OptumHealth Operations Guide

Kidney Resource Services

OptumHealth℠

Optimizing Health and Well-Being℠

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Operations Guide Overview

The purpose of this guide is to provide you with an ongoing reference tool that includes critical information regarding operational processes at OptumHealth.

KIDNEY RESOURCE SERVICES PROGRAM OVERVIEW

OptumHealth Care Solutions-Complex Medical Conditions, formerly United Resource Networks (U.R.N.), is a specialized care services division within UnitedHealth Group, one of the largest health insurers in the nation. Complex Medical Conditions (CMC) provides access to clinically superior, cost-effective health care for complex medical conditions. The CMC transplant network has been in existence since 1986, and has since added networks focused on complex cancer, congenital heart disease, infertility, kidney disease, neonatal intensive care and bariatrics.

Kidney Resource Services (KRS) provides guided access to a network of credentialed dialysis centers throughout the U.S. KRS, an NCQA-accredited provider of specialized renal disease management, with Chronic Kidney Disease (CKD) and End Stage Renal Disease (ESRD) management services. KRS CKD and ESRD programs conform to guidelines established by the National Kidney Foundation's Kidney Disease Outcomes Quality Initiative, KDOQI; as such, the programs offer the best opportunities to educate members and direct them to our network providers.

In both ESRD and CKD programs, care is coordinated by a registered nurse with extensive experience in renal disease. The nurses provide individualized education to help members understand their condition as well as related health issues common with individual chronic kidney disease. KRS nurses coordinate, and if necessary, augment some of the services provided by the member's primary care physician, nephrologists, dialysis providers and other medical specialists to help manage co-morbidities such as anemia, obesity, diabetes, and cardiovascular disease. Nurses are guided by the KRS Medical Director, a board certified nephrologist.

HEALTH CARE PROVIDER ON-BOARDING PROCESS

As contracts are negotiated between your medical center and OptumHealth, information is gathered that will facilitate the on-boarding process. On-boarding activities include:

- The Clinical Sciences Institute (CSI) Centers of Excellence network qualification process.
- An initial overview session between your OptumHealth Network Relations Representative and designated representatives from your medical center to learn about your processes and medical center structure.
- A request for information (RFI) to gather important contact and operational information about your programs.

CLINICAL SCIENCES INSTITUTE CENTERS OF EXCELLENCE NETWORK QUALIFICATION PROCESS

Clinical Sciences Institute conducts a review of all Kidney facilities and programs. This process determines if your center qualifies to be included in the Kidney network on an annual basis and/or quarterly upon contract changes. This process helps ensure that our clients have access to only those programs that demonstrate continued clinical excellence in their field.

Completing the KRS Survey will provide timely clinical information, further communicating the value and performance of the dialysis center to all KRS clients.

Critical health care provider information is captured in order to provide accurate information to our clients and members regarding your programs.

NETWORK RELATIONS

Overview of Health Care Provider Implementation Activities

Upon notification of a new health care provider agreement, a Network Relations Representative will be assigned to your medical center. This person will call your operations contact to begin the contract implementation process.

In general, this call will consist of the following:

- Overview of the OptumHealth Kidney Solutions Preferred network
- Collection of basic information about your medical center
- Scheduling of training sessions with your clinical and billing staff
- Outline of subsequent steps in the implementation process

Questions your medical center may have during the time period surrounding the implementation of a new or amended agreement should be directed to your designated Network Relations Representative.

The OptumHealth Health Care Provider RFI

The Request for Information (RFI) enables OptumHealth to gather detailed, program-specific operational information. The RFI will be forwarded to your medical center for completion following the overview call from your Network Relations Representative. The KRS Contract Manager will also engage in this activity to ensure both parties are working effectively to promote and drive members to the preferred network provider.

Timely completion of the RFI is imperative in order to effectively enter your programs into the OptumHealth systems and market your medical center to our clients and members. If the RFI is not received, it may impact patient referral as well as claims processing and payment.

When contact, address, telephone and/or Web site information changes at your medical center, it is critical that you notify OptumHealth so that updates can be made on all OptumHealth systems (Web sites, claims payment, marketing, etc.).

Contract Implementation

Upon signature, OptumHealth will enter the terms and provisions of your contract in our systems. Typically, this process is completed without additional input from your medical center based on timely submission of the RFI. However, if the RFI has not been returned, the assigned Network Relations Representative will contact you to obtain the information needed to add your contract to OptumHealth's systems. Our goal is to create and implement a productive working partnership with our preferred providers. Having accurate, complete and timely information can assist in this process.

Health Care Provider On-boarding for New Contracted Providers

Following the execution of a new agreement or amendment, the Network Relations Representative will work with the main operations contact at your medical center to help ensure that all aspects of the relationship with OptumHealth are functioning smoothly.

The on-boarding phase of the implementation process will end when operations are established to the mutual satisfaction of all parties (operational contact(s) at your dialysis centers, OptumHealth, Network Relations Representative and Supervisor).

Once the on-boarding period has ended, service responsibilities between your dialysis centers and OptumHealth will reside with the customer service and network relations teams.

Health Care Provider Training

Concurrent with the execution of a new agreement, training will be scheduled with clinical and billing staff at your medical center. All processes and tools provided by OptumHealth and referenced in this guide will be discussed during these training sessions. This training is important to ensure that your staff is comfortable with the operational efficiencies available.

Additional training is always available upon request. Please contact your Contract Manager or Network Relationship Manager to set up additional training.

CUSTOMER SERVICE CONTACT GUIDE

If your medical center has questions about working with OptumHealth, please refer to the table below for contact information. If you encounter an issue that is not listed below, please contact our customer service team at:

(877) 801-3507
Prompt 3 – Health Care Provider
cmc.customer.service@optumhealth.com

Topic / Question	Contact who?	How?
Questions about information on a Notification Form or to obtain a copy of an NF form.	Network Relations	(877) 801-3507 Prompt 3 – Health Care Provider cmc.customer.service@optumhealth.com
We have not yet received an NF for a patient that is currently being seen at our medical center.	Payer Case Manager	(877) 801-3507 Prompt 3 – Health Care Provider cmc.customer.service@optumhealth.com
Questions about patient eligibility, inpatient preadmission, patient benefit information.	Payer Case Manager	See case manager contact information on Notification Form.
Administrative issues on a Kidney Resource Services case requiring special coordination between the health care provider and OptumHealth	Network Relations	(877) 801-3507 Prompt 3 – Health Care Provider cmc.customer.service@optumhealth.com
Contract interpretation	Network Relations	(877) 801-3507 Prompt 3 – Health Care Provider cmc.customer.service@optumhealth.com
Contract negotiation	Network Development	(877)801-3507 Ask for your designated OptumHealth Contracting Representative
Request for training	Network Relations	(877) 801-3507 Prompt 3 – Health Care Provider cmc.customer.service@optumhealth.com
Questions about EDI claims submission	Network Relations	(877) 801-3507 Prompt 3 – Health Care Provider cmc.customer.service@optumhealth.com
Questions on the annual survey or the Clinical Sciences Institute qualifying process	Clinical Sciences Institute	(877) 801-3507 Prompt 3 – Health Care Provider cmc.customer.service@optumhealth.com
Payment status for UnitedHealthcare patients	Network Relations	(877) 801-3507 Prompt 3 – Health Care Provider cmc.customer.service@optumhealth.com

Complex Medical Conditions Web Portal

OptumHealth Care Solutions has developed a secure Web site to specifically address the needs of our contracted facilities. The Web site provides access to important information about your active and closed cases and the ability to view claims receipt and pricing details. The provider Web site is www.myoptumhealthcomplexmedical.com and you can request access to all centers that you are required to monitor and view.

Our client Web portal, www.myoptumhealthcomplexmedical.com/client, is a resource for our employer, payer, and public sector clients. The site is designed for our clients and serves many purposes throughout the OptumHealth experience. One can see the provider networks available to their members, submit a notification or case referral and monitor open cases and claim information. The Find a Health Care Provider section is one of the areas most frequented by our clients. This functionality allows them to locate the most appropriate health care provider for their members based on user-selected criteria (facility name, chain name, dialysis program type, geographic location, etc.). Once the search is refined, data provided on our client site at a facility level includes survival rankings (URR and HGB), number of stations, after 5pm hours, certification date, as well as a brief provider contract summary demonstrating the financial value of a facility.

PAYER CLIENT PROCEDURES

As described in your OptumHealth agreement, OptumHealth payer clients may have procedures that providers must follow, such as prior authorization and eligibility verification. Please contact the member's primary payer to obtain such procedures, or you may refer to any existing procedure documentation that your organization has from the member's primary payer.

PROVIDER PARTICIPATION RULES: OPTUMHEALTH KIDNEY SOLUTIONS PREFERRED NETWORK

Health care providers participating in the OptumHealth Kidney Solutions Preferred network must abide with and by all provisions below. Failure to adhere to any provision will result in exclusion from the Kidney Solutions Preferred network.

Criteria

OptumHealth, in conjunction with an expert panel of nephrology specialists respected in their field, develop proprietary criteria upon which you are evaluated for inclusion in OptumHealth's Kidney Solutions Preferred network. The evaluation criteria are updated in response to emerging clinical data or medical techniques and technologies. OptumHealth's Clinical Sciences Institute department performs the provider evaluations on an initial and annual basis. You will be evaluated against the following benchmark criteria:

1) Dialysis adequacy

2) Anemia management

3) Survival

4) CMS certification

Compliance with OptumHealth's Operations Guide

You must comply with all provisions located in the OptumHealth Operations Guide. This may include, but is not limited to, the following topics:

- Eligibility, coverage, prior approval/authorization inquiries – Client's directions should be followed for verifying a prospective member's eligibility and level of coverage. You may also be required to request prior approval/authorization for services on the prospective member's behalf.
- Standards of practice guidelines, along with a panel of multi-disciplinary specialty physicians may set standards of practice guidelines for Kidney Solutions and ESRD-related treatment of OptumHealth members or OptumHealth's client's members.
- Claims – the Operations Guide contains information for proper claims submission. You will need to fill out all applicable forms and fields before OptumHealth will process the claims.
- Utilization review guidelines should be followed for furnishing the appropriate information to allow OptumHealth to perform its own utilization review of a member's inpatient stay.

Consultation

Please consult the CSI team at clinical.science@optumhealth.com regarding OptumHealth's qualification review process.

NOTIFICATION FORM

OptumHealth member referrals are communicated to our contracted Kidney Resource Services centers via the Notification Form (NF). The NF should be received prior to the member's first visit to your medical center and is used to provide your staff with key information about a member who has been referred for dialysis treatments.

The OptumHealth notification form is our organization's form of a member ID card. This informs the center that a member will be accessing the OptumHealth contract with the effective date of the member's case. This form has the claims mailing address and the Case Manager assigned to manage the case. Once a notification is received, you are able to submit claims to OptumHealth for pricing per your contract language.

We suggest that distribution of this information occur as indicated below:

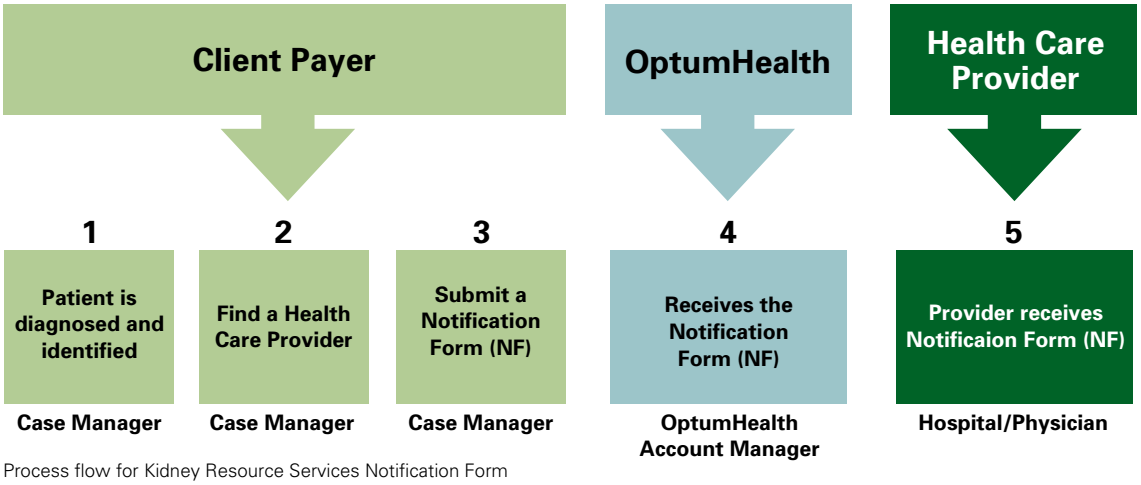
- Clinical staff should be given the contact name and phone number of the payer case manager. This information is used to obtain authorization for care and to provide updates on member status.
- Billing and administrative staff are notified by the NF that claims are to be sent directly to OptumHealth.
- Your facility is responsible for forwarding the NF sent to any affiliated entities or contacting your affiliates to provide the OptumHealth case effective date and OptumHealth billing address.

Additionally, we recommend that your administrative system be flagged so that the member is identified as an OptumHealth Kidney Resource Services member. This will help ensure that dialysis related claims are submitted to OptumHealth.

Reminder: It is your organization's responsibility to verify member benefits at the beginning of the case.

NF Process

The NF is completed by an OptumHealth case manager/clinical consultant, or by an OptumHealth client and sent to OptumHealth. A member record is created within our systems based on the information provided on the NF. The NF is then forwarded to designated contacts at your medical center. (This contact information is collected within the health care provider RFI.)



Process flow for Kidney Resource Services Notification Form

Kidney Resource Services Notification Form (Client Submitted)

OptumHealth℠

CONFIDENTIAL

NOTIFICATION FORM
CLIENT

Use this form to notify OptumHealth of your intent to access its participating health care provider agreement for evaluation and/or specialized services. Please fax to OptumHealth at (262) 313-9808 or email to cmc_client_services@optumhealth.com.

Complete Sections 1–4 for the following referrals:	Complete sections 1-4 and the corresponding section for the following referrals:
☐ Transplant Network ☐ Transplant Access Program	☐ Congenital Heart Disease (section 5) ☐ Cancer Resource Services (section 6) ☐ Bariatric Resource Services (section 7) ☐ Kidney Resource Services (section 8)

Is this an Extra Contractual or non-OptumHealth contracted medical center/program referral? ☐ Yes ☐ No

SECTION 1 - MEDICAL CENTER INFORMATION

Medical Center: Program Type:

SECTION 2 - CLIENT INFORMATION

Client: _____ Distributor: _____

Stop Loss Carrier: _____

Stop Loss Carrier Contact: _____ Stop Loss Carrier Contact Phone #: _____

Client Case Manager: _____ Phone #: _____ Fax #: _____

Street Address: _____ E-mail Address: _____

City: State: Zip Code:

SECTION 3 - CLAIMS INFORMATION

Claims Mailing Contact: _____ Phone #: _____ Fax #: _____

Claims Mailing Address: _____ City, State & Zip: _____

Claims Status Contact: Phone #: Fax #:

SECTION 4 - PATIENT INFORMATION (Patient Name and ID# must be exactly as it appears on health care ID card)

Name: _____ ID #: _____ ☐ M ☐ F DOB: _____ Phone #: _____

Street Address: _____ City, State & Zip: _____

Diagnosis: _____ ICD/9 Code: _____

Has the patient been evaluated, received services or had surgery at this center? ☐ Yes ☐ No ☐ Eval/Svcs/Surgery not scheduled

☐ Eval/Svcs/Surgery rendered on: _____ ☐ Eval/Svcs/Surgery scheduled for: _____

Employer/Group: _____

Patient Coverage Effective Date: _____ Eligibility Verification Phone #: _____

Other Coverage (if applicable): _____ ☐ Primary ☐ Secondary

☐ Medicare ☐ Medicaid Effective Date (if applicable): _____

Accessing Phase V? (Optional post-transplant phase of the OptumHealth contract) ☐ Yes ☐ No

SECTION 5 - FOR IN-UTERO OR NEWBORN CHD REFERRALS, PLEASE COMPLETE THE FOLLOWING:

Mother's Full Name: _____ ID #: _____ Primary Insured? ☐Yes ☐ No

Father's Full Name: _____ ID #: _____ Primary Insured? ☐Yes ☐ No

The Importance of the Notification Form

The OptumHealth Notification form is our organizations form of a member ID card. This informs the center that a member will be accessing the OptumHealth contract with the effective date of the case. This form has the claims mailing address and the Case Manager assigned to manage the case. Once a notification is received, you are able to submit claims to OptumHealth for pricing per your contract language.

Kidney Resource Services

All hospital and physician billing should be forwarded to:

OptumHealth Care Solutions
PO Box 30758
Salt Lake City, UT 84130

Or use Electronic Payer ID 41194

NOTIFICATION FORM

Date:

Client Name:

Medical Center:

Case Manager:

Address:

Primary Fax: **Primary Phone:**

Case Effective Date: *Please submit all claims to OptumHealth as of this date*

PATIENT INFORMATION

Name: **Date of Birth:**

Member #: **Phone:**

Address:

Please remember:
Upon receipt of the Notification Form, and before providing non-emergency health services to a member, Medical Center will contact Payer to verify Member's eligibility for health services under a benefit plan. Medical Center is responsible for verifying Member's continued eligibility for health services. OptumHealth is not responsible for determining Member eligibility for health services, authorization for services, or interpretation of benefit contracts.

Client Case Manager is responsible for notifying Medical Center of their request that clinical correspondence be copied to the case manager, primary physician and/or referring physician. Client Case Manager is responsible for coordination of patient care.

The health services described on this Notification Form fall within the terms of the participation agreement between OptumHealth and Medical Center as named above. Client, through its agreement with OptumHealth has access to the rates described in that participation agreement.

NOTICE OF CONFIDENTIALITY: This information is intended only for the person or entity to which it is addressed and may contain confidential and/or privileged material. Any review, retransmission, dissemination or other use by persons or entities other than the intended party is prohibited.

KRS-010807

Locating the Payer Case Manager on the NF

OptumHealth or Payer case manager contact information is provided on the Kidney Resource Services notification form sent to the health care provider for each member. This information is located in the upper-third of the form.

Communication with the Payer Case Manager

Payer case managers have a variety of critical responsibilities that vary from payer to payer. Normally, they are the contact point for information about benefit eligibility, eligible services, preauthorization of services and discharge planning.

It is important to keep in mind that the OptumHealth or payer case manager is influential in referring patients to Kidney Resource Services centers. Their relationship with the clinical contacts within your Kidney Resource Services program, as well as the ease with which they can obtain the information they need, has an impact on referral decisions. OptumHealth strongly encourages timely communication with payer case managers to help facilitate administration of patient care and timely payment of claims.

Clinical Operations

The Clinical Operations Team is responsible for working with members who have been diagnosed with Stage 4, Stage 5 or End Stage Renal Disease. This team consists of registered nurses and a board certified Nephrologist and is supported by administrative resources. These nurses, collaborating with providers, may request lab results to support their efforts. The main responsibilities of the team, by program component, include:

Chronic Kidney Disease (pre-dialysis) Disease Management Program

- Referral to a Nephrologist
- Promotion of pre-emptive kidney transplantation
- Management of co-morbidities
- Guidance to top performing, in network dialysis centers

End Stage Renal Disease (dialysis) Disease Management Program

- Management of co-morbidities
- Collection of labs to ensure patients are receiving optimal care
- Promotion of kidney transplantation
- Guidance to top performing, in network dialysis centers

When to Contact the Payer Case Manager

Noted below is a table that can be used as a reference guide for communication with payer case managers.

When?	Call Who?	About What?
Initial Referral	OptumHealth or Payer Case Manager	• Exchange contact information • Discuss pre-certification process • Choose facility • Identify follow-up plans
	Referring Physicians	• Scheduled date of surgery or other treatment

During Dialysis Treatment	OptumHealth or Payer Case Manager and Referring Physician	• Date of dialysis initiation, pre-certification notification
		• Establish follow-up plan for routine inpatient updates
		• Discuss discharge planning at least 2 days prior to discharge:
		  • Home care needs
		  • DME needs
		  • Medication needs through an agreed-upon pharmacy
		• Follow-up plans
		• Establish ongoing communication plan

Always contact the Payer Case Manager in the case of death. It is also important to keep the referring physician informed throughout the treatment process. Regular communication is key.

ACTIVE NETWORK CLIENT LIST

Confirmation of member's status with OptumHealth can be accomplished by contacting us at:

(877) 801-3507
Prompt 3 – Health Care Provider
cmc.customer.service@optumhealth.com

CLAIMS SUBMISSION

Claims must be sent to the OptumHealth claims team for pricing. Once priced according to the contract, claims will be forwarded to OptumHealth payers for payment. All claims submitted are priced based on the OptumHealth agreements and member setup information from the Notification Form. Therefore, it is important that planned services be verified on the Notification Form for accuracy prior to claims submission.

Where to Submit Claims

All claims filed on both UB04 and CMS1500 claims must be forwarded to OptumHealth as indicated below:

Electronic Claims Payer ID Information

OptumHealth
Emdeon and ClaimLynx Payer ID #41194

Paper Claims Address Information

OptumHealth
PO Box 30758
Salt Lake City, UT 84130

Emergency Claims Submission

In cases of emergency, your medical center can submit claims to OptumHealth using overnight delivery. Please call our toll-free number (877-801-3507) to provide us with notification of overnight claims delivery.

LASON – SCS RMO
Attention: OptumHealth
4050 South 500 West, Suite 50
Salt Lake City, UT 84123

How and When to Submit Claims

Claims should be filed electronically or on paper in an 837 HIPAA compliant format on standard UB04 and HCFA1500 claims forms and completed using industry standard coding.

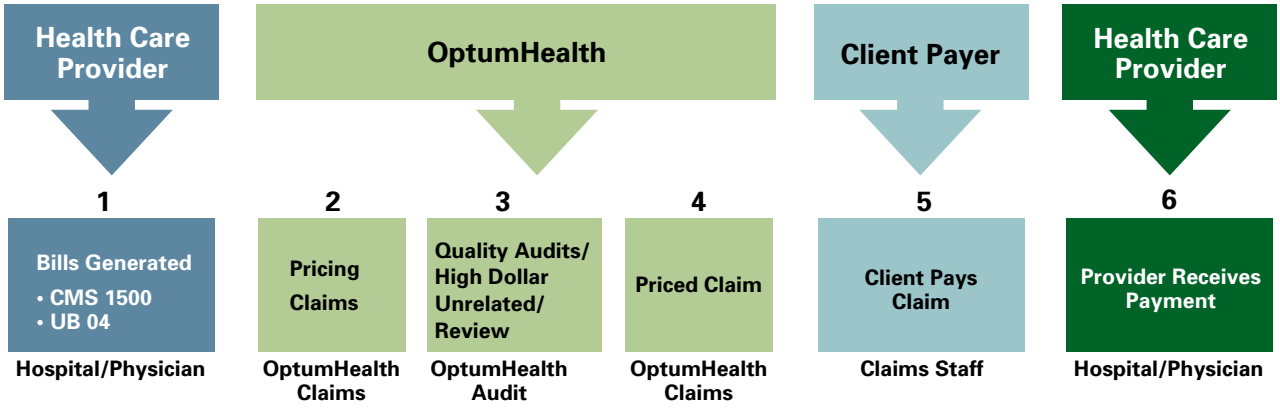
Timely Filing

Your medical center agreement contains a claim filing deadline. Please consult your agreement for the timely filing deadline for your medical center. OptumHealth or its payers, at their discretion, may elect to not accept claims that are submitted after the timely filing deadline.

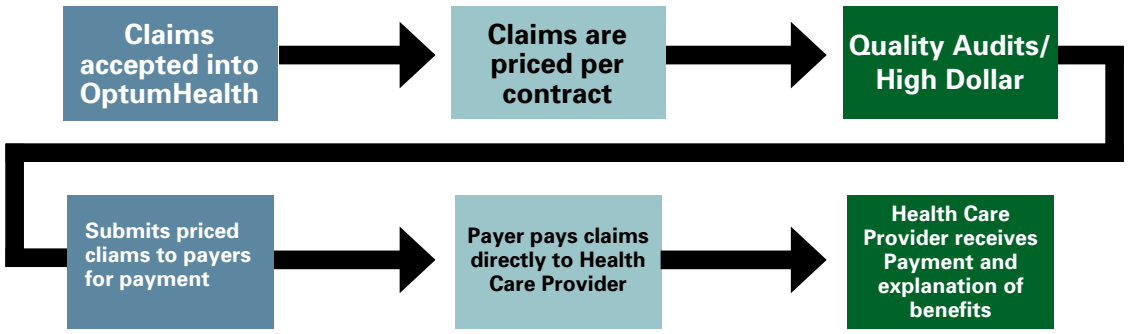
WHAT HAPPENS TO CLAIMS UPON SUBMISSION TO OPTUMHEALTH?

Claims submitted to OptumHealth follow a defined process that allows for timely and accurate pricing prior to submission for payment by our payer clients.

Claims Intake and Pricing Process Flow



Priced Claims Payment Process



After OptumHealth prices the claims, they are sent to clients along with a report explaining the claims. See Appendix A for an example of a Client Claims Report.

CLAIMS THAT ARE CLOSED OR SENT BACK TO THE HEALTH CARE PROVIDER

Occasionally OptumHealth will close claims submitted by health care providers and accepted into our system. Reasons for claims closure include:

- Duplicate claims
- Missing or invalid data
- Claim submission by an unaffiliated provider
- Claims dates of service that do not fall into the eligibility period for the member

Some claims are rejected before entry into our system because the member's name, date of birth or the provider's tax identification number does not match information set up for the member's case or the medical center.

CLAIMS PRICING AND PAYMENT PROCESS

Process Overview and Guidelines

- OptumHealth prices claims received from your medical center based on your specific OptumHealth agreement.
- OptumHealth sends priced claims to payers for processing.
- OptumHealth payers apply patient benefits to the priced claim amount and determine which services are eligible for reimbursement. Member responsibility amounts such as co-payments, coinsurance and deductibles are applied.
- Your medical center may bill the member for any amounts that are the responsibility of the member. These amounts will be shown as member responsibility on the explanation of benefits/health care provider remittance advice.
- If there is an overpayment, OptumHealth will notify your medical center of the overpayment via a refund notice. We will also notify the payer of an underpayment on the final invoice.

CLAIMS STATUS PROCESS

Claims inquiries can be submitted to OptumHealth if payment has not been received within 45 days of services rendered. Inquiries are tracked by the Network Relations team. Assigned team members will contact payers, as needed, to verify payment status.

There are three ways you can submit inquiries as illustrated in the table below:

# Claims	Method	How to Submit?
Internal 1-10 Internal >10	Phone/email Email	(877) 801-3507 Prompt 3, Health Care Provider cmc.customer.service@optumhealth.com
External Any volume	Phone	Contact payer directly either by phone or payer Web site
External Any volume	Email	Email : cmc.customer.service@optumhealth.com

OptumHealth Claims Status Submissions

The following is a summary of the Network Services policy regarding handling of customer service inquiries:

Following submission of an inquiry, you will be issued an inquiry ID number to track the progress of your status request to resolution. If you submit your request by phone, the inquiry ID number will be provided at the end of the call. If your request was submitted via fax or email, the inquiry ID number will be returned within 24 hours to the contact information provided on the request.

Your Network Relations Representative will provide regular status updates on the resolution of your request. The frequency of these updates will vary depending on the number of cases, claims and payer(s) included in the request.

CLINICAL DATA SHARING

Participation and Cooperation with Kidney Resources Services (KRS) Clinical Consultants:

Payer case managers have a variety of critical responsibilities that vary from payer to payer. They are normally the contact point for information about benefit eligibility, eligible services and preauthorization requirements. Timely communication will facilitate your administration of the dialysis patient, including the timely payment of claims.

The payer case manager is influential in referring patients to dialysis centers. Their relationship with the clinical contact with the dialysis program, as well as the ease with which they can obtain the information they need, has an impact on referral decisions.

Clinical Data Sharing, Routine and Ad-hoc:

In an effort to manage the volume of clinical data required to ensure quality of care, we are encouraging all dialysis providers to send electronic information whenever possible to the KRS staff. Specific Agreement requirements can be found in Appendix 5 of the Ancillary Provider Agreement.

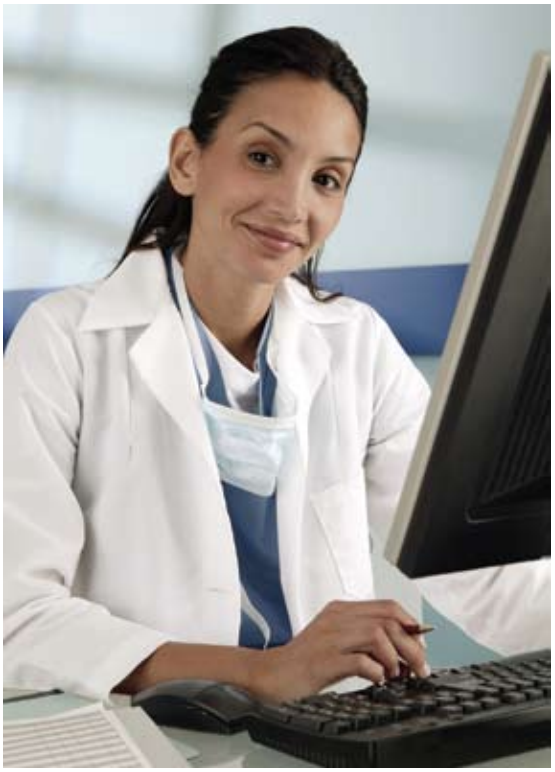
Routine Data Sharing: This clinical data is required on a monthly basis in order to monitor lab values and dialysis treatment information as a minimum. The intent of this requirement is to monitor and improve clinical quality outcomes for the member.

Ad-hoc Data Sharing: As medically appropriate, the case managers may request additional clinical information.

Medical Records Standards

Medical records will contain all information necessary and appropriate to support claims for services submitted by you. In providing care for OptumHealth clients and members, we expect that you have policies to address the following:

1. Maintain a single, permanent medical record that is current, detailed, organized and comprehensive for each member that is available at each visit
2. Protect member records against loss, destruction, tampering or unauthorized use
3. Maintain medical records in accordance with state and federal regulations



GLOSSARY OF ACRONYMS

Listed below are commonly used acronyms.

CED	Case Effective Date
CM	Case Manager
COB	Coordination of Benefits
COE	Centers of Excellence network
CSI	Clinical Sciences Institute (OptumHealth)
DOS	Date of Service
DX	Diagnosis
EDI	Electronic Data Interchange
EOB	Explanation of Benefit
ESRD	End Stage Renal Disease
CMS 1500	Physician claim form
ID	Identification #. Typically associated with Claim ID or Member ID.
KRS	Kidney Resource Services
LOS	Length of Stay
NF	Notification Form
PDF	Portable Document Format
PHI	Protected Health Information
POS	Place of Service
RFI	Request for Information
RMO	Remote Mail Office
TAT	Turn Around Time
UB04	Uniform Billing Code of 2004; also known as the hospital claim form
Provider Website	OptumHealth's secured web site for contracted facilities

APPENDIX

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Client Claim Detail Report

Cpay ID MILL90065
Group Id 10012078

Distributor Name ConnectiCare, Inc
Client Name ConnectiCare, Inc.

Member/U.R.N. Case ID		*Evaluation Date*	7/5/2005
Facility		*List Date*	7/14/2005
Program Type	CHD CATEGORY 2	*Admit/Transplant Period Begin Date*	8/7/2005
Inactive Date	10/5/2005	*Transplant Date*	
Inactive Reason	Manual	*Discharge Date*	10/5/2005

Case Summary	Physician Billed	Hospital Billed	Physician Repriced	Hospital Repriced
Phase I	$47,446.00	$83,119.00	$33,212.20	$58,183.30
Phase II	$5,157.00	$207,446.00	$1,051.10	$128,616.52
Phase III	$0.00	$0.00	$0.00	$0.00
Totals	**$52,603.00**	**$290,565.00**	**$34,263.30**	**$186,799.82**

Case Summary is intended as a reference and is subject to change with additional claim activity.

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Client Claim Detail Report

Cpay ID MILL90065
Group Id 10012078

Distributor Name ConnectiCare, Inc
Client Name ConnectiCare, Inc.

Claim ID	Claim Line No.	From DOS	Thru DOS	Proc Code	Billed Amt	Repriced Amt	Method	Phase	U.R.N. Repricing Description
052220228400	1	7/5/2005	7/5/2005	7102026	$69.00	$48.30	Percent	1	OptumHealth Contract Percentage
Totals					**$69.00**	**$48.30**			

Claim ID: 052220228400 **Bill Type: HCFA** **U.R.N. claim repriced amount: $48.30** **OptumHealth Contract Percentage**

Total Claim Count: 1

Notes

Notes

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Care Solutions

*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.

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 M47707 5/10