committee, the provider has 30 days from the date of the termination notice to submit a written request for an appeal. Failure to submit an appeal request within the 30-day time period will constitute waiver of the right to an appeal, unless state regulations mandate a different time frame. If state regulations mandate a different time frame, Optum will abide by the state law. The termination is final if the 30-day time period has passed and no written request for appeal has been received.

During the credentialing/recredentialing process, Optum may contact the provider for additional information.

The Provider has the right to:

- Review information submitted to support their credentialing/recredentialing application
This may include information obtained from such outside primary sources such as malpractice carriers, state licensing boards, and/or other outside agencies. This does not apply to information that is peer-reviewed, protected or restricted by law.
- Correct erroneous information
- Be informed of the status of their application, upon request, by calling the Optum Provider Service Department at 800-873-4575. In response, Optum will provide status information by phone.

For inclusion as an Optum participating provider, and to maintain good standing, the provider must meet the requirements stated below.

<p>Licensure: Provider’s license shall not have been previously revoked. The license must not be encumbered or restricted and the provider must not have any pending actions against them, or their office, by any Board of Examiners/Licensing Board or other local, state, or federal authority.</p>
<p>Criminal Activity: Provider must not have been convicted of any crime within the last five years that affects his/her ability to practice. The provider must never have been convicted of sexual misconduct by any local, state, or federal authority, including but not limited to, a Board of Examiners/Licensing Board.</p>
<p>Disciplinary Actions: Provider must not currently, or previously been prohibited or restricted in any way from participating in Medicaid, Medicare, or any other local, state, and federal government-sponsored programs. With each credentialing or recredentialing application, the health care provider must disclose knowledge, and/or information of any pending investigation of themselves, their clinic or practice, by any state board of examiners or any federal, state, or local authority. The provider must disclose denial of any membership, or renewal, or disciplinary actions or reprimand by any state board, administrative agency, peer review committee, professional association, health care organization, insurance carrier, third party administrator, or any other type of health care organization. The provider does not and must not have engaged in any conduct involving dishonesty, fraud, deceit, or misrepresentation.</p>
<p>Chemical Abuse: Providers must certify that they do not have an active problem with drugs and/or alcohol. Rehabilitated providers must provide reasonable documentation that they have been drug and/or alcohol free for the past 12 months. Conditional acceptance may be granted that will include the condition that discovery of an incident after acceptance will result in immediate network termination and permanent network ineligibility. Providers applying for initial network participation or recredentialing will use this requirement as a baseline. Optum maintains the right to immediately terminate a Provider’s participation upon substantiating noncompliance with the Optum policy regarding drugs and/or alcohol.</p>
<p>Patient Safety: Provider must not have any current medical or physical condition likely to adversely affect the functions essential to his/her profession or constitute a direct threat to the health and/or safety of others. Written description of relevant accommodations must be submitted to Optum. Any such occurrences or condition may result in failure to credential or termination if accommodations cannot reasonably ensure patient safety.</p>
<p>Professionalism: The provider must exhibit a professional approach when communicating with patients, Optum staff, or Plan staff. Repetitive occurrences of inappropriate interactions may result in termination.</p>
<p>Procedural Compliance: The provider, and the provider’s staff, is expected to use good faith efforts to comply with the procedures defined in the Provider Operations Manual, Plan Summaries, other communications of Optum, and procedures of the Plan or the Payer. Continued disregard for these procedures may result in termination.</p>

Office Operation Expectations

Code of Conduct

Optum identifies 5 core values which are reflected in the Code of Conduct and include: Integrity, Compassion, Relationships, Innovation and Performance. These values describe the kind of behaviors expected by our employees and the people we serve, including our Participating Providers and their staff members.

As a Participating Provider with Optum, you acknowledge that you understand and will abide by the Code of Conduct. This includes maintaining professionalism with all interpersonal communication including but not limited to, cell phone messages, text messages, social media posts, emails, peer-to-peer discussions, patient interactions, faxes and refraining from the use of profanity, intimidation, threats of physical harm, harassment or disparaging or offensive comments. Providers who violate these standards may face consequences for their actions including referral to Optum’s Credentialing Risk Management committee for action up to and including termination from the network.

Patient Confidentiality & Privacy

Maintaining appropriate confidentiality and privacy of your patient's health information is not only a moral and ethical obligation of each provider; it is also a legal one. Each provider must comply with all pertinent Health Insurance Portability & Accountability Act (HIPAA) privacy rules and other obligations conferred upon them by federal and state agencies. This includes an obligation to protect written records, electronic data, and privacy in the physical setting. The physical setting must include appropriate division to allow privacy during examination, consultation, and treatment. The office must be handicapped accessible with an adequate well-lit waiting room, be clean and follow safety standards. The waiting room must include at least one seat per average number of routine appointments scheduled per hour per practitioner. In an area where multiple patient-staff communications routinely occur (i.e., open-bay setting), the use of cubicles, dividers, shields, curtains, or similar barriers may constitute a reasonable privacy safeguard.

Patient Complaints

If a complaint of any type is received from a health plan member, the provider will notify Optum of the nature of such complaint and the resolution that was reached. Provider cooperation in the investigation of any complaint is expected, including provision of any necessary records or participation in conversation necessary to determine an appropriate resolution. If records are requested, the provider will use best efforts to comply with the request within five days. In the event of a complaint by a patient, the provider must continue to maintain an appropriate professional relationship with the patient.

Managing Patient Expectations

We encourage providers to educate their patients about what to expect when they present for treatment. A clear explanation of diagnosis, prognosis, treatment plan, and the expected length and course of treatment is vital to setting clear expectations for the patient. It is also helpful to explain to patients that the treatment will be focused on their presenting problems and/or symptoms and that various aspects of the therapy can be performed as self-care outside of the provider's office. Providers are encouraged to advise patients that treatment will typically terminate when the patient has returned to pre-injury status or has regained the maximum amount of function that can be attained from the current method of treatment.

Advertising

Advertising that is deceptive or misleading is prohibited. Advertisements claiming symptom improvement must be substantiated by recognized literature. Telephone solicitation is considered inappropriate and should not occur. Advertising should clearly represent your title and should only include credentials, special training and certifications that have been recognized by the state licensing board. Advertising must not offer to waive patient expenses.

It is important to note that the CMS has additional requirements specific to marketing materials for public sector programs. Please visit the CMS Web site at cms.hhs.gov or contact the Optum Provider Service Department at 800-873-4575.

Referral of Patient to Other Providers

If a patient requires services that are not provided within your office, you should refer the patient to their Primary Care Physician, or other participating health professional, or facility in accordance with the terms and conditions of the patient's Plan. The clinical file should include documentation of communication with the patient and other providers about the referral.

Availability of Provider

Patients must be able to access care for urgent services within 24 hours from the time of the request for an appointment. The provider should return all urgent calls from patients within 30 minutes. In addition, patients should be able to access care for non-urgent services within 10 business days from the time of the request for an appointment. If the provider is unavailable, instructions must be provided for patients via a 24-hour telephone answering machine or service that:

- Refers them to dial their pager number if such a service is available
- Refers them to another participating provider or their medical Plan for non-emergency conditions
- Refers them to dial 911 for life-threatening or emergency situations

Once a patient reports to your office for his/her appointment, the wait time should not exceed 30 minutes.

Certain public sector programs may require levels of provider availability other than what is described above. These requirements will be outlined within the Provider Agreement and/or Plan Summary, and supersede the information above.

When a provider is going to be on vacation, or otherwise unavailable, the provider is responsible for making arrangements for coverage. Coverage must be provided by an Optum participating provider eligible to treat patients of affected Plans. Please be aware that:

- Clinical submissions during the period of absence must be submitted with the covering provider listed as the treating provider with a comment indicating "on behalf of [absent provider's name]."
- Treatment plans that were in effect prior to the first date of temporary coverage can be utilized by the covering provider as long as the claims are submitted with the absent provider's tax identification number (TIN) and the absent provider's name in Box 31 of the CMS 1500 form. These claims will be paid using the absent provider's TIN, who will be responsible for financial remuneration to the covering provider. Any claims or clinical submissions submitted with the covering provider's name at the absent provider's location will be denied unless the covering provider normally practices at that location.
- If the covering provider renders services in his/her own office and would like to submit claims with his/her TIN (already on file with Optum), the covering provider must submit new clinical information for the patients being seen. This applies even if a clinical submission had already been made under the absent provider.

Urgent Care

Providers may request a visit on an urgent basis if the Department of Labor urgent care definition is met. Care may qualify as urgent if the application of the time period for making a non-urgent care determination could seriously jeopardize the life or health of the patient or the ability of the patient to regain maximum function. A determination for urgent care will be issued within 24 hours of Optum receiving all required information.

During Optum business hours providers may reference the phone number in the applicable Plan Summary. Providers may call 877-271-6809 during non Optum business hours to initiate a request for urgent care.

During Optum business hours California providers may contact their assigned support clinician at 800-428-6337. California providers may call 800-428-6337 during non Optum business hours and follow the instructions provided in the message.

Health Plan has established the following standards to ensure Members are able to obtain treatment in a timely manner.

California Only: Timely Access to Care

Health Plan ensures that Members, during normal business hours, can speak to a customer service representative and will not have a waiting time that exceeds ten (10) minutes. Members may also have Health Plan's standards for access to care from the time of the request of an appointment from a member are as follows:

Type of Visit	Description	Wait Time
Urgent/Expedited Care	An urgent case is one that involves an imminent and serious threat to the health of the patient, including, but not limited to, severe pain, potential loss of life and/or limb or major bodily function, or lack of timeliness would be detrimental to the member's ability to regain maximum function.	Members/patients must be offered an appointment within 24 hours of the request for appointment.
Routine (Non-Urgent)	Care provided to a patient that is not defined as urgent/expedited care.	Members/patients must be offered an appointment within 10 business days of the request for appointment. (**Refer to rescheduling of appointments below)

Type of Visit	Description	Wait Time
Routine Office Visit Wait Time	In-office wait time	Not to exceed 30 minutes
Plan Customer Service Calls	Inquiries to the plan's customer service phone lines.	Not to exceed 10 minutes
After-Hours Answering System and Messaging	Messaging must include instructions for obtaining emergency care.	Immediate
Network Provider Availability	To the extent feasible, all member/patients shall have a residence or workplace within 30 minutes or 15 miles of a contracting provider. For rural areas, to the extent feasible, all member/patients shall have a residence or workplace within 60 minutes or 60 miles of a contracting provider.	Within urgent/non-urgent appointment standards

Note: The time for a routine appointment may be extended if it is determined¹ and documented that a longer waiting time will not have a detrimental impact on the member's health.

****Rescheduling of appointments:** When it is necessary for a Provider or a Member to reschedule an appointment, the appointment shall be promptly rescheduled in a timely manner appropriate for the nature of the Member's condition and/or health care needs, and ensures continuity of care consistent with good professional care with no detriment to the member. More stringent time frames required by applicable law should apply.

Interpreter services are available to Members at the time of the appointment, as requested by the member or provider. To request interpreter services contact Health Plan at 1-800-428-6337. Language interpretation services are available at no cost to the member

If a patient/member is unable to obtain a timely referral to an appropriate provider, the provider or member/patient can contact Optum at 1-800-428-6337 to obtain assistance or may contact the DMHC Health Plan Help Center at 1-888-466-2219 to file a complaint.

¹An extension to the time for a routine appointment may be determined by the referring or treating licensed health care provider, or the health professional providing triage or screening services, as applicable, acting within the scope of his or her practice and is consistent with professionally recognized standards of practice..

Facility and Practice Hours

The office must employ at least the equivalent of one full-time qualified and trained individual to administer the office. Operation of a home office requires a waiting room and treatment area that is separate from the home. Health club/gym offices must have their own entrance, waiting, file, treatment, and examination rooms.

Chiropractic providers must be available to render services in each of their facilities a minimum of 12 hours per week over a minimum of three separate days each week (i.e., if a provider has two approved offices, he/she must practice a minimum of 12 hours per week and see patients on three days per week at each facility).

Physical therapy providers must be available to render services in each of their facilities and the facility must be available to render services to patients a minimum of 35 hours per week and be open at least three days per week.

An exception to the minimum practice hours may be made in certain circumstances by written request.

Participating Provider Status

The Optum Provider Agreement does not extend to other providers in the office, unless otherwise stated in the Optum Provider Agreement. A participating provider may not allow another provider to treat under the terms of the Provider's Agreement. Additionally, if the office includes providers that are not participating providers, the participating provider has the obligation to inform incoming patients of the non-participation status of such other providers.

If the provider intends to add additional clinical staff to the practice, be aware that the credentialing process may take two to four months, depending upon the completeness of the application and the response time of the malpractice carrier and/or licensing agencies. Providers should contact us for an application and begin the process immediately upon considering expansion of the practice.

Insurance Coverage

To maintain continued participation with Optum, each office must be covered by at least \$250,000/\$500,000 general liability insurance and each individual provider must maintain malpractice coverage of at least \$100,000/\$300,000 or as indicated in each Plan Summary to maintain participation in each Plan.

Notices & Information Updates

Changes in Demographic Information & Office Relocation

A Participating Provider or an entity delegated to conduct credentialing activities on behalf of Optum is expected to review and update provider records on a regular basis and attest on a quarterly basis to the information, listed below, available to members. If the Participating Provider or delegated entity cannot attest to the information, they must supply corrections to Optum by submitting such changes per the Provider Status Change instructions below. A Participating Provider or delegated entity must notify Optum of changes in writing, including but limited to, the below information, within 30 days of the change. Delegated entities are responsible for notifying Optum of these changes for all of the participating providers credentialed by the delegate. In addition, Participating Providers must respond to requests for provider data validation within 30 days, if requested by Optum.

In California, Optum is required to conduct annual and/or semi-annual outreaches to confirm your information on file is accurate.

Failure to comply with this section may result in being placed on unavailability status or termination.

- the address(es) of the office locations where the participating provider currently practices
- the phone number(s) of the office locations where the participating provider currently practices
- the email address of the participating provider
- if the participating provider is still affiliated with listed provider groups,
- the specialty of the participating provider,
- the license(s) of the participating provider,
- the NPI(s) of the participating provider,
- the provider's name
- the clinic name/affiliation
- federal Tax Payer Identification (TIN),
- the telephone number,
- the office hours
- the provider is accepting new patients
- provider languages (California only)

Provider Status Change

Submit demographic changes (including relocation and TIN changes) to one of the following:

Web

www.myoptumhealthphysicalhealth.com Log on, click on "Tools and Resources" and then "Forms."

Fax

888-626-1701

Mail

Optum Provider Data Mgmt.
PO Box 1459
MN103-0700
Minneapolis, MN 55440-1459

When moving to a new location or opening an additional office, a review will occur to determine if it can be included as an approved location. The request for a review of a new location must be provided in writing at least 30 days in advance. The review will include:

- Determination of whether the minimum practice hours will be maintained
- Adequacy of the facility and equipment
- Necessity of an additional location in that area for each particular Plan network

Optum reserves the right to exclude any new or additional office location from participation in Optum or a Plan's network. Failure to provide the required advance notice may result in treatment of the location as a non-participating location until appropriate approval has occurred. Claims payment may be denied for locations that have not been credentialed and approved.

In accordance with CMS regulations, Optum may contact providers monthly to validate key provider information. It is important that Participating Providers return all correspondence, in a timely manner, related to these update requests. Failure to do so may result in being placed on unavailability status or termination.

Other Required Notices

Certain events create an obligation upon the provider to provide us with a notice of the event. Review the chart below to become familiar with these obligations.

Notify Optum within 10 days of knowledge of the following:
Action which may result in or the actual termination, suspension, restriction, stipulation, limitation, disciplinary or corrective action, or investigation by governmental agencies or otherwise involving the provider's license, certifications, and/or privileges at any health care facility
Changes in insurance carriers, termination of, or other material changes in liability insurance
Indictment, arrest or conviction for a felony or for any criminal charge related to the provider practice or profession
Claims or legal actions for professional negligence or bankruptcy
If the provider is aware of situations that may impact the care and/or safety of the patient or continuity of care of any patient, including, but not limited to, a provider's health status
Any occurrence or condition that might materially impair the ability of provider to discharge their duties or obligations under this Agreement
Termination, for cause, from a provider network offered by a Plan

CALIFORNIA: Notify Optum within 5 days of the following:
If you are no longer accepting new patients or, alternatively, if you were previously not accepting new patients and are now open to new patients.
If you are not accepting new patients and contacted by a new patient, you must direct the patient back to Optum to find a provider AND you must contact the Department of Managed Health Care at 1-888-466-2219 , to report a directory inaccuracy.

Medical Records

Proper and complete documentation in the patient's medical record is critical. Without adequate documentation, the provider will not be able to support the level of service that is being requested or billed. Providers must obtain the following information and maintain documents as outlined below:

- Each page in the file must contain either the patient's name or the patient's ID number.
- File entries must be dated and contain the author identification. The author identification can be stamped, hand written, or electronically written.
- Files must be organized and legible to those other than the author.
- Adverse reactions, history of adverse reactions, and/or contraindications to care must be clearly noted in the file i.e., pregnant, strokes, history of clots, use of blood thinners, etc.
- Working diagnosis/clinical impressions must be documented and consistent with the findings.
- Treatment plans must be documented and correlate with the patient's history and examination findings.

- A patient's health history must be present in the record.
- A problem list must be in the record.
- Results of procedures, tests, and treatment are to be noted in the record. Results of any diagnostic/radiological study must be recorded in the patient's file.
- Daily notes are required in accordance with your professional association and state guidelines.
- An expected time for return visit or follow up plan for each encounter should be in the record. This can be noted by a return visit date following each entry in the daily record or treatment plan initiated with the onset of care. No-show and recall efforts should be documented in the file. Discharge record must include reason given with patient's health status.
- Records must be stored in such a way that they are not easily accessible to unauthorized users.

If Optum, a federal or state agency, or other authorized organization requests medical records, x-rays, or other documents, the provider must comply with this request as soon as possible, but no later than 14 days from the request. If you have any concerns regarding a specific request, contact the Optum Provider Service Department at 800-873-4575 for more information.

Optum Audit and Recovery Unit may request medical records for the purpose of verifying paid services. It is the responsibility of participating providers to comply with this request and submit requested records within the time specified in the request. Failure to comply with these requests may result in actions to recover payments for services rendered for those cases during the period for which the records are requested.

Termination of Participation

Resignation

If a provider is retiring or desires to resign from Optum, please provide advance notice in accordance with the terms of the Optum Provider Agreement.

Obligations upon termination

In the event of termination, regardless of which party initiated the termination, the provider must continue to provide services to existing patients during the termination notification period (period from receipt of termination notice until termination date). This requirement exists unless specifically removed in the Optum notice of termination. Existing patients must be notified of the impending non-participation prior to the date of termination. The provider must clearly communicate to new patients the date upon which the provider will no longer be participating. These provisions allow the patient to make an informed decision regarding future care and associated financial implications.

Dispute resolution process

If a provider's participation is terminated from Optum, the provider has appeal rights.

If an appeal is desired, the provider will have 30 days from the date of the termination notice to submit a written request for review. Failure to submit an appeal request within the 30-day time period will constitute waiver of the right to an appeal, unless state regulations mandate a different time frame. If state regulations mandate a different time frame, Optum will abide by the state law. The termination is final if the 30-day time period has passed and no written request for appeal has been received from the provider.

If state requirements specify a second level of appeal, the provider has 30 days from the date of the first appeal determination notice to submit a written request for another review. Failure to submit a second appeal request within the 30-day time period will constitute waiver of the right to the appeal, unless state regulations mandate a different time frame. If state regulations mandate a different time frame, Optum will abide by the state law. The termination is final if the 30-day time period has passed and no written request for appeal has been received from the provider. No other appeals are accepted after the final appeal decision has been made.

If an appeal is requested, the written request should include any statement or additional information the provider deems relevant to the termination. Such information should be limited to the reason for the termination as stated by Optum in the termination notice. The provider has the right to be represented by an attorney or another person of their choice during the appeals process.

**Federal Consolidated Appropriations Act (CAA)
for Continuity of Care (COC) regulations**

Continuity of care

Health insurance issuers, plan sponsors and/or care providers are required to comply with the continuity of care requirements under the CAA unless your participation agreement states otherwise.

Continuity of care is provided in the following circumstances:

1. Your participation agreement with us, or between you and a downstream provider is terminated by us, a payer, you, or a downstream provider.
2. The terms of your network participation with us or a payer changed, and that change leads to certain members no longer receiving in-network coverage for your care.
3. A fully insured group contract between us and a group health plan is terminated, and that termination leads to members no longer receiving in-network coverage for your care.

Under the CAA, continuity of care must be offered to members in your care or the care of your downstream contracted providers who are:

1. Undergoing treatment for a serious and complex medical condition.
2. Undergoing inpatient or institutional treatment.
3. Scheduled to undergo nonelective surgery, including receipt of postoperative care with respect to such a surgery.
4. Pregnant and receiving treatment related to the pregnancy.
5. Terminally ill per the Social Security Act and are receiving treatment for the terminal illness.

In accordance with the CAA, you must accept payment from us, or a payer based on your participation agreement and negotiated rates for any services rendered pursuant to the continuity of care requirements under the CAA. Any care you render to a member under continuity of care is subject to Insurance coverage provided by or through UnitedHealthcare Insurance Company or its affiliates. Health plan coverage provided by our or any payer's applicable policies, procedures, and quality standards. You also acknowledge additional rights for continuity of care may be required under state or local law or as specifically required in your participation agreement with us.

OptumHealth™ Physical Health of California (Optum)

California Language Assistance Program Information and Requirements

What is required of Contracted Providers?

- Offer free interpretation services to patients with Limited English Proficiency, even when the patient is accompanied by a family member or friend who can interpret, or if the provider can speak in the patient's language.
- Document the acceptance or refusal of interpreter services in the patient's treatment record.
- Post a notice in the waiting room/facility regarding the availability of language assistance. This notice is available in the Optum Provider Operations Manual, on our provider Web site, or upon request by calling Optum Customer Service at 800-428-6337.
- Make the Department of Managed Health Care (DMHC) grievance process and Independent Medical Review (IMR) application and instructions available to patients upon request. Providers may access the DMHC grievance instructions and IMR application on the Department's Web site at www.dmhc.ca.gov in over 10 languages. The IMR application and instructions are available from the Plan in the threshold languages of Spanish and Chinese on our provider Web site or upon request by calling Optum Customer Service at 800-428-6337.
- Obtain the pre-translated versions of the grievance form in each threshold language as well as the English version, accompanied by the notice of availability of language assistance. You may also contact us to obtain a paper copy for the patient on our Provider Web site or by calling Optum Customer Service at 800-428-6337.
- If language assistance is required, contact Optum Customer Service at 800-428-6337. You will then be connected with Language Line Services, where certified interpreters are available to provide telephonic interpretation services, free of charge to you and the patient.

Optum will monitor provider compliance with the language assistance program, as required by the regulations, through treatment record reviews.

We will continue to post educational and resource links at myoptumhealthphysicalhealth.com to assist you in working with diverse populations and patients with language assistance needs so be sure to keep an eye on the site for new information.

Member Grievances

A subscriber, enrollee, or an agent acting on his or her behalf may request voluntary mediation with the Plan prior to exercising the right to submit a grievance to the DMHC. Grievances may be submitted orally or in writing by an enrollee or member. The Plan shall not discriminate against an enrollee or member solely on grounds that the enrollee filed a grievance. Complaint forms and a copy of the grievance procedures shall be readily available at each service location. Any person requesting a complaint form will be forwarded the Optum Member Complaint Form ("Complaint Form") within one (1) business day of receipt of the request. At each grievance location, the Plan shall provide assistance in the filing of any grievance. A "patient advocate" or ombudsperson may be used.

A. Oral Grievances

- 1) Oral grievances being voiced by current or former members of contracting health plans or their representatives will be received and recorded by Plan staff. Members may file grievances by calling the Plan's toll-free number(s). Every attempt will be made to resolve the oral grievance at the time the information is received and ensure the member is accommodated.
- 2) The staff person receiving the oral grievance shall complete the Complaint Form using the Plan's Complaint Information Guidelines. The completed Complaint Form shall be routed immediately to the Grievance Coordinator, investigated, resolved, and reported according to Sections C through F.

B. Written Grievances

Grievances received in writing shall be routed immediately to the Grievance Coordinator. The Grievance Coordinator is responsible for obtaining any missing information. The Grievance Coordinator will enter all grievance information on the electronic Complaint Form.

C. All Grievances

- 1) The Grievance Coordinator will date-stamp receipt of the grievance, make a hard file complaint record, enter the information on the complaint log, assign a reference number, and investigate the grievance using the Plan's Complaint Investigation Guidelines. A formal complaint or an appeal may be submitted, for a denial of a service or denied claims within 180 calendar days of receipt of an initial determination through our Appeals, Complaints, and Grievances Department.
- 2) If the grievance pertains to a
 - a) Quality of Service issue, it may be investigated and resolved by the Grievance Coordinator in collaboration with any other involved departments according to the Complaint Investigation Guidelines.
 - b) Quality of Care issue and is routine, the Grievance Coordinator has up to three (3) business days to transfer the information to the Medical Director. The Medical Director or his/her licensed clinical designee will investigate the grievance. The Medical Director or his/her licensed clinical designee will record the findings of the investigation and the actions taken on the electronic Complaint Form and notify the Grievance Coordinator, who will make the appropriate entries on the Complaint Log.
 - c) Quality of Care issue and is urgent, the receiving staff member will immediately refer the grievance to the Grievance Coordinator, who will initiate the Expedited Review process. (Refer to Section D, Expedited Review of Grievances).
- 3) Peer Review Process for Quality of Care Complaints. The Plan will initiate peer review for any Quality of Care grievances that are determined to have the potential of being life threatening to the health, safety or well-being of the member. In addition, the Plan, at its discretion, may refer any other grievance for peer review. The peer review body will provide recommendations to the Credentialing Subcommittee regarding action(s) to be taken against network providers.
 - a) Network providers will conduct peer review in a meeting that covers only peer review items.
 - b) In accordance with California Health and Safety Code, Section 1370, and California Evidence Code, Section 1157, neither the proceedings nor the records of the Plan or Plan providers of quality of care or UR by the peer review committee shall be subject to discovery.

4) Grievance Acknowledgment. The Grievance Coordinator shall acknowledge receipt of the grievance in writing for urgent issues on the day of receipt and all routine grievances within five calendar days of receipt. These deadlines do not apply to grievances that are received by telephone, by facsimile, or by e-mail; that are not coverage disputes, disputed health care services involving medical necessity, or experimental or investigational treatment; and that are resolved by the next business day.

a) The member's medical condition shall be considered when determining the response time.

b) The Plan's grievance acknowledgment letter to a member must inform the member of the following items specifically related to the grievance process:

- i. The date that the Plan received the grievance
- ii. His/her rights to file a grievance with the Plan or with his/her full service health plan in accordance with the Benefit Plan
- iii. How to contact the Plan regarding a grievance
- iv. The name and direct telephone number of the Plan staff person handling the grievance
- v. His/her right to request that the DMHC review the Plan's determination following completion of the Plan's grievance process.
- vi. The DMHC required statement concerning grievances in type size and style identified in Health and Safety Code, Section 1368.02(b), including a statement regarding eligibility for Independent Medical Review (IMR).
- vii. The DMHC toll-free consumer telephone number
- viii. The DMHC TDD line for the hearing and speech impaired
- ix. The DMHC Internet address

5) Grievance Resolution Notification. The Grievance Coordinator shall provide a written statement on the disposition or pending status of any grievance except for grievances that are received by telephone, by facsimile, or by e-mail; that are not coverage disputes, disputed health care services necessity, or experimental or investigational treatment; and that are resolved by the next business day.

a) The written response shall contain a clear and concise explanation of the Plan's decision and shall include the following:

- i. His/her rights to file a grievance with the Plan or with his/her full service health plan in accordance with the Benefit Plan
- ii. How to contact the Plan regarding a grievance
- iii. The name and direct telephone number of the Plan staff person handling the grievance
- iv. His/her rights to and eligibility for the IMR process designated by the DMHC, including an IMR application, instructions and DMHC addressed envelope
- v. His/her right to request review by the DMHC of the Plan's determinations following completion of the Plan's grievance complaint process
- vi. The DMHC required statement concerning grievances in type size and style identified in the Health and Safety Code, Section 1368.02(b)
- vii. The DMHC toll-free consumer telephone number
- viii. The DMHC TDD line for the hearing and speech impaired
- ix. The DMHC Internet address
- x. For all grievances involving the delay, denial, or modification of services for whatever reason, including medical necessity, the Plan's response shall describe all criteria used and the clinical reasons for its decision, including all criteria and clinical reasons related to medical necessity.

- xi. If the Plan or one of its contracting providers issues a decision delaying, denying, or modifying health care services based in whole or in part on a finding that the proposed health care services are not a covered benefit under a contract that applies to the enrollee, the Plan decision shall clearly specify the provisions in the contract that exclude that coverage.

b) The timelines for response are as follows:

- i. For an urgent grievance in which medical/clinical services are underway, notify the complainant and the DMHC within 24 hours of the Plan's receipt of the grievance.
- ii. For all other urgent grievances, notify the complainant and the DMHC within three calendar days of the Plan's receipt of the grievance.
- iii. For routine grievances, notify the complainant within five calendar days of the Plan's receipt of the grievance.

D. Expedited Review of Grievances

When urgent grievances are received, the Plan shall initiate the Expedited Review process.

Urgent grievances may be received from any complainant or from the DMHC.

1) Upon receipt of a request for Expedited Review of a grievance, the Grievance Coordinator shall:

- a)** Respond to the complainant on the day of receipt of the urgent grievance.
- b)** Immediately inform the complainant of his/her right to notify the DMHC regarding the urgent grievance (Health and Safety Code Section 1368.01(b)).
- c)** Review the grievance with the Medical Director and determine an appropriate plan of action and investigation. The Medical Director or his/her licensed clinical designee will investigate the grievance. The Medical Director or his/her licensed clinical designee will record the findings of the investigation and the actions taken on the electronic complaint form and notify the Grievance Coordinator, who will make the appropriate entries on the Complaint Log.
- d)** Provide the Complainant and the DMHC with a written statement on the disposition or pending status of the urgent grievance within three calendar days of receipt of the grievance.

2) Request for Expedited Review of urgent grievances may also come from the DMHC. Plan staff shall be available 24 hours a day, seven days a week, to receive contacts by the DMHC regarding urgent grievances. Designated Plan staff shall be available with the financial authority to act on the Plan's behalf to resolve urgent grievances and authorize the provision of covered health care services. Staff so designated includes, but may not be limited to, the Medical Director and the Grievance Coordinator (see attached list). These members may consult with other Plan staff, as appropriate in order to reach a determination.

- a)** During normal business hours, the Grievance Coordinator will contact the DMHC within 30 minutes following DMHC contacts regarding urgent grievances.
- b)** After normal hours, on weekends, or holidays, Plan weekend/after hours staff who are either available on site or by pager will contact the DMHC within one hour following DMHC contact regarding an urgent grievance.
- c)** Provide the complainant and the DMHC with a written statement on the disposition or pending status of the urgent grievance within three calendar days of receipt of the grievance, except for those urgent grievances in which the medical/clinical services are underway, in which case the written statement shall be provided within 24 hours.

E. Grievance Procedures for Terminally Ill Enrollees

- 1) If coverage is denied to an enrollee with a terminal illness, which refers to an incurable or irreversible condition that has a high probability of causing death within one year or less, for treatment, services, or supplies deemed experimental, as recommended by a participating plan provider, the Plan shall provide to the enrollee within five business days all of the following information:
 - a) A statement setting forth the specific medical and scientific reasons for denying coverage.
 - b) A description of alternative treatment, services, or supplies covered by the Plan, if any.
 - c) Copies of the Plan's grievance procedures, complaint form, or both. The complaint form shall provide an opportunity for the enrollee to request a conference.
- 2) Within 30 calendar days of receiving a complaint form requesting a conference, the Plan shall provide the enrollee an opportunity to attend a conference to review the information provided to the enrollee. The conference shall be conducted by a Plan representative having authority to determine the disposition of the complaint. The Plan shall allow attendance, in person, at the conference of an enrollee, a designee of the enrollee, or both or, if the enrollee is a minor or incompetent, the parent, guardian, or conservator of the enrollee, as appropriate. The conference shall be held within five business days if the treating participating provider determines, after consultation with the Plan's medical director or his or her designee, based on standards of practice in the organized provider community, that the effectiveness of either the proposed treatment, services, or supplies or any alternative treatment, services, or supplies or any alternative treatment, services, or supplies covered by the Plan, would be materially reduced if not provided at the earliest possible date.

F. Appeal of Denied Benefits of Claims Payment

The Plan's notification letter to a member denying benefits or claims payment must inform the member of his/her appeal rights and how to contact the Plan to file an appeal. The letter must also include the DMHC's required statement concerning grievances and the DMHC's toll-free telephone number, the DMHC's TDD line for the hearing and speech impaired, and the DMHC's Internet address.

Complaint forms and a copy of the grievance procedures shall be readily available at each service location. Any person requesting a complaint form will be forwarded the Optum Member Complaint Form ("Complaint Form") within one business day of receipt of the request. If a member requests, you must provide assistance in the filing of a grievance.

DMHC Independent Medical Review

After completing the Optum appeals/grievance process, the member may seek a review by the DMHC. If you are assisting a member in a grievance, you may call the DMHC complaint line at 888-466-2219.

A. Independent Medical Review

In cases involving the delay, denial, or modification of a health care service on medical necessity grounds (a "disputed health care service"), the member may be eligible for IMR. The member must utilize the Plan's complaint process prior to requesting IMR of a disputed health care service except as Section C below.

In addition to the complaint process or any other procedures or remedies that may be available to the member, the member shall have the right to request an IMR of a disputed health care service, provided all of the following conditions are met:

- 1) The member's provider has recommended a service as medically necessary, or
- 2) The member has received urgent care or emergency services that a provider has determined were medically necessary, or

- 3) The member, in the absence of a provider recommendation or the receipt of urgent care or emergency services, has been seen by an in-plan provider for the diagnosis or treatment of the medical condition for which the member seeks independent review. The Plan shall expedite access to an in-network provider upon request of the member. The contracting provider need not recommend the disputed health care service as a condition for the member to be eligible for IMR. The member's provider may be an out-of-network provider; however, the Plan shall have no liability for payment of these services except as provided in the Health and Safety Code Section 1374.34(c).
- 4) The disputed service has been denied, modified, or delayed by the Plan based in whole or in part on a decision that the service is not medically necessary.
- 5) The member has filed a complaint with the Plan and the disputed decision is upheld or the complaint remains unresolved after 30 days. The member is not required to participate in the complaint process for more than 30 days. In the case of a complaint that requires an expedited review, the member shall not be required to participate in the complaint process for more than three days.

B. IMR Application and Review Process per California Health and Safety Code

- 1) The member may apply to the DMHC for IMR of a decision regarding a disputed health care service within six months of any of the qualified periods or events described above. The DMHC may extend the application period beyond six months if circumstances so warrant.
- 2) The member does not pay an application or processing fee for this review.
- 3) As part of the Plan's notification correspondence as to the disposition of the member's complaint that denies, modifies, or delays health care services, an application and an addressed envelope are enclosed that the member may return to the DMHC to initiate the IMR process. The member must utilize the Plan's complaint process prior to requesting IMR, except as provided in Section C below.

C. Expedited Review Process

- 1) If there is an imminent and serious threat to the health of the member, all necessary information and documents shall be delivered to the IMR organization within 24 hours of the DMHC approval of the request for the review. The DMHC may waive the requirement that the member follow the complaint process in extraordinary or compelling cases where the DMHC finds that the member has acted reasonably.
- 2) The DMHC will expeditiously review requests and immediately notify the member in writing as to whether the request for IMR has been approved, in whole or in part, and, if not approved, the reasons therefore.
- 3) Upon approval by the DMHC of an expedited review, the Plan shall promptly issue a notification to the member after submitting all of the required materials to the IMR organization, which includes an annotated list of documents submitted, and offer the member the opportunity to request copies of these documents from the Plan.
- 4) The DMHC will promptly approve member requests whenever the Plan has agreed that the case is eligible for an IMR.
- 5) The DMHC will not refer coverage decisions for IMR. This does not include coverage decisions for services that are deemed experimental or investigational or a decision regarding a disputed health care service.
- 6) To the extent a member request for IMR is not approved by the DMHC, the member request will be treated as an immediate request for the DMHC to review the complaint pursuant to Health and Safety Code Section 1368(b).

The IMR process is coordinated with the patient's Health Plan. Contact Optum to determine the applicability of this process to your patient's Health Plan.

Member Grievance Form

If you are not satisfied with any aspect of your contact with Optum, an Optum-Contracted Provider or its representatives, please complete this form and return it to the address provided on this form.

Information of Person Submitting Grievance:

Name_____

Address_____

City_____ State CA Zip Code_____

Telephone Number(s)_____

Relationship to Patient:

Self Personal Representative Employer Patient's Practitioner Other

Patient's Information:

Name_____

Patient Health Plan_____

Patient ID#:_____ DOB ____/____/____

Treating Provider's Information:

Name_____

Specialty_____

Address_____

City_____ State CA Zip Code_____

Telephone Number(s)_____

Please see page 37 for important information regarding Member Grievance Rights Please describe your grievance in as much detail as possible; include dates and names. Please include any copies of receipts or supporting documentation as proof of services paid out of pocket. We will notify you within five calendar days of our receipt of the grievance. We will respond in writing no later than 30 calendar days of our receipt of your grievance. You can include a separate piece of paper if you need more room.

Grievance_____

Please see page 37 for important information regarding Member Grievance Rights.
I attest that all of the information is true.

Signature_____Date_____

Please forward this completed form by mail to:

OptumHealth Physical Health of California
P.O. Box 880009
San Diego, CA 92168-0009
Attention: Grievance Coordinator

DMHC Notification Grievance Process and IMR

The DMHC is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at 800-428-6337 or for TDDY services call 888-877-5379 (voice), or 888-877-5378 (TDDY) and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance.

You may also be eligible for an IMR. If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number 888-466-2219 and a TDD line 877-688-9891 for the hearing and speech impaired. The department's internet website (dmhc.ca.gov) has complaint forms, IMR application forms and instructions online.

Hmong

NCAUJ LUS TSEEM CEEB TXOG KEV TXUAS LUS:

Tej zaum koj yuav tsim nyog tau cov cai thiab kev pab cuam hauv qab no. Koj yuav tau ib tug kws txhais lus los sis txhais ntawv pub dawb. Yuav puav leej txhais tau cov ntaub ntawv ua qee hom lus pub dawb. Kom tau kev pab rau koj hom lus, thov hu rau qhov chaw pab them nqi kho mob rau koj ntawm: ACN Group of California, Inc. 1-800-428-6337 / TTY: 711. Yog koj xav tau kev pab ntxiv, hu rau HMO Help Line ntawm tus xov tooj 1-888-466-2219.

Japanese

言語支援サービスについての重要なお知らせ :

お客様には、以下のような権利があり、必要なサービスをご利用いただけます。お客様は、通訳または翻訳のサービスを無料でご利用いただけます。言語によっては、文書化された情報を無料でご利用できる場合もあります。ご希望の言語による援助をご希望の方は、お客様の医療保険プランにご連絡ください : ACN Group of California, Inc. 1-800-428-6337 / TTY: 711. この他のサポートが必要な場合には、HMO Help Line に 1-888-466-2219 にてお問い合わせください。

Korean

중요 언어 정보:

귀하는 아래와 같은 권리 및 서비스를 누리실 수 있습니다. 귀하는 통역 혹은 번역 서비스를 비용 부담 없이 이용하실 수 있습니다. 일부 언어의 경우 서면 번역 서비스 또한 비용 부담 없이 제공될 수도 있습니다. 귀하의 언어 지원 서비스가 필요하시면 귀하의 건강보험에 다음 전화번호로 문의하십시오. ACN Group of California, Inc. 1-800-428-6337 / TTY: 711. 더 많은 도움이 필요하신 분은 HMO 헬프 라인(안내번호: 1-888-466-2219)으로 문의하십시오.

Punjabi

ਮਹੱਤਵਪੂਰਨ ਭਾਸ਼ਾ ਦੀ ਜਾਣਕਾਰੀ:

ਤੁਸੀਂ ਹੇਠਾਂ ਦਿੱਤੇ ਅਧਿਕਾਰ ਅਤੇ ਸੇਵਾਵਾਂ ਦੇ ਹੱਕਦਾਰ ਹੋ ਸਕਦੇ ਹੋ। ਤੁਸੀਂ ਬਨਿ ਕਸਿ ਲਾਗਤ 'ਤੇ ਦੁਭਾਸ਼ੀਆ ਜਾਂ ਅਨੁਵਾਦ ਸੇਵਾਵਾਂ ਪ੍ਰਾਪਤ ਕਰ ਸਕਦੇ ਹੋ। ਲਿਖਤੀ ਜਾਣਕਾਰੀ ਕੁਝ ਭਾਸ਼ਾਵਾਂ ਵੱਲੋਂ ਬਨਿ ਕਸਿ ਖਰਚੇ ਦੇ ਮਲਿ ਸਕਦੀ ਹੈ। ਆਪਣੀ ਭਾਸ਼ਾ ਵੱਲੋਂ ਸਹਾਇਤਾ ਪ੍ਰਾਪਤ ਕਰਨ ਲਈ, ਕਰਿਪਾ ਕਰਕੇ ਆਪਣੀ ਸਹਿਤ ਯੋਜਨਾ ਨੂੰ ਇੱਥੇ ਕਾਲ ਕਰੋ: `ACN Group of California, Inc. 1-800-428-6337 / TTY: 711। ਜੇ ਤੁਹਾਨੂੰ ਹੋਰ ਮਦਦ ਚਾਹੀਦੀ ਹੈ, ਤਾਂ HMO ਹੈਲਪ ਲਾਈਨ 'ਤੇ ਕਾਲ ਕਰੋ 1-888-466-2219।

Russian

ВАЖНАЯ ЯЗЫКОВАЯ ИНФОРМАЦИЯ:

Вам могут полагаться следующие права и услуги. Вы можете получить бесплатную помощь устного переводчика или письменный перевод. Письменная информация может быть также доступна на ряде языков бесплатно. Чтобы получить помощь на вашем языке, пожалуйста, позвоните по номеру вашего плана: ACN Group of California, Inc. 1-800-428-6337 / линия TTY: 711. Если вам все еще требуется помощь, позвоните в службу поддержки HMO по телефону 1-888-466-2219.

Tagalog

MAHALAGANG IMPORMASYON SA WIKA:

Maaaring kwalipikado ka sa mga karapatan at serbisyo sa ibaba. Maaari kang kumuha ng interpreter o mga serbisyo sa pagsasalina nang walang bayad. Maaaring may available ding libreng nakasulat na impormasyon sa ilang wika. Upang makatanggap ng tulong sa iyong wika, mangyaring tumawag sa iyong planong pangkalusugan sa: ACN Group of California, Inc. 1-800-428-6337 / TTY: 711. Kung kailangan mo ng higit pang tulong, tumawag sa HMO Help Line sa 1-888-466-2219.

Thai

ข้อมูลสำคัญเกี่ยวกับภาษา :

คุณอาจมีสิทธิ์ได้รับสิทธิและบริการต่าง ๆ ด้านล่างนี้ คุณสามารถขอล่ามแปลภาษาหรือบริการแปลภาษาได้ โดยไม่ต้องเสียค่าใช้จ่ายแต่อย่างใด นอกจากนี้ ยังมีอาจมีข้อมูลเป็นลายลักษณ์อักษรบางภาษาให้ด้วย โดยไม่ต้องเสียค่าใช้จ่ายแต่อย่างใด หากต้องการขอความช่วยเหลือเป็นภาษาของคุณ โปรดโทรศัพท์ถึงแผนสุขภาพของคุณที่ : ACN Group of California, Inc. 1-800-428-6337 / สำหรับผู้มีความบกพร่องทางการฟัง : 711 หากต้องการความช่วยเหลือเพิ่มเติม โปรดโทรศัพท์ถึงศูนย์ให้ความช่วยเหลือเกี่ยวกับ HMO ที่หมายเลขโทรศัพท์ 1-888-466-2219

Vietnamese

THÔNG TIN QUAN TRỌNG VỀ NGÔN NGỮ:

Quý vị có thể được hưởng các quyền và dịch vụ dưới đây. Quý vị có thể yêu cầu được cung cấp một thông dịch viên hoặc các dịch vụ dịch thuật miễn phí. Thông tin bằng văn bản cũng có thể sẵn có ở một số ngôn ngữ miễn phí. Để nhận trợ giúp bằng ngôn ngữ của quý vị, vui lòng gọi cho chương trình bảo hiểm y tế của quý vị tại: ACN Group of California, Inc. 1-800-428-6337 / TTY: 711. Nếu quý vị cần trợ giúp thêm, xin gọi Đường dây hỗ trợ HMO theo số 1-888-466-2219.

Notice to Providers of the Availability of the Provider Dispute Resolution Mechanism

Questions About Your Claim

If your claim has been denied and you believe that additional information will affect the processing of the claim or if you have a general inquiry, you may call the Optum Customer Services Department at 800-428-6337. The Optum Customer Services Department can answer many questions over the telephone and will provide a complete response within 30 days or less if your question cannot be answered immediately.

You can also check your claim status online at myoptumhealthphysicalhealth.com.

Contact the Optum Customer Services Department if you require assistance.

Dispute Resolution Mechanism

You may access the dispute resolution mechanism to request review or reconsideration of a claim (or a bundle of claims) that has been denied, adjusted or contested; to dispute a request for reimbursement of the overpayment of a claim; or to address any other contract dispute. Disputes must be submitted in writing and must include a detailed explanation of the issue and your:

- 1) Name
- 2) ID number
- 3) Contact information

If your dispute relates to a claim, you must also supply specific claim information including:

- 1) Claim number (or the range of claim numbers, if the dispute concerns a bundle of claims),
- 2) Dates of service
- 3) Procedure codes
- 4) Dollar amounts

Disputes must be received within 365 calendar days from the date of Optum action or inaction regarding the claim or other dispute. Optum will notify you of the resolution within 45 working days of receipt of the dispute.

To initiate the dispute resolution mechanism, or to submit additional information, you may contact:

OptumHealth Physical Health of California
P.O. Box 880009 San Diego, CA 92168-0009
Telephone: 800-428-6337; or 619-641-7100
Fax: 619-641-7185
Hours: 8:30 a.m. to 5:00 p.m., PST



11000 Optum Circle, Eden Prairie, MN 55344

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