2024 Optum claims provider manual

Key information and support for submitting claims

Optum

Contents

Chapter 1: Overview

Purpose and use

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

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

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

Medicare compliance expectations and training

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

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

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

Standards of conduct awareness

What you need to do

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

Fraud, waste and abuse and general compliance training

What you need to do

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

Exclusion checks

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

What you need to do

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

- oig.hhs.gov/: Health and Human Services – Office of the Inspector General OIG List of Excluded Individuals and Entities (LEIE)
- sam.gov/sam: General Services Administration (GSA) System for Award Management

Review the exclusion lists every month and disclose to OCN any exclusion or any other event that makes an individual ineligible to perform work directly or indirectly on federal health care programs. Maintain a record of exclusion checks for 10 years. We, our plan sponsors, or CMS, may request documentation of the exclusion checks to verify they were completed.

Preclusion list policy

The Centers for Medicare and Medicaid Services (CMS) has a preclusion list effective for claims with dates of service on or after April 1, 2019. The preclusion list applies to both MA plans and Part D plans.

The preclusion list is a register of prescribers and individuals or entities who:

- Are revoked from Medicare, are under an active re-enrollment bar and CMS has determined that the underlying conduct that led to the revocation is detrimental to the best interests of the Medicare program;
- Have engaged in behavior for which CMS could have revoked the prescriber, individual or entity to the extent possible if they had been enrolled in Medicare and the underlying conduct that would have led to the revocation is detrimental to the best interests of the Medicare program, or
- Have been convicted of a felony under federal or state law within the previous 10 years that CMS deems detrimental to the best interests of the Medicare program.

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

Reporting misconduct

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

Privacy

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

Guide updates

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

Chapter 2
Claims submission

Electronic data interchange

The preferred method of claim submission is electronic, known as the Electronic Data Interchange (EDI). EDI is the computer-to-computer transfer of data transactions and information between payers and providers. Electronic claims submission allows the provider to eliminate the inconvenience and expense of printing and mailing claims to the network. It substantially reduces the delivery, processing, and payment time of claims. EDI is a fast, inexpensive, and safe method for automating daily business practices.

There is no charge from Optum for submitting claims electronically to the network. Providers are able to use any major clearinghouse. Claim submissions must be in a HIPAA-compliant 837 I or P format.

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

For electronic claim submissions:
Use Payer ID: LIFE1. For Connecticut 2022 and earlier date of service (DOS), use payer ID: E2387

Click here for additional information regarding CMS HIPAA EDI submission

Benefits of EDI:

- Reduces costs
- Eliminates handling, sorting, distributing or searching for paper documents
- Keeps health care affordable to the end customer
- Reduces errors
- Improves accuracy of information exchange between health care participants
- Improves quality of health care delivery and its process
- Reduces cycle time
- Enables quicker access to enhanced information
- Ensures reliable, accurate, secure and detailed information

Paper claims, reconsideration and refund submission

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

Arizona, Colorado, Idaho, Kansas City, New Mexico, Nevada, Utah, Wisconsin

Mail claims to:

Optum
P.O. Box 30539
Salt Lake City, UT
84130-0539

Connecticut, Indiana, New York, Ohio, South Carolina

Mail claims to:

Optum
P.O. Box 30781
Salt Lake City, UT
84130-0539

Oregon and Washington

Mail claims to:

Optum
P.O. Box 30788
Salt Lake City, UT
84130-0539

How to complete the 1500 claim form

Patient information

Box 1a: Member's External ID

Box 2-6: Member demographics including name, DOB, address, and gender

Box 9D: Other insurance information (i.e., another primary payer)

Provider/line item details

Box 17: Referring provider

Box 19: Provider comments (i.e., corrected claim, 911)

Box 21: Diagnostic codes

Box 22: Resubmission code (if 7 in box, claim is a correction of a previously-submitted claim)

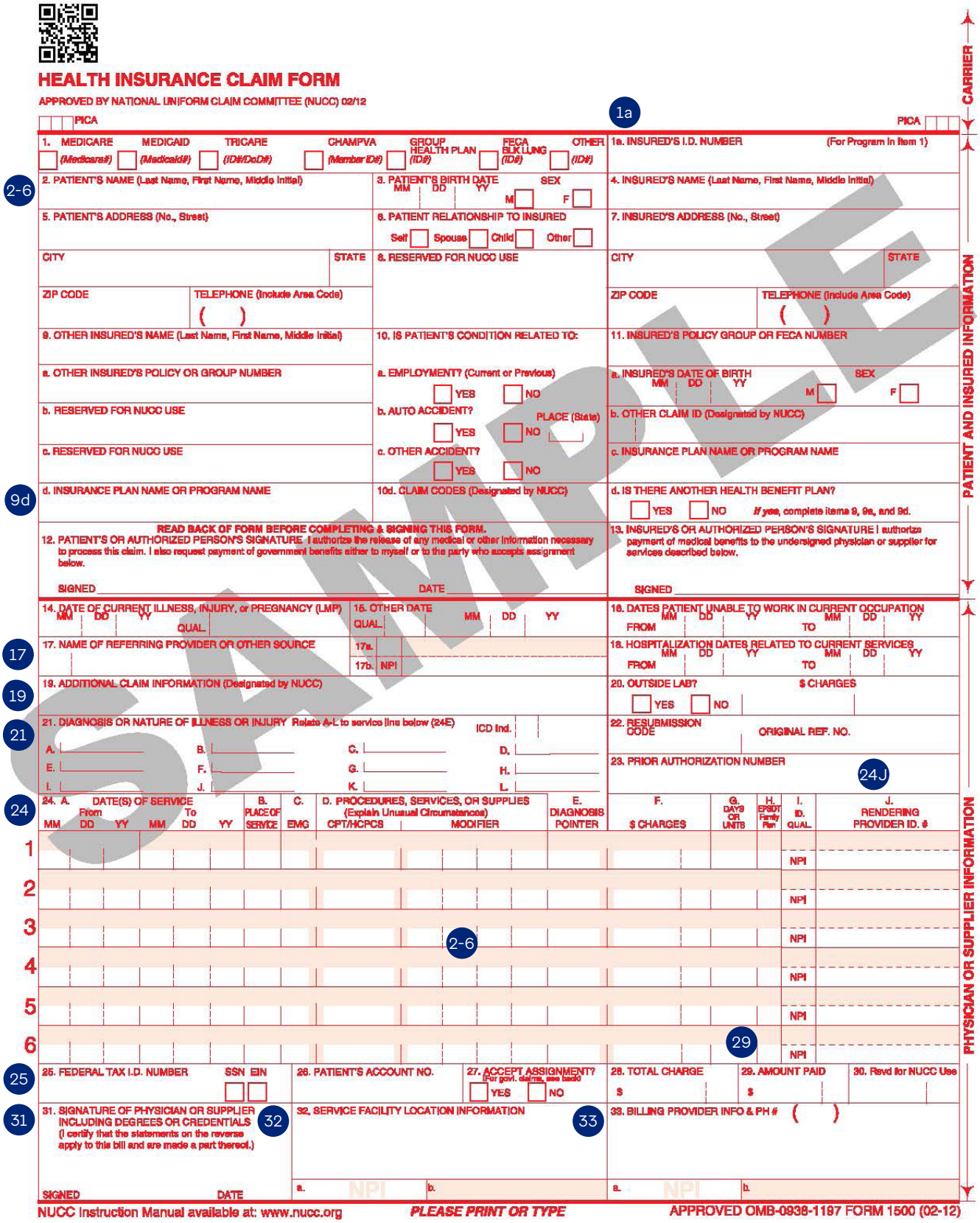
Box 24A-G, 28, 29: Line item details/charges about services rendered by provider

Box 24J, 25, 31: Rendering provider information

Box 32: Location services were rendered

Box 33: Billing provider (sometimes provider group information)

1500 claim type image



HEALTH INSURANCE CLAIM FORM

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

PICA

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

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

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

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

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

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

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

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

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code)

ZIP CODE TELEPHONE (Include Area Code)

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

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

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

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? PLACE (State) YES NO

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

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

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED DATE

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

SIGNED

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

15. OTHER DATE QUAL MM DD YY

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

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

A. B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

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

1 NPI

2 NPI

3 NPI

4 NPI

5 NPI

6 NPI

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For gov't. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

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

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

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

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

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

SAMPLE

How to complete the UB04 (1450) claim form

Box 1: Provider name and address

Box 2: Pay-to name and address (if different from Box 1)

Box 3a/b: Patient control number, medical record number

Box 4: Bill type

Box 5: Facility tax ID

Box 6: Statement covers period (DOS)

Box 7: Administrative necessary days

Member validation

Box 8a-b: Patient name

Box 9a-d: Patient address

Box 10: Patient DOB

Box 11: Patient gender

Admission information

Box 12: Admission date

Box 13: Admission hour

Box 14: Admit type (reason for admission)

Box 15: Source of admission

Box 16: Discharge hour

Box 17: Patient discharge status

Box 18-28: Condition codes

Box 29: Accident state (State in which accident occurred)

Box 30: Accident date

Box 31-34: Occurrence codes and dates

Box 35-36: Occurrence span

Box 39-41: Value codes

Line items

Box 42-49: Claim lines with information on services and charges provided

Box 56: Facility NPI

Patient insured information

Box 58-62: Any additional information such as External ID listed which can be used to validate the member

Box 67 A-Q: Diagnosis Codes

Other providers

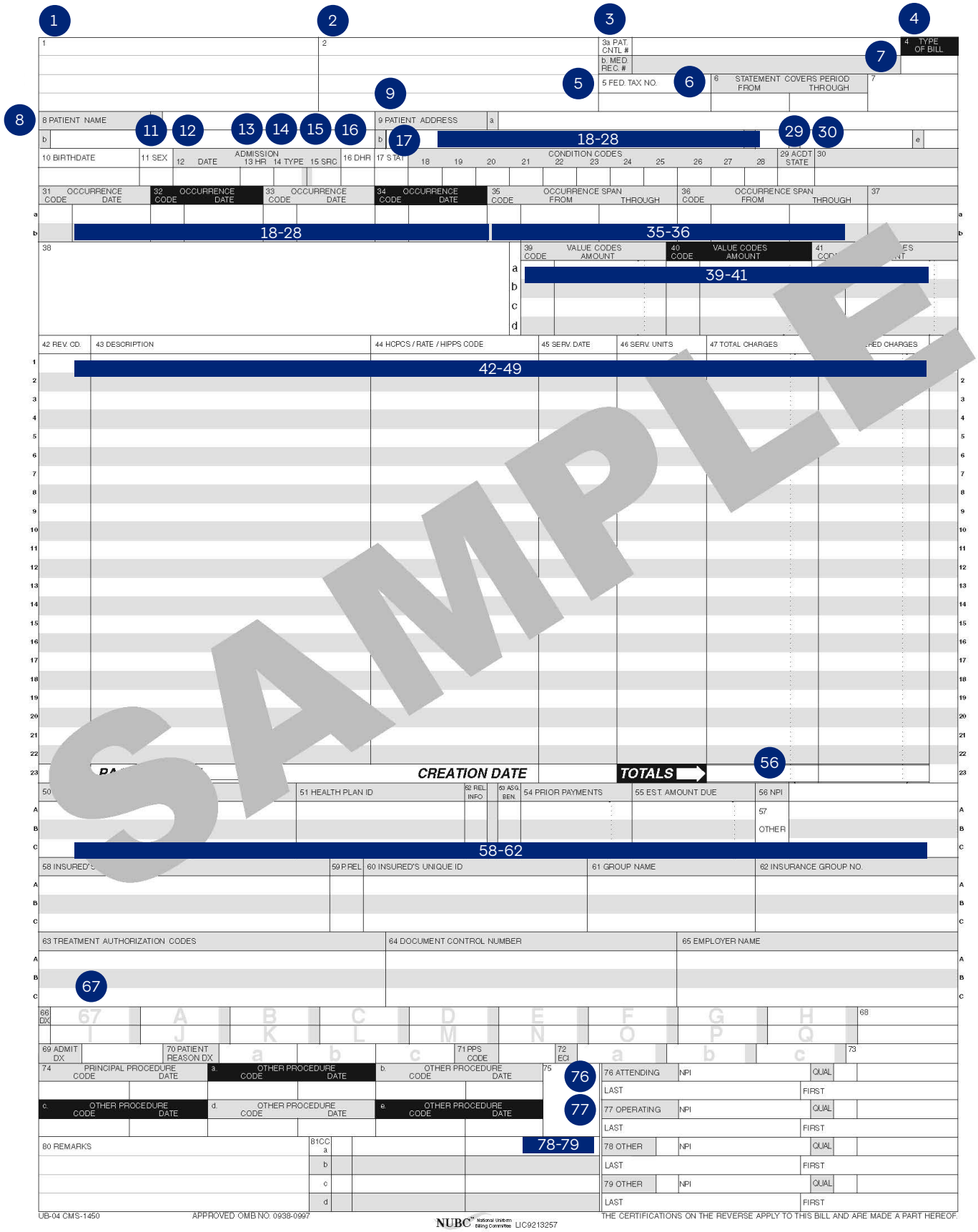
Box 76: Attending (admitting) name

Box 77: Operating ID

Box 78-79: Other provider ID

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

UBO4 (1450) claim type image



Chapter 3
Timely filing submissions

Submission timeframes

All parties must adhere to required timeframes when submitting claims, regardless of submission method (electronic or paper).

If you dispute a claim that was denied due to timely filing, you must show proof you filed your claim within your timely filing limits. Please see the provider dispute section of this manual for the required supporting documentation.

Examples of claims that may be denied as untimely include:

- Claims resubmitted because the original claim was denied for additional information or was processed incorrectly.
- Corrected claims resubmitted for reprocessing (e.g., additional/ reduced charges, updated fee schedule).
- Claims with outdated member insurance information where Optum was either the primary or secondary payer.

Submissions timeframe:
Timely filing limit is 90 days or per the provider contract.

Reconsideration and payment disputes

The timely filing limit is typically 60 days or per the provider contract. A request submitted after this timeframe may be denied. In the event of a conflict or inconsistency between this administrative guide and your network contractual agreement or applicable federal and state statutes and regulations, the terms of the contractual agreement (along with federal and state statutes and regulations) shall prevail.

Reconsiderations or disputes timeframe:
Timely filing limit is 60 days or per the provider contract.

Chapter 4
Common billing errors

Corrected claims

Include all codes for rendered services that should be considered for payment.

Follow the billing terms of the contractual agreement, if applicable, along with federal and state statutes and regulations.

The appropriate claim change reason code is required on corrected or voided claims. Any facility claim billed with bill type XX7 must contain a "claim change reason" Condition Code i.e. D0-D9, E0

Professional(1500) bill typee

- Resubmission code of 7 required in box 22 with original Optum reference/claim number
- Resubmission code of 8 required in box 22 for a voided claim

Facility (1450) bill type

- Resubmission code of 7 (type of bill) required in box 4

Helpful billing and claim tips

Things to remember when billing and submitting claims:

- EDI submission is the preferred method of claims submission. It's fast, easy and cost-effective.
- Always verify the patient's eligibility at the time of service.
- Submit the most current information. This supports accurate payment processing.
- Provide accurate data and complete all required fields on the claim.
- Be sure all billing staff is familiar with current billing and contract requirements, and submit claims in accordance with any provider time limits for claims submission outlined in the contract.

To verify and view claim status, go to the Optum Pro Portal

Chapter 5
Common denial errors

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

Chapter 6: Electronic funds transfer (EFT)

Optum processes payments through OptumPay, the Optum Financial online tool. Healthcare professionals enrolled in Optum Pay receive electronic payments. Healthcare professionals not enrolled in Optum Pay receive a paper check or virtual card payment (VCP) that is mailed to the address on file with Optum (until Optum Pay enrollment has been activated).

About Optum Pay:

- Secure, easy access to claims payment data
- Data download options drive efficiencies
- Flexible administrative management options

Optum Pay Enrollment

The following information is required to complete your enrollment:

- Current bank account and routing numbers
- A copy of a voided check
- A W-9 or bank letter

It may take up to 10 business days after submission for your enrollment to be activated.

Note: To receive Electronic Remittance Advice (ERA), i.e. 835, through a clearinghouse, please contact Payment Services Support for more information at 1-888-477-0256, 7 a.m. - p.m. CT, Monday-Friday.

For more details, please review the below helpful links/videos:

- How to enroll in Optum Pay
- Frequently asked questions
- Learn more about Optum Pay (benefits, resources, and videos)

To obtain 835s through a clearinghouse, providers must:

- Enroll in Optum Pay.
- Enroll in Smart Data Solutions (providers can call Optum Pay for enrollment assistance). SDS authenticates the user within 3 days.
- Notify the clearinghouse that the originator for 835s for LIFE1 payer ID is changing from Instamed to Optum Pay/Smart Data solutions.

  Note: Requirements for updating the LIFE1 payer ID may vary based on clearinghouse.

To access or enroll in Optum Pay go to optumproportal.com. Select "Payments" from the navigation ribbon on the left.

Need help receiving ERA? Contact Payment Services support at 1-888-477-0256

Need help? Contact Optum Pay at 1-888-477-0256 between 7am and 7pm CT Monday-Friday

Chapter 7
Reconsideration requests

Provider dispute resolution

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

Examples of types of disputes

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

Provider dispute submission requirements

Each provider dispute must contain the following information:

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

Provide the following to dispute a claim or reimbursement of an overpayment of a claim from Optum:

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

For provider disputes not concerning a claim, include a clear explanation of the issue along with provider's position on the issue.

Helpful provider dispute submission tips

- Complete provider dispute forms in full and include them with the dispute. Disputes with missing information are returned to the submitter.
- To submit a provider dispute, follow the dispute language on the Explanation of Payment (EOP). Refer to the Provider Dispute Resolution forms found at Optum.com > Business > Providers > Resources > Forms and resources.
- Send provider disputes as indicated in the blue box on the right.

Submit provider disputes
claimdispute@optum.com

Visit Optum.com to find Provider Dispute Resolution forms

Or contact an Optum service center at:

Arizona: 1-877-370-2845

Colorado: 1-888-685-8491

Connecticut: 1-888-556-7048

Idaho: 1-855-822-4340

Indiana: 1-866-565-3361

Kansas City: 1-855-822-4325

New Mexico: 1-800-620-6768

Nevada: 1-855-893-2297

New York: 1-866-565-3468

Ohio: 1-866-566-4715

Oregon: 1-866-565-3664

South Carolina: 1-800-556-6834

Utah: 1-877-370-2845

Washington: 1-877-836-6806

Wisconsin: 1-800-384-0853

Optum Service Center hours of operation are Monday through Friday 8am-6pm market local time.

Dispute escalations

If a timely or reasonable resolution on a submitted dispute has not been achieved, escalate to Optum Market Operations Research and Escalation department for triage and intervention. For example:

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

Provider escalation process

1. Market Operations receives provider and claim escalation disputes via email from internal and external customers. Examples may include incorrect rates, provider contract status, and incorrect claim denials.
2. Research Analysts triage and research inquiries to determine root cause and identify potential trends.
3. After the root cause is identified the Research Analyst engages the appropriate operational team to assist with resolution. The submitter receives communication notifying them of findings and next steps for resolution.
4. After confirming resolution, the Research Analyst validates that the issue has been remediated and documents findings.
5. The Research Analyst communicates resolution to the submitter.

Be sure to include:
the original dispute tracking number with your escalation request

Chapter 8

OON appeals and disputes

UnitedHealthcare appeal language

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

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

Submit UHC appeal requests to:
UnitedHealthcare Medicare & Retirement
P.O. Box 6106
Cypress, CA 90630
MS: CA124-0157

Humana appeal language

Appeals process for non-contracted Medicare providers

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

- A statement indicating factual or legal basis for appeal
- A signed waiver of liability form (you may obtain a copy at https://www.humana.com/provider/medical-resources/payment-integrity-and-disputes/reconsiderations-appeals)
- A copy of the original claim
- A copy of the remittance notice showing the claim denial
- Any additional information, clinical records, or documentation

Payment dispute process for non-contracted Medicare providers:

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

- A statement indicating factual or legal basis for the dispute
- A copy of the original claim

Submit Humana appeal requests or payment disputes to:

Mail:
Humana Inc. Appeals and Grievance Department
P.O. Box 14165
Lexington, KY
40512-4165

Fax: 1-800-949-2961

- A copy of the remittance notice showing for the claim payment
- Any additional information, clinical records, or documentation to support the dispute

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

Elevance appeal language

Appeals process for non-contracted Medicare providers

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

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

Payment dispute process for non-contracted Medicare providers

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

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

Need help?

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

Phone: 1-877-370-2845 for Arizona and Utah
Phone: 1-888-685-8491 for Colorado
Phone: 1-855-893-2297 for Nevada
Phone: 1-800-620-6768 for New Mexico

Fax: 1-877-370-2848

Email via our secure web portal: https://www.optumcare.com/sign-in/optum-care-professionals.html

Submit Anthem Nevada appeal requests to:

Mail:
Elevance Blue Cross and Blue Shield Medicare Advantage
Mail Stop: OH205-A537
4361 Irwin Simpson Rd.
Mason, OH 45040

Fax: 1-800-949-2961

Submit payment disputes to:

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

Premera appeal language

Appeals process for non-contracted Medicare providers

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

- A statement indicating factual or legal basis for appeal
- A signed waiver of liability form (you may obtain a copy at: https://www.cms.gov/Medicare/Appeals-and-Grievances/MMCAG/Downloads/Model-Waiver-of-Liability_Feb2019v508.zip)
- A copy of the original claim
- A copy of the remittance notice showing claim denial
- Any additional information, clinical records or documentation

Payment dispute process for non-contracted Medicare providers

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

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

If you have additional questions related to a dispute decision made, you may contact us at 877-836-6806.

If you do not agree with the dispute determination, you have the option to request a health plan dispute review. Please send all dispute requests in writing, accompanied by all documentation to support your position, directly to the Provider Appeals and Disputes team . The request for health plan dispute review must be received 120 calendar days from the determination date of the initial dispute.

Submit Premera appeal requests to:
(Washington only)

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

Submit Premera payment disputes to:
(Washington only)

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

Submit Premera health plan dispute review request to:
(Washington only)

Mail:
Premera Blue Cross
Medicare Advantage Plans
Attn: Appeals and grievances
P.O. Box 262527
Plano Tx, 75026

Presbyterian appeal language

Contracted provider reconsiderations

As a provider, you have the right to request a reconsideration if you believe your request for payment was denied or paid incorrectly, or your authorization for services was not appropriately approved. If you would like to file a reconsideration, you may do so within 60 calendar days from the date of this notice by submitting a written request.

Appeals process for non-contracted Medicare providers

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

- A statement indicating factual or legal basis for appeal
- A signed waiver of liability form (you may obtain a copy at https://www.cms.gov/Medicare/Appeals-and-Grievances/MMCAG/Downloads/Model-Waiver-of-Liability_Feb2019v508.zip)
- A copy of the original claim
- A copy of the remittance notice showing the claim denial
- Any additional information, clinical records or documentation that supports the argument for reimbursement

Payment dispute process for non-contracted Medicare providers

Pursuant to federal regulations governing the Medicare Advantage program, non-contracted health care professionals may file a payment dispute for a Medicare Advantage plan payment determination. A payment dispute may be filed when the provider contends the amount paid by the plan for a Medicare covered service is less than the amount that would have been paid under original Medicare. To dispute a claim payment, submit a written request within 120 calendar days of the remittance notification date and include at a minimum:

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

If you have additional questions relating to a dispute decision made, you may contact us at: (New Mexico) 1-800-620-6768 or email via our secure web portal: https://www.optum.com/en/sign-in/optum-care-professionals.html

Submit Presbyterian appeal requests to:

Mail:
Optum Provider Dispute Resolution
P.O. Box 30539
Salt Lake City, UT
84130-0539

Submit Presbyterian appeals for non-contracted Medicare providers to:

Mail:
Presbyterian Health Plan
P.O. Box 27489
Albuquerque, NM
87125-748

Submit Presbyterian dispute resolution requests for non-contracted Medicare providers to:

Mail:
Optum Provider Dispute Resolution
P.O. Box 30539
Salt Lake City, UT
84130-0539

Blue Cross Blue Shield appeal language

Contracted provider reconsiderations

As a provider, you have the right to request a reconsideration if you believe your request for payment was denied or paid incorrectly, or your authorization for services was not appropriately approved. If you would like to file a reconsideration, you may do so within 60 calendar days from the date of this notice by submitting a written request to Optum Provider Dispute Resolution:

If you have additional questions relating to a Reconsideration decision made, contact us at: (Arizona) 1-877-370-2845

Payment Dispute Process for non-contracted Medicare providers

Medicare Advantage organizations are required to pay non-contracted providers no less than the amount they would receive under original Medicare for Medicare covered services. Non-contracted providers may file a payment dispute directly with the health plan when they disagree that the amount paid was equal to what Medicare would have paid for the same service.

To dispute a claim payment, submit a written request within 120 calendar days of the remittance notification date and include:

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

Claim Appeal Process for non-contracted Medicare providers

Medicare Advantage organizations are required to receive and process all claim appeal requests from non-contracted providers. A non-contracted provider may file an appeal of the denial of payment (including down coding, bundling, or coding edits) directly with the health plan.

To appeal denied services, submit a written request within 60 calendar days of the remittance notice date and include:

- A statement indicating the factual or legal basis for appeal
- A signed Waiver of Liability (Form available on our website at https://www.azblue.com/medicare/resources/provider-resources)
- A copy of the remittance notice showing the claim denial
- Any additional information, medical records, and documentation to support the appeal.

A decision on the appeal request is issued within 60 calendar days of receipt of the written appeal request. If the health plan decision is less than fully favorable to the non-contracted provider, the appeal case file is forwarded to the Independent Review Entity (IRE).

For questions and additional information, please call 1-800-446-8331 (TTY: 711) and ask for the Non-Contracted Provider Appeal Department. Hours are from 8 a.m. to 8 p.m., Monday through Friday from April 1 to September 30; and seven days a week from October 1 to March 31.

Submit Blue Cross Blue Shield appeal requests to:

Mail:
Optum Provider Dispute Resolution
P.O. Box 30539
Salt Lake City, UT
84130-0539

Submit Blue Cross Blue Shield payment dispute requests for non-contracted Medicare providers to:

Mail:
Blue Cross Blue Shield of AZ
Attn: MA NCP Disputes
P.O.Box 29234
Phoenix, AZ
85038-9234

Fax: 602-544-5658

A decision on the dispute is issued within 30 calendar days of receipt of the written dispute request. If a non-contracted provider exhausts the claim dispute process and continues to disagree with the decision made by the health plan, they have the right to file a complaint with the Centers for Medicare & Medicaid Services (CMS) at 1-800-MEDICARE, 24 hours a day/7 days a week.

Submit Blue Cross Blue Shield appeal requests for non-contracted Medicare providers to:

Mail:
Blue Cross Blue Shield of AZ
Attn: MA NCP Disputes
P.O.Box 29234
Phoenix, AZ
85038-9234

Fax: 602-544-5658

Chapter 9

Claims Edit System (CES)

Optum® CES uses logic to check each claim for errors, omissions, and questionable coding relationships by testing the data against an expansive database containing industry rules, regulations and policies governing health care claims. Services identified to be out of required coding compliance are administratively denied. Should you disagree with the administrative denial, please submit your payment dispute via the options identified.

Submit payment disputes via the options below:

Phone
Contact Optum Provider Services

Email
claimdispute@optum.com

Mail
See Provider Dispute Resolution

Chapter 10

Payment integrity programs

Coordination of Benefits (COB) post-pay program

When a person is covered by two health plans, coordination of benefits is the process the insurance companies use to decide which plan pays first for covered medical services or prescription drugs and what the second plan pays after the first plan has paid. Insurance companies coordinate benefits for several reasons:

1. To avoid paying twice for the same covered service.
2. To determine which plan is primary, which means the insurer pays for covered services first according to the benefits provided by the plan. The other insurer pays secondary, which means it pays the remaining unpaid balance according to the benefits provided by its plan.
3. To help keep health and prescription drug costs affordable.

Medical records request

If Optum receives information about other primary insurance, information is requested. Providers are encouraged to fulfill all medical record requests within the designated timeline communicated within the request.

Please provide all information relevant to the claim and date of service requested. Failure to provide all essential documentation may delay the review or cause denial of the claim line charges due to services not being supported.

At times there may be a medical record request for a procedure that received prior authorization. OptumInsight requests are separate from prior authorization reviews, as these reviews are an attempt to verify services billed and documented.

Initial review findings

If the medical review results in any part of the associated claim being denied, you will receive an initial review findings letter from Optum Insight. This letter states the reason for denial and provides instructions for filing a reconsideration, should you so choose. If you are an out-of-network provider and no payment has been made, appeal information can be found on the EOP/ERA sent from the payment vendor.

COB process for submitting overpayment refunds

You may satisfy the overpayment by sending your check and the signed letter to the Optum Claims Investigation and Recovery Department within 30 days. You may choose to initiate the debit process. This process applies future claims payment against the amount owed until the debt is satisfied. Please sign the letter and return it to the address listed here.

Submit overpayment refunds to:

Mail:
Optum
Claims Investigation and Recovery Dept.
P.O. Box 30539
Salt Lake City, UT 84130

Please be advised that if a refund is not received within 30 days, future payments made to you for covered services may be reduced by the overpayment amount to recover overpayments.

Data mining

Data mining is an analytic program which identifes aberrant payments due to various root causes. Services identified as overpayment are administratively denied.

Process for submitting overpayment refunds

You may satisfy the overpayment by sending your check and the signed letter within 30 days.

You may choose to initiate the debit process. This process applies future claims payment against the amount owed until the debt is satisfied. Please sign the letter and return it to the address listed here.

Please be advised that if a refund is not received within 30 days, future payments made to you for covered services may be reduced by the overpayment amount to recover overpayments.

Submit payment disputes via the options below:

Phone
Contact Optum Provider Services

Email
claimdispute@optum.com

Mail
See Provider Dispute Resolution

Payment Integrity review

Payment Integrity review is a PI Operations program designed to detect, prevent, and recover funds for services deemed ineligible for payment due to policy and coding non-compliance. The program is comprised of three types of reviews:

1. Post payment review
2. Pre-payment review
3. Provider education

Medical record requests

Please provide all information relevant to the claim and date of service requested. Failure to provide all essential documentation may delay the review or potentially deny the claim due to documentation not received.

At times there may be a medical record request for a procedure that received prior authorization. Optum requests are separate from prior authorization reviews, as these reviews are an attempt to verify that services billed are supported by documentation.

Initial review findings

If the medical record review results in any part of the associated claim being denied, you will receive an initial review findings letter from Optum. This letter states the reason for denial and provides instructions for filing a reconsideration, should you so choose. If you are an out-of-network provider and no payment has been made, appeal information is found on the EOP/ERA sent from the payment vendor.

Process for submitting medical records

Medical records may be sent by paper copy or CD/DVD. Instructions on how to submit by each method is included with each medical record request.

Should you disagree with the overpayment notification, please submit your payment dispute via the options outlined in the blue box.

Submitting medical records

Mail:
Optum Payment Integrity
P.O. Box 30773
400 S 500 West
Salt Lake City, UT 84123

Optum Prepayment Review System (OPRS)

OPRS is a predictive analytic tool for professional and institutional medical claims. The OPRS review identifies aberrant behavior requiring additional review prior to payment. Post-adjudication, pre-pay claims are reviewed by the OPRS coding review nurse team. OPRS returns a process recommendation for each service line. One of four recommendations are applied:

1. Allow
2. Deny
3. Pend (for medical records)
4. Hold (48-hr hold for additional internal review)

OPRS is managed by Optum Insight, a vendor partner to the Optum Payment Integrity (OCPI) program.

Medical record requests

Pend recommendations trigger a medical record request from Optum Insight. All reviews are validated by Optum Payment Integrity. Providers are encouraged to fulfill all medical record requests within the designated timeline communicated within the request.

Please provide all information relevant to the claim and date of service requested. Failure to provide all essential documentation may delay the review or result in a denial of the claim line charges due to services not being supported. At times there may be a medical record request for a procedure that received prior authorization. Optum Insight requests are separate from prior authorization reviews, as these reviews are an attempt to verify that services billed are supported by documentation.

Corrected claims submission

Upon receiving a medical record request, you may also realize that you would like to submit a corrected claim in lieu of medical records. Corrected claims appropriately billed should follow the normal claim resubmission process to Optum via Payor ID: LIFE1 or the Optum claims address.

Initial review findings

If the medical record review results in any part of the associated claim being denied, you will receive an initial review findings letter from Optum Insight. This letter states the reason for denial and provides instructions for completing a reconsideration, should you so choose. If you are an out-of-network provider and no payment has been made, appeal information is found on the EOP/ERA sent from the payment vendor.

OPRS process for submitting medical records

Instructions on how to submit by each method is included with each medical record request. Online submission is preferred for accuracy, speed and security.

Provider Inquiry Resolution Team (PIRT)

Should you need to call and discuss a medical record request or review findings, please contact Optum Insight at 1-800-940-5732 between the hours of 8:00 a.m. – 8:00 p.m, Monday -Friday, ET.

Optum Insight

Optum Insight is a vendor partner to the Optum Payment Integrity program, providing pre- and post-pay reviews on DRG Coding and Compliance™, Outpatient Facility™, Itemized Bill Review™, Short Stay Hospital Bill Validation™ and Hospital Bill Audit™.

DRG Coding and Compliance™

DRG Coding and Compliance™ is a coder-driven, post-claim-payment process of reviewing claims and matching to medical records to ensure the DRG, diagnosis and procedures are aligned with the services rendered.

Outpatient Facility™

Outpatient Facility™ is a post-claim-payment process of reviewing claims and matching to medical records to ensure the billed services are aligned with the services rendered.

Itemized Bill Review (IBR)™

Itemized Bill Review (IBR)™ are pre-pay claim reviews for DRG claims which have hit an outlier status. Optum works directly with the Facility providers to obtain the itemized bill and ensures all outlier charges are billed appropriately.

Short Stay Hospital Bill Validation™

Short Stay Hospital Bill Validation™ (SSBV) is a nurse-driven, post-claim-payment audit to determine if an inpatient intensity was provided appropriately. The nurse auditor compares the medical record against the claim submission.

Hospital Bill Audit™

Hospital Bill Audit™ (HBA) is the post-claim-payment process of reviewing claims and matching to medical record to ensure physician orders, nursing documentation, provider contracts and payments are aligned and consistent with CMS guidelines. Registered nurses are responsible for the review of these audits and use historical data to conduct focused reviews.

Medical record requests

You will receive a medical record request letter for all reviews conducted by Optum Payment Integrity. Providers are encouraged to fulfill all medical record requests within the designated timeline communicated within the request. Please provide all information relevant to the claim and date of service requested. Failure to provide all essential documentation may delay the review or potentially deny the claim due to documentation not received. At times there may be a medical record request for a procedure that recevied prior authorization. Optum requests are separate from prior authorization reviews, as these reviews are an attempt to verify services billed and documented.

Submitting medical records

Online:
databankimx.com

Mail:
Optum
P.O. Box 51056
Philadelphia,PA 19115

Delivery:
(FedEx/UPS)
Optum
458 Pike Road
Hungtingdon Valley,
PA 19006

Type	Records	Mail	Delivery (FedEx/UPS ground)	Phone
DRG Coding and Compliance	Email: recordsintake@optum.com Fax: 1-646-349-2406	Optum DRG Validation PO Box 31338 Salt Lake City, UT 84131	Optum DRG Validation 1355 S 4700 West Salt Lake City, UT 84104	1-877-787-2310
DRG Appeals	Fax: 1-781-240-0509	Optum Attn: DRG Appeal Dept PO Box 31338 Salt Lake City, UT 84131	Optum Attn: DRG Appeal Dept 1355 S 4700 West Salt Lake City, UT 84104	1-877-787-2310
Itemized Bill Review	Email: reconsiderations@optum.com Fax: 1-866-700-5769	Optum - IBR IBR Claims Disputes PO Box 1090 Draper, UT 84020-1090	Optum - IBR 12921 S Vista Station Blvd Draper, UT 84020	1-888-895-2254
Itemized Bill Review Appeals	Email: reconsiderations@optum.com Fax: 1-866-700-5769	Optum - IBR IBR Claims Disputes PO Box 1090 Draper, UT 84020-1090	Optum - IBR 12921 S Vista Station Blvd Draper, UT 84020	1-888-895-2254
Outpatient Facility	Email: recordsintake@optum.com Fax: 1-646-349-2406	Optum Outpatient Validation PO Box 31338 Salt Lake City, UT 84131	Optum Outpatient Validation 1355 S 4700 West Salt Lake City, UT 84104	1-877-787-2310
Outpatient Facility Appeals	Email: recordsintake@optum.com Fax: 1-646-349-2406	Optum Outpatient Validation PO Box 31338 Salt Lake City, UT 84131	Optum Outpatient Validation 1355 S 4700 West Salt Lake City, UT 84104	1-877-787-2310
Short Stay Bill Validation	Email: recordsintake@optum.com Fax: 1-646-349-2406	Optum SSBV Appeal Dept PO Box 31338 Salt Lake City, UT 84131	Optum SSBV Appeal Dept 1355 S 4700 West Salt Lake City, UT 84104	1-877-787-2310
Hospital Bill Audit	Email: schedulers@optum.com Fax: 1-800-861-9361	Optum HBA Validation PO Box 31338 Salt Lake City, UT 84131		1-800-777-5589
Hospital Bill Audit Disputes	Email: schedulers@optum.com Fax: 1-800-861-9361	Optum HBA Validation PO Box 31338 Salt Lake City, UT 84131	Optum Attn: HBA Claims Disputes 1355 S 4700 West Salt Lake City, UT 84104	1-800-777-5589

Payment Resolution Services (PRS)

Payment Resolution Services is a recovery team within Optum tasked to pursue overpayment recovery efforts for unsatisfied overpayment balances within 150 days of the initial requests for refund.

These efforts may be in the form of phone calls or letter correspondence on behalf of Optum to reach overpayment recovery resolution.

Initial review findings

Upon overpayment identification, Optum adjusts services on the original claim and generates letter correspondence to the provider explaining the request for overpayment refund. Should no refund or overpayment dispute be received from the provider within 150 days, PRS retains management of all future overpayment recovery for the identified services.

Submitting payment
Submit payment directly to PRS.

Phone: 615-472-9204

To pay online:
Provide required information located on the letter including PRS accoun number and date of services to **payprs.com**.

To pay by check or money order:
Mail to address located on letter.