UnitedHealthcare
Indiana State Medical Association
Commercial Payer Forum

June 6, 2014
Indianapolis

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Optum Cloud Dashboard

CONNECT. EXCHANGE. EVOLVE.

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What is it?

One website--Build a single platform to bring together multiple websites and incorporate new applications to simplify future transactions.

Electronic Attachments--Creating an application to allow the submission of attachments electronically for claim reconsiderations.

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Registration Process

Access to UHCO will be suspended until Cloud registration is complete, during Q1-3

Password Owners and ID Administrators will register by logging on and visiting UnitedHealthcareOnline.com > User ID & Password Management > Optum Cloud Dashboard

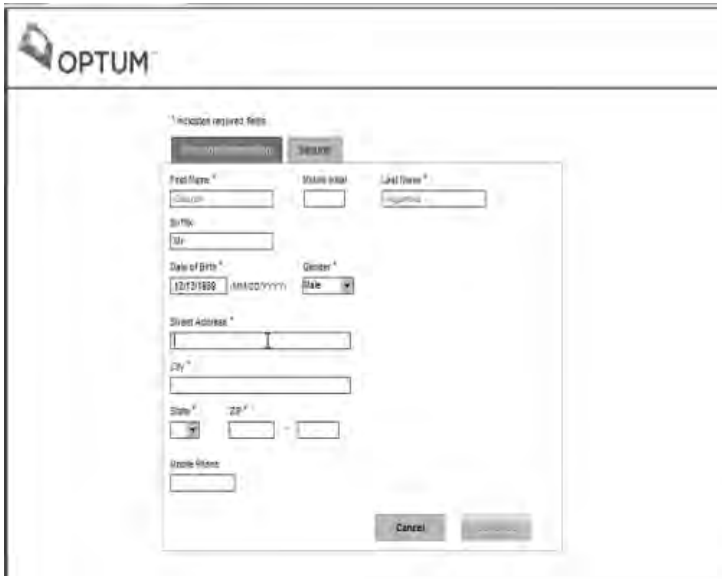
After registering, Password Owners and ID Administrators will initiate registration for others in their organization.

Password Owners/ID Administrator must initiate the registration for UnitedHealthcareOnline.com standard users via the Provider Managed Security app.

Standard Users will receive an email invitation to finish their online registration, enabling them to access Optum Cloud Dashboard.

After the registration process is completed, the user is directed to Optum Cloud Dashboard.

Future access to www.unitedhealthcareonline.com should be initiated by clicking the "b Link" app button on your Optum Cloud Dashboard.



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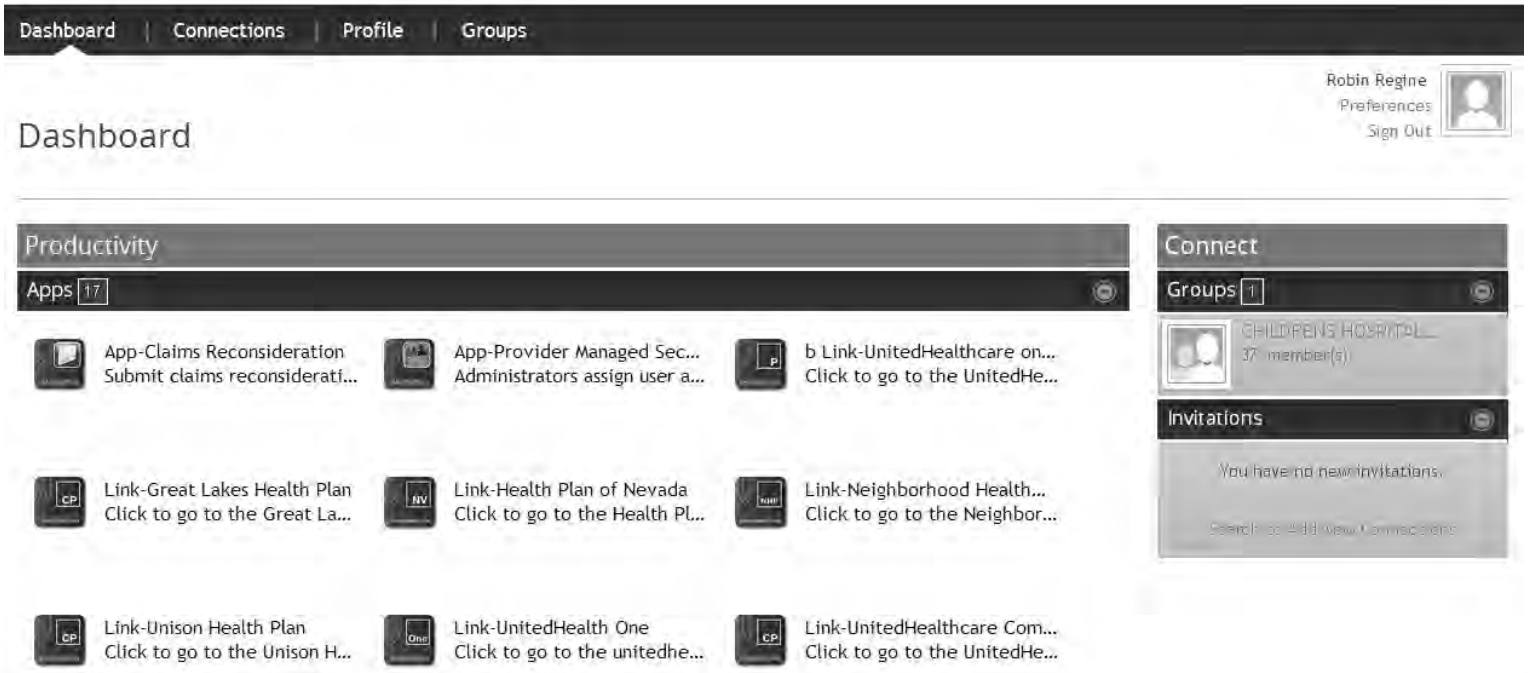
Features & Functionality

The initial roll out included the following applications (apps):

- Provider Managed Security
- Claim Reconsideration *with Attachments*

Recently Added Applications:

- Claims Management
- Eligibility and Benefits



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Quick Reference Guides

UnitedHealthcare® OPTUM™ Cloud

UnitedHealthcare® OPTUM™ Cloud

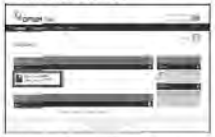
Claim Reconsideration with Attachment QUICK REFERENCE

This application allows you to submit claim reconsideration requests requiring supporting documentation electronically via the Optum Cloud Dashboard, a cloud-based website where UnitedHealthcare will launch new features and functionality for physicians and health care professionals. Note: Tips are included at the end of this document.

Getting Started

1. **Sign In to Optum Cloud (Cloud.Optum.com)**

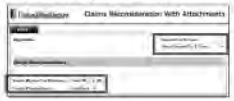
2. Select the **Claim Reconsideration** application, from the Optum Cloud Dashboard.



Create new Claim Reconsideration Request

Initiate Claim Reconsideration Request

1. Select the **Corporate Tax ID Owner, Provider/ Physician Tax ID Number and Provider/Physician Name** from the application homepage



2. Select **Create Request**

Note: Requests can only be submitted for claims in a paid or denied status.

Create new Claim Reconsideration Request (continued)

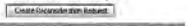
Perform Member Search

1. Enter the First Date of Service
2. Select the appropriate Family Indicator. Select one of three available Search Criteria from the drop-down menu
3. Enter the appropriate criteria
4. Click **Search Member**

Perform Claim Search (*If prompted, by the system*)

1. Select one of the search criteria from the "Search by:" drop down menu
2. Enter the appropriate search criteria
3. Click **Search Claim**

4. Select radio button for the correct claim listed
5. Click **Create Reconsideration Request**



Note: If you weren't prompted to enter a claim search or you will be asked to enter the Claim Information

Then click on **Add/View Attachments** to continue.

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Claims Management Center QUICK REFERENCE

The Claims Managements Center is where you can look up claim status and payment and understand how a claim was paid, through the Optum Cloud Dashboard, the next evolution of our online tools, a cloud-based website where United Healthcare is launching new features and functionality for physicians and health care professionals.

Get Started

1. Sign in to Optum Cloud Dashboard (Cloud.Optum.com)
2. Select **Claims Management Application**

3. Click **Start Here**

Corporate Information

1. Select the appropriate **Corporate Name, Tax ID Number** and **Provider/Physician Name**
2. Click **Submit**

NOTE: If you have flagged claims, you can view them directly from this page without doing a search. **Select** the desired claim.

Member Search

1. Select **Search Method** by clicking on appropriate radio button
2. Enter required information
3. Choose **Individual** or **Family**, if offered
4. Click **Search**

5. **Select** the desired patient

Claim Search

1. Choose a search method
2. Enter the required information
3. Click **Search**

4. **Select** the desired Claim

NOTE: To flag/unflag a claim, click on the flag icon.

UnitedHealthcare® OPTUM™ Cloud

Eligibility & Benefits Center QUICK REFERENCE

The Eligibility and Benefit Center is where you can obtain information about your patient's medical coverage, through the Optum Cloud Dashboard, the next evolution of our online tools, a cloud-based website where United Healthcare is launching new features and functionality for physicians and health care professionals.

Get Started

1. Sign in to Optum Cloud Dashboard (Cloud.Optum.com)
2. Select **Eligibility & Benefits Application**

3. Click **Start Here**

Corporate Information

1. Select the appropriate **Corporate Name, Tax ID Number** and **Provider/Physician Name**
2. Click **Submit**

Member Search

1. Select **Search Method** by clicking on appropriate radio button
2. Enter required information
3. Choose **Individual** or **Family**, if needed
4. Click **Search**

Member Search (continued)

5. **Select** the desired patient

NOTE: If detailed benefits are in a different location, you would click the icon to open a new page.

6. Review the **Patient and Benefits Information**

7. Scroll down to choose specific **Benefit Category** from pull-down menu.

8. Return to **Home** tab and click **Start Here** to perform another search.

Additional Quick Reference available on UnitedHealthcareOnline.com

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Training Available

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Training Available

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Learn about Optum™ Cloud Dashboard's newest features: Eligibility & Benefits Center and the Claims Management application.

Webinar sessions are offered on Wednesdays and Thursdays. View available dates and times and register now.

In this 30 minute instructor-led webinar, you will learn about:

Eligibility & Benefits Center (for UnitedHealthcare, UnitedHealthcare Community Plan, UnitedHealthcare Medicare Solutions, UnitedHealthcare West and Oxford)

- Check eligibility for all lines of business.
- Get in- and out-of-network benefit information for most UnitedHealthcare members.
- Review Coordination of Benefits information.
- Select additional copay and coinsurance categories to display.

Claims Management (for UnitedHealthcare, UnitedHealthcare Medicare Solutions and UnitedHealthcare West)

- Flag claims to view them automatically each time you login.
- View line level and claim level remark codes.
- Get a clear definition of payment allocation.

There will be time at the end for questions and answers.

No time for a webinar? You can also explore Optum Cloud Dashboard's features on your own.

- If you're not registered to use secure features on Optum Cloud Dashboard, please refer to the instructions for Standard Users or Administrators.
- Use our Quick Reference Guides to learn more about available applications.

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Helpful Links

Home > Tools & Resources > Health Information Technology > Optum Cloud Dashboard

Home > Help > Optum Cloud Dashboard

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Need Assistance?

- Call the Optum Cloud Dashboard Help Desk at: **855-819-5909**
- Email: OptumCloudSupport@optum.com
- Training: Home > Tools & Resources > Training & Education

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Questions?

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Claim Resolution Process

1) You must submit your Claim Reconsideration within 12 months from the date of the Explanation of Benefits (EOB) or Provider Remittance Advice (PRA).

2) If you do not agree with the outcome of the Claim Reconsideration decision send to your Provider Advocate.

3) If decision is still upheld you may submit a formal appeal request to:

UnitedHealthcare Provider Appeals
P.O. Box 30559
Salt Lake City, UT 84130-0575

- You must submit your appeal to us within 12 months (or as required by law or your participation agreement), from the date of the Explanation of Benefits (EOB) or Provider Remittance Advice (PRA). Attach all supporting materials such as Customer-specific treatment plans or clinical records to the formal appeal request, based on the reason for the request. Include information which supplements your prior adjustment submission that you wish to have included in the appeal review.

*********Please note: Provider Advocates cannot submit claim inquiries on claims with dates of service greater than 18 months.**********

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Claim Resolution Process

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A Claim Reconsideration request is typically the quickest way to address any concern you have with how we processed your claim. With a Claim Reconsideration request, we review whether a claim was paid correctly, including if your provider information and/or contract are set up incorrectly in our system, which could result in the original claim being denied or reduced.

There are several ways to submit a Claim Reconsideration Request.

1. Submit an electronic Claim Reconsideration Request **with attachments** on Cloud.Optum.com *(preferred method)*.
   By using this method, you can:
   - Reduce the overall turnaround time for the request.
   - Receive immediate confirmation and a unique tracking number to show we received your request.
   - Check submission status throughout the process.

   To learn more, view the Optum Cloud Quick Reference Guide.

2. If you are a registered user on UnitedHealthcareOnline.com, use Electronic Claim Reconsideration for submissions **without attachments.**
   - You'll be notified that your request was received.

   View the Claim Reconsideration Quick Reference Guide for more information.

3. Paper Claim Reconsideration Request forms can be downloaded from:
   - UnitedHealthcareonline.com Claim Reconsideration
     - Paper Claim Reconsideration instructions (will add hyperlink to the combined document)
   - uhcwest.com
     >Library>choose your state>Resource Center>Claim Reconsiderations

   Where to send the paper Claim Reconsideration Requests:
   - **For UnitedHealthcare/UnitedHealthcare West**, if your request for a claim reconsideration is for a *commercial* or *Medicare* member, send the paper Claim Reconsideration Requests to one of the following:
     - the address on the Explanation of Benefits (EOB) or the Provider Remittance Advice (PRA)
     - the claim address on the back of the member's ID card
   - **For UnitedHealthcare Empire Plan**, send to:
     P.O. Box 1600
     Kingston, NY 12402-1600
   - **For UnitedHealthcare Community Plan**, if your request for a claim reconsideration is for a *Medicaid/Chip* member, go to:
   - Community Plan Claim Reconsideration Mailing Addresses

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Information needed to begin claim research:

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✓ Copy of the claim form including:

- ✓ Member name
- ✓ Member ID
- ✓ Member DOB
- ✓ Date of service
- ✓ Claim amount
- ✓ Tax ID

and…

✓ Brief synopsis of steps taken to resolve the claim

and…

✓ Claim reconsideration form and additional documents previously submitted

or…

✓ Ticket number from Optum Cloud (PTPCR-XXXXXX)

or…

✓ Reference number obtained from Customer Service which is a 15-digit number beginning with the letter C

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UnitedHealthcare Navigate®

An Introduction for Physicians

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UnitedHealthcare Navigate

What is UnitedHealthcare Navigate?

- Primary care-focused product suite
- Plan design options for choice and flexibility
- Referrals to network specialists
- Broad national network with narrowed networks in some states
- Efficient care & lower costs

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Navigate At-a-Glance

UnitedHealthcare Navigate Product Options	Benefit Levels	Network Physician with prior referral	Network Physician without prior referral	Non-Network provider
UnitedHealthcare Navigate	Network Only Benefit; Single Tier Benefits	Network Benefits	No Coverage* & **	No coverage except for Emergency Care*
UnitedHealthcare Navigate Balance	Network Only Benefit; Single Tier Benefits	Network Benefits	Lower Network** Benefits	No coverage except for Emergency Care*
UnitedHealthcare Navigate Plus	Network and Non Network Benefits; Three Tiered Benefit	Network Benefits	Lower Network** Benefits	Non Network Benefits

For example, a patient with Navigate Balance may have a $30 co-pay to see a network specialist with a referral and also have a choice to see a network specialist without a referral for a higher co-pay amount of $75;

***Member is responsible for the billed amount (subject to exceptions for which applicable law does not allow a referral requirement).**

****Member is responsible for charges incurred for visits to an In Network Physician <u>other than their PCP</u> without a referral.**

Note: Member will incur a higher co-pay for Urgent Care versus PCP visits

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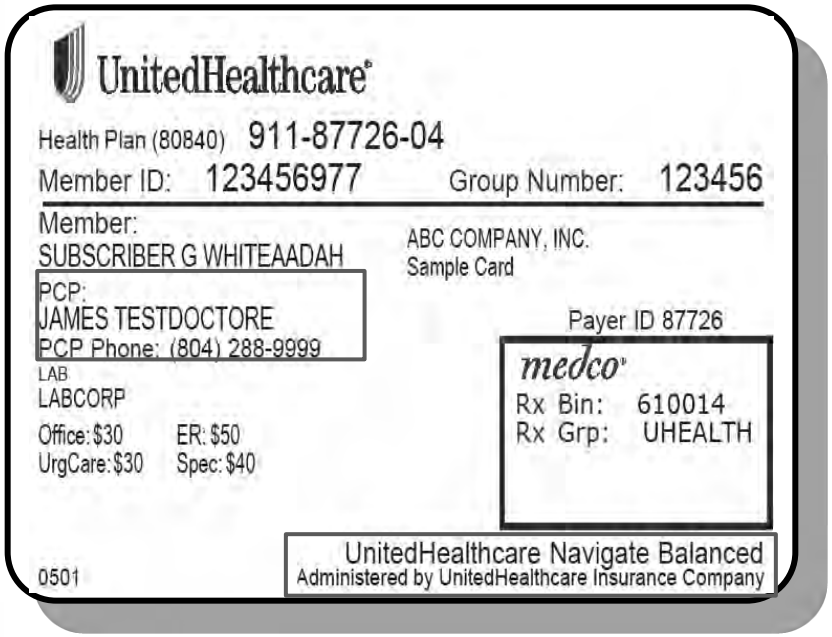
Navigate Health Care ID Cards



This sample ID card is for illustration only.
Actual information varies depending on payer, plan and other requirements.

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Navigate - Patient Eligibility

TIP! Submit demographic changes on UnitedHealthcareOnline.com

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Navigate Referral Requirements

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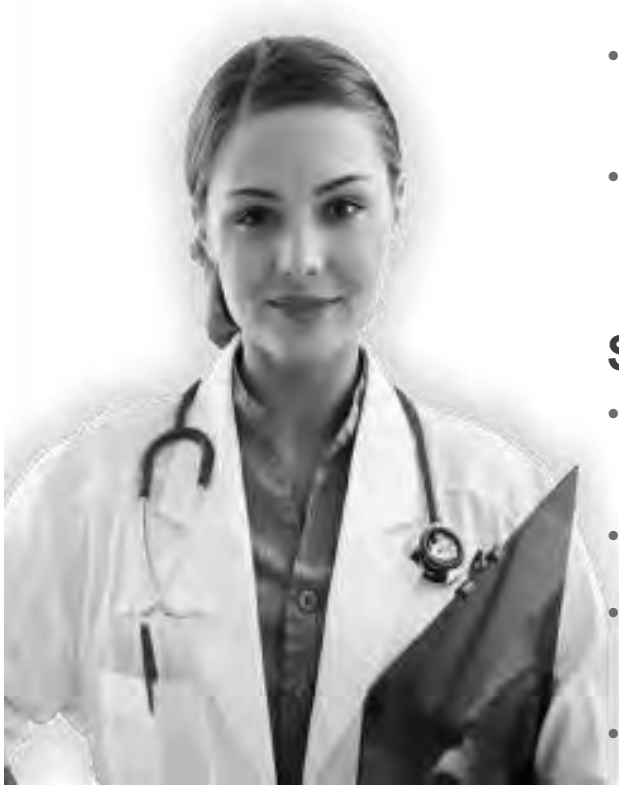
PCP makes electronic referrals to each network specialist



Routine Referrals

- PCP or covering physician with same TIN must submit electronic referral
- Six visits allowed per referral
- Valid up to six visits or six months, whichever comes first
- Any claim from specialist TIN is subtracted from number of visits within same date range

Standing Referrals

- For long-term treatment of chronic conditions
- 99 visits allowed per referral
- Valid up to 99 visits or six months, whichever comes first
- PCP can issue additional referrals after visits are used or referral expires

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Navigate Referral Requirements

Referrals required to see network specialists only

Eligible Services NOT Requiring a Referral

- Network Obstetrician/Gynecologist
- Routine refractive eye exam from a network provider[1]
- Mental health/substance use disorder services with network behavioral health clinicians
- Services from physicians in the same tax ID number (TIN) as the member's PCP
- Services from a pathologist, radiologist or anesthesiologist
- Services rendered in any emergency room or network urgent care center or convenience clinic
- Physician services for emergency/unscheduled admissions[2]
- Any services from inpatient consulting physicians
- **Any non-physician type services**
  - Outpatient lab, x-ray, or diagnostics.
  - Physical therapy, DME, home health, prosthetic devices or hearing aids
  - Or rehab services with the exception of manipulative treatment and vision therapy performed by physician

[1] One exam every two years is a standard benefit in fully insured medical coverage.
[2] Unscheduled admissions require standard notification after the patient is admitted, as described in the Administrative Guide.

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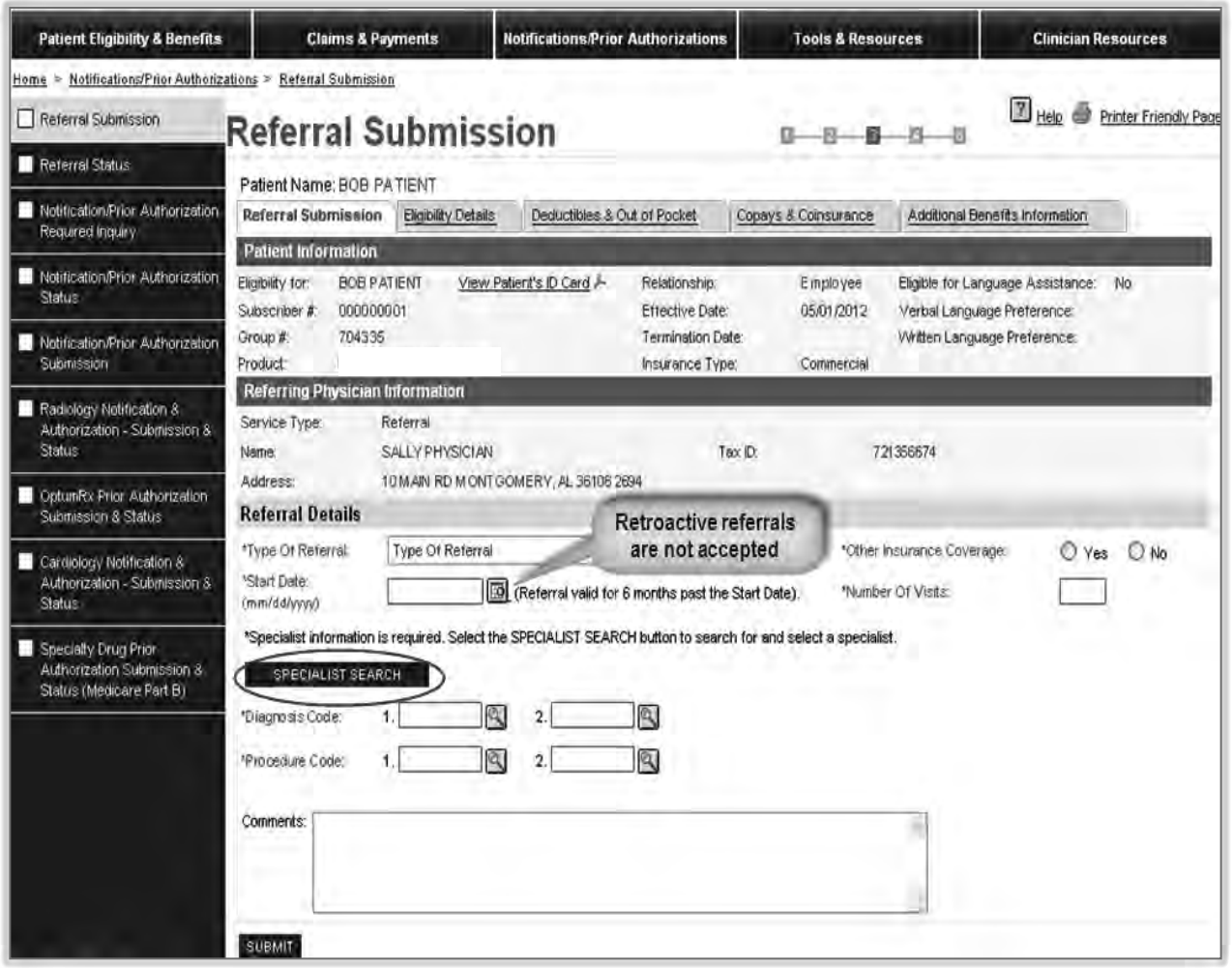
Navigate Referral Submission



Referral Submission

- **Electronic referrals required to notify UHN**
- Available 24/7
- Effective immediately
- Viewable online within 24 hours
- Printer friendly Referral Confirmation
- User profiles must have access to referral screen

Referral Status and Submission Online Tutorial available under Help

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Additional Resources

You can find more information, FAQ's, Quick Reference Guides & interactive tutorials at:

www.unitedhealthcareonline.com > Tools & Resources > Products & Services > UnitedHealthcare Navigate

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Measuring Patient Care:
Medicare Star Ratings

Patient Care Opportunity Reports PCOR

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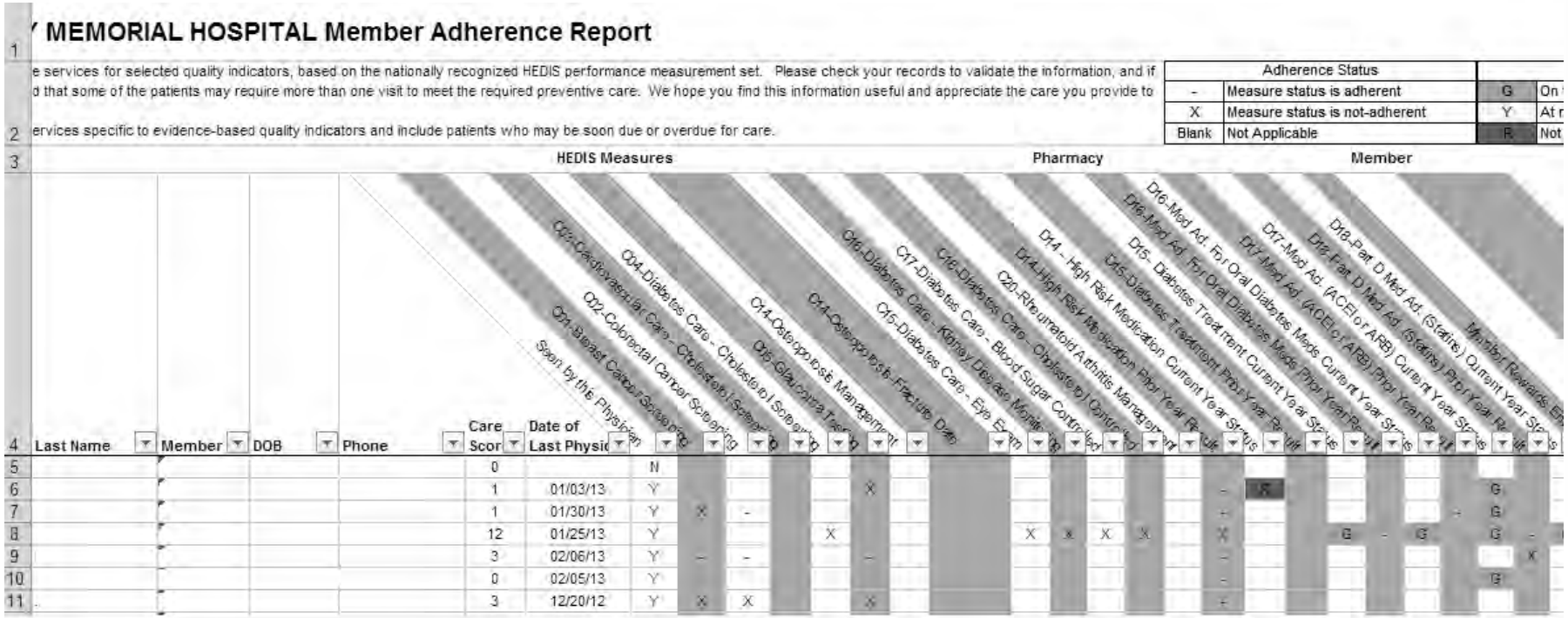
- **What is a PCOR Report**?
  - A tool that provides clear and actionable information for physician groups and organizations to use to identify their patients' adherence status.
  - The report uses UHC pre and adjudicated claims and other supplemental data to provide clinical and Part D information on members, either assigned or attributed to a PCP, in the group that have at least one open or closed care opportunity for the reporting year.
  - The report is generated monthly and shows progress at the member level as "gaps" are closed throughout the year. Reports are also now available directly from UnitedHealthcareOnline.com and instructions are printed on the cover page of the reports.

Patient Care Opportunity Report
PCOR

UnitedHealthcare®

Sample Patient Care Opportunity Report



Y MEMORIAL HOSPITAL Member Adherence Report

e services for selected quality indicators, based on the nationally recognized HEDIS performance measurement set. Please check your records to validate the information, and if d that some of the patients may require more than one visit to meet the required preventive care. We hope you find this information useful and appreciate the care you provide to

ervices specific to evidence-based quality indicators and include patients who may be soon due or overdue for care.

Adherence Status			
-	Measure status is adherent	G	On
X	Measure status is not-adherent	Y	At r
Blank	Not Applicable	R	Not

HEDIS Measures | Pharmacy | Member

Last Name | Member | DOB | Phone | Care Scor | Date of Last Physi | Seen by the Physician | C02-Colorectal Cancer Screening | C03-Breast Cancer Screening | C04-Diabetes Care - Cholesterol Screening | C05-Glaucoma Testing | C14-Osteoporosis Management | C15-Diabetes Care - Eye Exam | C16-Diabetes Care - Kidney Disease Monitoring | C17-Diabetes Care - Blood Sugar Controlled | C18-Diabetes Care - Cholesterol Controlled | C20-Rheumatoid Arthritis Management | D14 - High Risk Medication Prior Year Status | D14 - High Risk Medication Current Year Status | D15 - Diabetes Treatment Prior Year Status | D15 - Diabetes Treatment Current Year Status | D16-Med Adh. For Oral Diabetes Meds Prior Year Status | D16-Med Adh. For Oral Diabetes Meds Current Year Status | D17-Med Adh. (ACEI or ARB) Prior Year Status | D17-Med Adh. (ACEI or ARB) Current Year Status | D18-Part D Med Adh. (Statins) Prior Year Status | D18-Part D Med Adh. (Statins) Current Year Status | Member Rewards Eligibility

Last Name	Member	DOB	Phone	Care Score	Date of Last Physician	Seen by the Physician	C02-Colorectal Cancer Screening	C03-Breast Cancer Screening	C04-Diabetes Care - Cholesterol Screening	C05-Glaucoma Testing	C14-Osteoporosis Management	C15-Diabetes Care - Eye Exam	C16-Diabetes Care - Kidney Disease Monitoring	C17-Diabetes Care - Blood Sugar Controlled	C18-Diabetes Care - Cholesterol Controlled	C20-Rheumatoid Arthritis Management	D14 - High Risk Medication Prior Year Status	D14 - High Risk Medication Current Year Status	D15 - Diabetes Treatment Prior Year Status	D15 - Diabetes Treatment Current Year Status	D16-Med Adh. For Oral Diabetes Meds Prior Year Status	D16-Med Adh. For Oral Diabetes Meds Current Year Status	D17-Med Adh. (ACEI or ARB) Prior Year Status	D17-Med Adh. (ACEI or ARB) Current Year Status	D18-Part D Med Adh. (Statins) Prior Year Status	D18-Part D Med Adh. (Statins) Current Year Status	Member Rewards Eligibility
				0		N																					
				1	01/03/13	Y					X							-	R					G		
				1	01/30/13	Y	X		-									-						-	G		
				12	01/25/13	Y				X					X	X	X	X	X		G	-	G		G	-	
				3	02/06/13	Y	-		-		-							-								X	
				0	02/05/13	Y												-							G		
				3	12/20/12	Y	X		X		X							+									

Adherence Status		Alert Levels	
-	Measure status is adherent	G	On track for adherence
X	Measure status is not-adherent	Y	At risk
Blank	Not Applicable	R	Not likely to be adherent

Patient Care Opportunity Report PCOR

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How do I access our reports via UHConline?

Accessing Your Reports Online

1. Log into your UnitedHealthcareOnline.com account

1.1. For new user registration, visit UnitedHealthcareOnline.com, click the "New User" link in the upper right corner and follow the prompts. If you have questions about registration, call 866-UHC-FAST (866-842-3278), and select Option 2

2. Click on Clinician Resources

3. Click on Performance Measurement and Reporting

4. Click on Physician Performance and Reporting

5. Click on Reporting to access your reports

5.1 If this is the first time you are accessing your reports, enter your Program Identifier access pin: **012A34**

5.2 If you are unable to access your reports for any reason, please contact the Resource Center at 866-270-5588 from 8 a.m. to 7 p.m. (CST), Monday through Friday.

The Patient Assessment Form HQPAF

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- Another option available to our Primary Care Physicians to help close these open care opportunities is the HQPAF form. Providers are reimbursed $75 for each HQPAF form completed, submitted and accepted.

- The goal of the PAF program is to help ensure that these patients receive a complete and comprehensive health assessment at least once per year. The PAF program also supports a variety of CMS quality programs, including HEDIS and the Star Quality Rating system.

- Correctly completed forms submitted with the appropriate signed documentation will be reimbursed a one-time administrative fee for each comprehensive patient evaluation per calendar year. This reimbursement is solely to compensate you for any professional time and administrative costs you have incurred by participating in this program.

The Patient Assessment Form HQPAF

UnitedHealthcare®

Sample HQPAF

OPTUMInsight

Health Plan Logo

Healthcare Quality Patient Assessment Form

The Healthcare Quality Patient Assessment Form (HQPAF) program is developed and administered by Optum Insight on behalf of Health Plan L. For questions, please contact 1-877-751-9207.

Instructions

(1) **Schedule** a comprehensive exam for this patient or review this document during the patient's next office visit, completing and documenting only the sections of this form marked with this "pen" icon.

(2) **Document** in the progress note, including clear provider signature & credential(s), patient name, and date of service: *This form expires - eligible dates of service for submission limited to 01/09/2012 through 05/08/2013.*

(3) **Submit** pages of this form containing the "pen" icon and applicable progress note(s) to support all chronic conditions and co-morbid factors, documented to the highest level of specificity. Submission options:
Secure Fax Server: 877-489-5747
Traceable Carrier: Optum PAF Processing - 1021 Windrose Ct., Franklin, TN 37067

Administrative reimbursement of $X will be paid for completed forms with progress note(s) that meet CMS documentation requirements.

Patient & Provider Information

Patient: LAST_NAME1, FIRST_NAME1
Member ID: XXXXXXXX1 DOB: 09/09/9999
Phone: (999)999-9999

Complete this section only if you are not able to complete the assessment. A reduced reimbursement of $X will be paid after submission & processing.
Patient does not respond to contact efforts.
Invalid / incomplete contact information.
This member is deceased, as of ____/____/_____ MM DD YYYY

Complete this section only if you are not interested in completing the assessment.
No reimbursement will be made.
I am not interested in contacting this patient.

Indicate provider name and NPI, checking the first box to confirm name shown or the second box and printing name if another provider completed this assessment. Enter selected provider NPI if not already populated.

Provider: PCPName1
NPI:

Provider: _____ *print name above*
NPI:

Early Detection of Chronic Illnesses

Please consider screening for these chronic illnesses based on previously reported risk factors and/or co-morbid conditions and document any confirmed conditions that currently exist in your progress note(s). Screenings may result in out-of-pocket expense for the patient, depending on health plan benefits.

Chronic Illnesses to Consider	Risk Factors and/or Co-morbid Conditions	Was the screening completed? Yes	No	NA
Chronic Kidney Disease	Diabetes Mellitus (250.00), Hypertension (401.9), Cardiovascular Disease (414.00)			
Chronic Obstructive Pulmonary Disease	History of Smoking (V15.82), Obesity (278.00)			
Diabetes Mellitus	Chronic Pancreatitis (577.1)			
Diabetic Neuropathy	Diabetes Mellitus (250.00), Peripheral Autonomic Neuropathy (595.54)			
Major Depression	Chronic Pain (338.29)			
Peripheral Arterial Disease	History of Smoking (V15.82), Diabetes Mellitus (250.00), Arteriosclerosis-Coronary (414.00)			
Protein Calorie Malnutrition	Cystic Fibrosis (277.0)			

Note: Additional information and reference links on risk factors of chronic illnesses can be found in the PAF instructions.

HEALTHPLAN1 Page 1 PAF V4 Rev Date: 09/08/2010

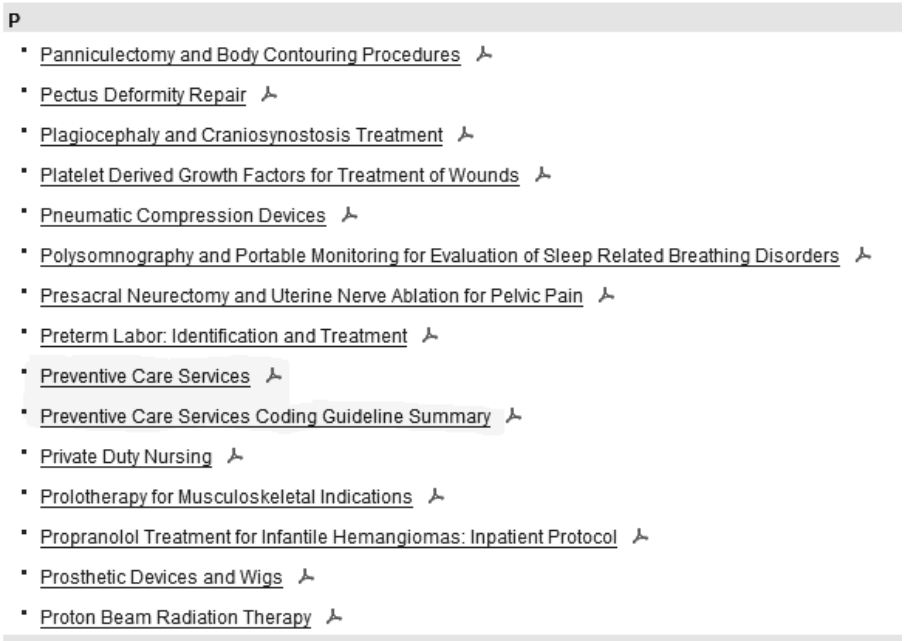
Questions?

Preventive Care Information

Information can be found on www.unitedhealthcareonline.com and following the pathway below:

Home > Tools & Resources > Policies, Protocols and Guides > Medical & Drug Policies and Coverage Determination Guidelines

***It is important to follow our Preventive Care Services Coding Guidelines Summary for instructions on proper CPT/ICD-9 coding combinations & criteria to ensure proper processing under the members preventive benefits.

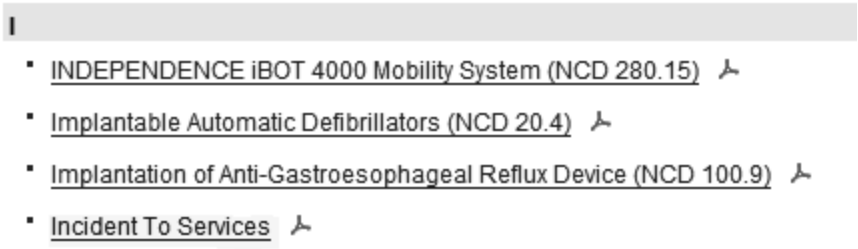


Incident To

Information can be found on www.unitedhealthcareonline.com and following the pathway below:

Home Tools & Resources Policies, Protocols and Guides Medicare Advantage Reimbursement Policies

***UnitedHealthcare does not currently have an “Incident To” policy that applies to our commercial plans.



Important Updates

Lab Bill Type 141 Claims Project:

- Commercial claims project has been completed
- Medicare claims will be re-processed over the next 10 weeks due to the high volume of claims that require re-processing

Denials for no NDC

- Edit has been turned off that was causing the denials
- Incorrectly denied claims will be re-processed
- Any Refund Requests were stopped and reversed
- An NDC is only required for drugs/biologics that do not have a specific J code.

Therapy Claims denying for “Not Meeting Vision Therapy LCD”

- Issue has been identified
- Still working on a fix
- Once the fix is implemented a National claims project will ensue and all incorrectly denied claims will be re-processed.

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Questions?

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