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*Plaintiff is self-represented*

# Commonwealth of Massachusetts

**NANTUCKET, ss.**

**SUPERIOR COURT DEPARTMENT OF THE TRIAL COURT**

Gustavo Kinrys, M.D.,

**PLAINTIFF**

**v.**

Mass General Brigham Health Plan, Inc. and Optum, Inc.,

**DEFENDANTS**

**SUPERIOR COURT CIVIL ACTION NO.:** 2375CV00038

**DEMAND FOR JURY TRIAL**



## COMPLAINT

Plaintiff Gustavo Kinrys, M.D. ("Plaintiff"), hereby sues Defendants Mass General Brigham Health Plan, Inc. (MGBHP) and Optum, Inc. ("Defendants"), alleging as follows:

## I. NATURE OF THE ACTION

This action arises from Defendants' systematic and unlawful failure to reimburse Plaintiff for over Ten Million Dollars ($10 million) in medical claims submitted from March 2017 to April 2021 for psychiatric services provided to Defendants' members, despite repeated assurances that Plaintiff would be properly reimbursed pursuant to the parties' provider agreement.

Defendant AllWays Health Partners, which operated as a regional health insurance company under that name during the relevant period, announced in 2022 that it would change its name to Mass General Brigham Health Plan, Inc. (MGBHP) effective January 1, 2023. This name change reflected AllWays Health Partners' membership within the Mass General Brigham health system and was meant to advance the system's provider-payer integration model. However, the entity remained the same regional health insurer that originally entered into the provider agreement with Plaintiff during the 2017-2021 period.

Optum, Inc., which administered the behavioral health benefits for AllWays Health Partners/Mass General Brigham Health Plan during that period, along with the health insurer itself, further interfered with Plaintiff's contractual relationships by terminating his provider status in retaliation for asserting his contractual rights.

## II. THE PARTIES

1. Plaintiff is an individual residing in Nantucket, Massachusetts. Plaintiff is a licensed psychiatrist who was credentialed and participated in Defendants' provider network.
2. Upon information and belief, Defendant Optum, Inc. is a subsidiary of UnitedHealth Group that administered the behavioral health benefits for AllWays Health Partners, now known as Mass General Brigham Health Plan, during the relevant period.

3. Upon information and belief, Defendant Mass General Brigham Health Plan, Inc. (MGBHP) previously operated under the name AllWays Health Partners when it entered into the provider agreement with Plaintiff. In 2022, AllWays Health Partners announced it would adopt the Mass General Brigham Health Plan name effective January 1, 2023 to reflect its integration within that health system. However, it remained the same legal entity that contracted with Plaintiff during the 2017-2021 period.

## III. JURISDICTION AND VENUE

4. This Court have jurisdiction over this matter pursuant to Massachusetts General Laws, (M.G.L.) c. 212, § 4, which grants jurisdiction to the Nantucket Superior Court for civil actions involving breach of contract and violations of Massachusetts Consumer Law (Chapter 93A) over $50,000.
5. Venue is proper in Nantucket County pursuant to M.G.L. c. 223 § 1, as Plaintiff resides in Nantucket County, Massachusetts.

## IV. STATEMENT OF FACTS

6. Plaintiff was a credentialed and participating provider in Defendants' provider network and the parties entered into a Participating Provider Agreement ("Agreement") effective January 1, 2011 and once again, into another Participating Provider Agreement on October 2019.
7. Pursuant to the Agreement and its payment policies (Exhibits A and B), Defendants are obligated to reimburse Plaintiff for covered medical services provided to Defendants' members at the negotiated contract rates (Exhibit C).

8. From March 2017 to April 2021, Plaintiff rendered covered medical services to Defendants' members as outlined in over 3,000 separate claims submitted to Defendants.
9. Defendants have systematically failed and refused to reimburse Plaintiff for any of these claims, which now total over Ten Million Dollars ($10 million) in billed charges.
10. Defendants' refusal to reimburse Plaintiff's claims constitutes a material breach of the Agreement.
11. On multiple occasions Plaintiff inquired as to the status of its unpaid claims and when reimbursement could be expected.
12. In response, Defendants assured Plaintiff that the claims were being processed and reimbursement would be issued promptly pursuant to the Agreement.
13. At the time such assurances were made, Defendants knew they were deceptive and misleading and had no intention to properly reimburse Plaintiff's claims.
14. Defendants' actions constitute unfair and deceptive trade acts and practices under M.G.L. c. 93A.
15. Plaintiff made numerous written and oral demands for reimbursement, all of which were ignored by Defendants without explanation.
16. Defendants provided shifting and inconsistent reasons for non-payment of claims, none of which are valid under the Agreement.
17. Defendants subjected Plaintiff to an onerous pre-authorization process not required under the Agreement, causing significant delays.
18. Defendants interfered with Plaintiff's business relationships with patients by deceptively representing that Plaintiff was intentionally overbilling.

19. In or around March 2017, Defendants apparently opened a fraud investigation against Plaintiff regarding the unpaid claims and accused Plaintiff of intentionally overbilling and providing medically unnecessary services.
20. Defendants accused Dr. Kinrys of fraudulent billing practices, when in reality, Defendants were systematically breaching the provider agreement by refusing to reimburse over 3,000 properly documented claims worth over $10 million. Defendants levied its spurious fraud allegations to deter Dr. Kinrys from pursuing compensation for services rendered to Defendants' members in good faith reliance on the provider agreement.
21. Defendants levied these accusations without any evidence of actual fraud by Plaintiff.
22. Defendants did not have any good faith basis to allege fraud, but instead made these allegations in order to intimidate Plaintiff from seeking reimbursement and to avoid its contractual obligations.
23. Defendants threatened criminal prosecution against Plaintiff if the overbilling was not corrected, even though Defendants knew the billing was proper under the Agreement.
24. Defendants continued to represent to patients and others in the community that Plaintiff was under fraud investigation and patients should avoid Plaintiff's services.
25. Defendants' misleading and deceptive fraud allegations were made intentionally and maliciously to harm Plaintiff's reputation and ability to seek reimbursement.
26. Immediately after opening the fraud investigation in or around March 2017, Defendants began auditing every single claim submitted by Plaintiff, which amounted to over 3,000 claims.

27. Defendants used the opened investigation as a pretense to deny reimbursement on claims it had previously verified and approved, including behavioral health services that require prior authorization, which were approved by Defendants before being rendered.
28. Defendants claimed they could not pay the claims until it received and reviewed all medical records, even though Plaintiff consistently provided all requested records.
29. Throughout the alleged fraud investigation, Defendants continued to review and approve Plaintiff's requests for prior authorization on specific services and treatments. Defendants granted these prior authorizations, allowing Plaintiff to provide the authorized services to Defendants' members with the understanding that Plaintiff would be properly reimbursed. However, despite of reviewing and approving the services and Plaintiff providing them in reliance on that approval, Defendants still refused to render payment for those very same services.
30. Over the next two years, Defendants continued to assure Dr. Kinrys that his claims were being processed and would be paid in due course. However, Defendants knew these representations were misleading and deceptive, and that it had implemented internal policies to intentionally delay and deny reimbursement for Dr. Kinrys' services.
31. When Plaintiff inquired about ceasing services to Defendants' members due to non-payment, Defendants urged Plaintiff to continue providing services, representing that reimbursement would be made once the records were received.
32. At the same time, Defendants continued telling patients and others that Plaintiff was under fraud investigation to avoid paying claims.
33. Defendants undertook this expanded audit and records request process in bad faith solely to impose additional costs on Plaintiff and deter Plaintiff from seeking proper reimbursement.

34. Through a deliberate strategy of systematically denying valid claims and imposing limitations on provider networks, Optum gravely compromises patients' access to the quality care they deserve. This oppressive tactic of forcing doctors into ceaseless battles for rightful compensation not only undermines their capacity to serve the ill but also detrimentally impacts the well-being of those seeking medical assistance.

35. Furthermore, Plaintiff asserts that Optum and MGBHP leveraged their monopolistic standing to exploit providers by imposing exorbitant and unreasonable reimbursement terms. This practice unduly restricts network providers, effectively handcuffing them with unjust constraints. Concurrently, Optum and MGBHP pursue the expansion of their reach by procuring additional management of mental health benefits from various insurers, a maneuver that systematically inflates its profits and further solidifies its control over the market.

36. These anticompetitive maneuvers starkly exemplify Optum and MGBHP's monopolistic abuse, starkly contravening established antitrust laws.

37. In or around June 2019, after Plaintiff's unpaid claims reached over $15 million, Defendants performed an internal audit and determined the amount Defendants actually owed Plaintiff far exceeded the overbilling amount alleged in Defendants' fraud investigation.

38. Upon realizing this, Defendants made the decision to terminate Plaintiff from its provider network in order to further avoid paying the owed reimbursements.

39. Defendants were aware that Plaintiff was prepared to take legal action over the unpaid claims, as Plaintiff's attorneys contacted Defendants in August 2018 requesting mediation and a cure for the issues stated.

40. Rather than mediate in good faith, Defendants chose to retaliate against Plaintiff by sending notification of Plaintiff's termination from the provider network effective on December 2020.
41. Defendants' termination of Plaintiff came directly on the heels of Plaintiff's demands for payment and threats of litigation, evidencing the termination was done intentionally to punish Plaintiff for asserting its contractual rights.
42. Optum and MGBHP have an extensive history of legal and regulatory actions taken against it for violating consumer protection and healthcare laws. This includes privacy breaches affecting hundreds of thousands of consumers, overcharging Medicare Advantage customers in violation of rate regulations, systematically denying mental health coverage in violation of parity laws, failing to provide required coverage under the ACA, and misleading subscribers about policy exclusions.
43. Additionally, Optum and MGBHP have faced complaints and lawsuits accusing it of improper claims handling and reimbursement practices such as denying or reducing payment to subscribers and providers, utilizing inconsistent and burdensome pre-authorization procedures that harm access to care, and subjecting claims to inadequate and biased reviews in order to restrict payment. This broad pattern of misconduct under Massachusetts and federal healthcare laws provides further support that OPTUM AND MGBHP have engaged in similarly unlawful practices in its dealings with Plaintiff.
44. As part of this scheme, Plaintiff alleges that Defendants engaged in concerted action with federal prosecutors, exchanging misleading and deceptive information, fabricating evidence, and exerting influence over the prosecution process to initiate sham investigations against Plaintiff and other healthcare providers.

45. Defendants conspired with federal prosecutors in an unlawful collaboration aimed at violating Plaintiff's constitutional rights and retaliating against providers who asserted their legal rights for proper reimbursement.
46. This concerted action was not limited to Plaintiff alone; other providers faced similar retaliation and unfounded investigations due to Defendants' connections with prosecutors, establishing a pattern of coordinated action.
47. Plaintiff contends that Defendants and federal prosecutors formed a joint enterprise with a common purpose and design to retaliate against healthcare providers, including Plaintiff, by leveraging improper criminal charges.
48. Defendants and prosecutors acted in cooperation and coordination, initiating fraudulent investigations and fabricating evidence to target Plaintiff and other providers unfairly.
49. The existence of other providers who were similarly targeted and victimized by this joint enterprise serves as additional evidence of its deliberate and patterned operation.
50. Defendants maintains established connections with federal and state law enforcement agencies, including the Office of the Inspector General, the Department of Human health Services, US Attorney's Office, and the Massachusetts Attorney General's Office. Defendants have leveraged these connections on multiple occasions in the past decade to initiate unjustified investigations against select physicians and medical practices.
51. Typically, the targets of these improper investigations are providers who Defendants considers "expensive outliers" due to higher than average reimbursement claims. Defendants makes use of intentional misinformation provided to law enforcement and elected officials to spur sham investigations meant to intimidate the providers.
52. Once a retaliatory investigation is opened, Defendants utilizes it as pretext to terminate or refuse to reimburse the affected providers. This pattern of weaponizing law enforcement

connections to influence investigations, trigger prosecutions on misleading and deceptive pretenses, and coordinate termination of the targeted providers constitutes an improper and extortionate enterprise.

53. Plaintiff alleges that Defendants Optum and MGBHP engaged in an unlawful concerted scheme with federal prosecutors to target Optum and MGBHP collaborated with prosecutors to exchange feigned evidence and misleading and deceptive information about Plaintiff and other providers. Optum and MGBHP then leveraged its connections to influence sham criminal investigations against these providers in retaliation for their complaints against Optum and MGBHP's reimbursement practices.
54. Optum and MGBHP and federal prosecutors operated as a joint enterprise with the common purpose of denying providers their rights and avoiding Optum and MGBHP's civil liability. This joint enterprise involved coordination between Optum and MGBHP and prosecutors to manufacture criminal cases against vocal providers like Plaintiff through improper means.
55. Plaintiff highlights that over the past 30 years and as recently as August 2023, Optum and MGBHP have faced multiple government lawsuits regarding its fraudulent schemes against Medicare and other programs, resulting in substantial civil settlements. However, despite this lengthy history of systemic misconduct, Optum and MGBHP have evaded any criminal prosecution through its undue influence over state and federal agencies.
56. In contrast, Plaintiff alleges that Optum and MGBHP have manipulated prosecutors to criminally charge individual providers who dare to assert legal rights against Optum and MGBHP's wrongdoing. By deflecting scrutiny onto solitary providers, Optum and MGBHP shield itself from accountability while still improperly avoiding payment to providers. This amounts to an egregious double standard that must be exposed.

57. Furthermore, Plaintiff contends that Optum and MGBHP and federal prosecutors formed a joint enterprise with a common purpose and design to retaliate against healthcare providers, including Plaintiff, by leveraging improper criminal charges. The joint enterprise involved a systematic coordination of actions, including fraudulent investigations and fabrication of evidence, targeting Plaintiff and other providers in an unfair manner.

58. It is essential to highlight that Optum and MGBHP's repeated involvement in lawsuits with the federal government over the last 30 years further substantiates the claims of concerted action and joint enterprise. Despite facing such legal actions, Optum and MGBHP consistently settled these matters by paying fines and penalties, thus skillfully avoiding criminal prosecution. To gain favor from state and federal agencies, Optum and MGBHP actively utilized their connections to hand-deliver individual providers that they deemed troublesome. Through this strategic approach, Optum and MGBHP managed to evade payment to these providers, while simultaneously maintaining a status of avoiding criminal charges. Instead, they only faced civil actions, which ultimately culminated in settlements without any criminal consequences.

59. The shocking aspect is the egregious and recurrent pattern of Optum and MGBHP breaking the law, involving fraudulent practices on a scale 100-fold greater than that of individual providers who end up facing criminal charges by the federal government. Despite these glaring disparities, Optum and MGBHP's efforts to manipulate and influence state and federal agencies have enabled them to remain insulated from criminal prosecution, perpetuating their unjust practices while escaping criminal accountability.

## V. STATEMENT OF CLAIMS

**COUNT I - BREACH OF CONTRACT**

60. Plaintiff fully incorporates by reference Paragraphs 1-60 as if fully stated herein.

61. The Agreement between Plaintiff and Defendants is a valid and enforceable contract.

62. Plaintiff have complied with all terms and conditions of the Agreement.

63. By failing and refusing to reimburse Plaintiff's claims as required by the Agreement, Defendants have breached the Agreement.

64. As a direct result of Defendants' breach, Plaintiff have suffered damages in excess of $18 million.

**COUNT II - M.G.L. c. 93A VIOLATIONS**

65. Plaintiff fully incorporates by reference Paragraphs 1-65 as if fully stated herein.

66. Defendants' assurances that Plaintiff's claims were being processed and would be reimbursed, when in fact Defendants had no intention of paying the claims, constitute unfair and deceptive trade acts and practices under M.G.L. c. 93A.

67. These unfair and deceptive acts occurred primarily in Massachusetts.

68. As a direct result of Defendants' unfair and deceptive acts and practices, Plaintiff have suffered damages in excess of $18 million.

**COUNT III - PROMISSORY ESTOPPEL:**

69. Plaintiff fully incorporates by reference Paragraphs 1-69 as if fully stated herein.

70. Defendants, through its representatives, made clear and unambiguous promises that Plaintiff's claims for medical services would be properly reimbursed pursuant to the Provider Agreement.

71. Defendants reasonably expected these promises would induce Plaintiff to continue providing medical services to Defendants' members.

72. Plaintiff justifiably and foreseeably relied on Defendants' promises by continuing to provide covered services to Defendants' members per the Agreement, despite non-payment.
73. Plaintiff suffered substantial detriment due to its reliance on Defendants' promises, including staff costs, equipment costs, opportunity costs, and loss of profits.
74. Injustice can only be avoided by enforcing Defendants' promises of reimbursement.
75. Defendants is therefore estopped from withholding payment for the claims and Plaintiff is entitled to recover damages resulting from its reasonable reliance.

**COUNT IV - INTENTIONAL INTERFERENCE WITH CONTRACTUAL/BUSINESS RELATIONS:**

76. Plaintiff fully incorporates by reference Paragraphs 1-76 as if fully stated herein.
77. Plaintiff had valid business relationships with patients covered by Defendants' plans.
78. Defendants knowingly interfered with these relationships through misleading and deceptive representations regarding billing practices.
79. Defendants' actions were improper, intentional, and malicious.
80. Plaintiff suffered damages as a result.

**COUNT V - DEFAMATION:**

81. Plaintiff fully incorporates by reference Paragraphs 1-81 as if fully stated herein.
82. Defendants made misleading and deceptive and defamatory written and oral statements accusing Plaintiff of fraudulent overbilling of medical claims.
83. Defendants published these misleading and deceptive statements to third parties, including patients of Plaintiff, and regulatory agencies.

84. At the time the statements were made, Defendants knew they were misleading and deceptive or acted in reckless disregard as to the truth of the statements. These misleading and deceptive statements harmed Plaintiff's reputation and good will as a medical provider in the community.

85. Plaintiff suffered economic and reputational damages as a direct and proximate result of Defendants' misleading and deceptive and defamatory statements.

86. Therefore, Defendants have defamed Plaintiff and Plaintiff is entitled to compensatory damages, punitive damages, and any other relief afforded under the law.

**COUNT VI - VIOLATION OF UNFAIR CLAIMS SETTLEMENT PRACTICES REGULATIONS:**

87. Plaintiff fully incorporates by reference Paragraphs 1-87 as if fully stated herein.

88. Defendants, as a health insurance corporation, is subject to state insurance regulations, including Unfair Claims Settlement Practices Regulations.

89. Defendants' systematic refusal to reimburse Plaintiff for valid medical claims constitutes a violation of these Unfair Claims Settlement Practices Regulations.

90. Such violations demonstrate a pattern of unfair and deceptive practices in handling claims, resulting in harm to Plaintiff.

91. As a direct result of these violations, Plaintiff have suffered damages in excess of $18 million.

**COUNT VII - NEGLIGENT MISREPRESENTATION:**

92. Plaintiff fully incorporates by reference Paragraphs 1-92 as if fully stated herein.

93. In deceptively assuring Plaintiff that its claims were being processed and would be reimbursed, Defendants negligently misrepresented the status of the claims and Defendants' intention to reimburse.

94. Defendants owed Plaintiff a duty to provide accurate and truthful information regarding the claims.

95. Defendants' misleading and deceptive representations induced Plaintiff to rely on such assurances and continue providing services to Defendants' members.

96. Plaintiff suffered financial losses and damages due to its reasonable reliance on Defendants' negligent misrepresentations.

**COUNT VIII - TORTIOUS INTERFERENCE WITH ECONOMIC RELATIONS:**

97. Plaintiff fully incorporates by reference Paragraphs 1-97 as if fully stated herein.

98. Plaintiff had established business relationships with patients and other providers in the community.

99. Defendants intentionally and improperly interfered with these economic relations through misleading and deceptive fraud allegations and threats of criminal prosecution.

100. Defendants' actions were undertaken with the purpose of damaging Plaintiff's reputation and economic interests.

101. As a direct and proximate result of Defendants' tortious interference, Plaintiff suffered significant economic harm, including loss of patients and business opportunities.

**COUNT IX - VIOLATION OF MENTAL HEALTH PARITY ACT:**

102. Plaintiff fully incorporates by reference Paragraphs 1-102 as if fully stated herein.

103. The Mental Health Parity Act requires insurers to provide equal coverage for mental health services as they do for medical or surgical services.

104. Defendants' refusal to reimburse Plaintiff for psychiatric services provided to Defendants' members constitutes a violation of the Mental Health Parity Act.

105. Plaintiff is entitled to damages resulting from Defendants' failure to comply with the Act, which includes the value of the unpaid claims and additional costs incurred by Plaintiff due to the denial of reimbursement.

**COUNT X - BREACH OF THE DUTY OF GOOD FAITH AND FAIR DEALING:**

The Agreement between Plaintiff and Defendants imposes a duty of good faith and fair dealing in the performance and enforcement of the contract.

106. Plaintiff fully incorporates by reference Paragraphs 1-107 as if fully stated herein.

107. Defendants' systematic refusal to reimburse Plaintiff for valid medical claims, despite assurances of prompt payment, constitutes a breach of the duty of good faith and fair dealing.

108. Defendants' actions were intentional and designed to withhold proper reimbursements owed to Plaintiff, thereby violating the fundamental principles of fair dealing under the Agreement.

**COUNT XI - VIOLATION OF THE RACKETEER INFLUENCED AND CORRUPT ORGANIZATIONS ACT (RICO):**

109. Plaintiff fully incorporates by reference Paragraphs 1-109 as if fully stated herein.

110. Defendants' pattern of deceptive practices, including making misleading and deceptive fraud referrals and fabricating documents to initiate sham investigations, constitutes a violation of the Racketeer Influenced and Corrupt Organizations Act (RICO).

111. Defendants' actions were part of an ongoing scheme to defraud healthcare providers and unlawfully withhold reimbursements.

112. Defendants engaged in interstate mail and wire fraud by using electronic and postal communications to further schemes to defraud healthcare providers of proper payments. This involves a pattern of racketeering activities across state lines to further Defendants'

fraudulent reimbursement schemes and retaliation against providers who assert their legal rights. Defendants' coordinated fraudulent actions violate Federal RICO statutes.

113. Defendants' conduct harmed Plaintiff's business and financial interests and was done with the intent to further its fraudulent practices.

114. As a direct result of Defendants' RICO violations, Plaintiff have suffered substantial damages and financial losses.

**COUNT XII - VIOLATION OF THE MEDICAL LOSS RATIO REQUIREMENTS:**

115. Plaintiff fully incorporates by reference Paragraphs 1-115 as if fully stated herein.

116. The Affordable Care Act (ACA) imposes Medical Loss Ratio (MLR) requirements on health insurers, including Defendants.

117. Defendants' systematic refusal to reimburse Plaintiff for valid medical claims resulted in an inflated MLR, wherein Defendants failed to meet the ACA's mandated percentage of premiums spent on medical claims.

118. By not meeting the MLR requirements, Defendants violated the ACA and caused harm to Plaintiff by withholding rightful reimbursements and unfairly skewing its financial performance.

119. Plaintiff is entitled to damages resulting from Defendants' failure to comply with the ACA's MLR requirements.

**COUNT XIII - INTENTIONAL INFLICTION OF EMOTIONAL DISTRESS:**

120. Plaintiff fully incorporates by reference Paragraphs 1-120 as if fully stated herein.

121. Defendants' deliberate and malicious actions, including misleadingly and deceptively accusing Plaintiff of fraud, interfering with patient relationships, and withholding reimbursements, were extreme and outrageous conduct.

122. Defendants' intentional conduct caused Plaintiff severe emotional distress and anxiety.

123. Defendants' actions were done with the intent to cause emotional harm to Plaintiff, and such harm was a foreseeable consequence of Defendants' conduct.

124. As a direct result of Defendants' intentional infliction of emotional distress, Plaintiff have suffered significant emotional harm and is entitled to compensatory and punitive damages.

**COUNT XIV - VIOLATION OF ANTI-KICKBACK STATUTES:**

125. Plaintiff fully incorporates by reference Paragraphs 1-125 as if fully stated herein.

126. In a calculated effort to undermine Plaintiff's services and hinder Plaintiff's reimbursement claims, Defendants embarked on a series of unlawful kickback arrangements with other healthcare providers.

127. The actions of Defendants are unequivocally in violation of federal and state Anti-Kickback Statutes, laws designed to safeguard the integrity of healthcare transactions by prohibiting inducements that promote improper financial gains at the expense of other providers.

128. Through these illicit kickback arrangements, Defendants deliberately engaged in a web of fraudulent and illegal practices, systematically disadvantaging other providers like Plaintiff and inflicting substantial harm upon Plaintiff's financial interests and crucial business relationships.

129. As a direct consequence of Defendants' deliberate violation of the Anti-Kickback Statutes, Plaintiff have incurred tangible damages, thereby entitling Plaintiff to rightful compensation commensurate with the harm inflicted upon them.

**COUNT XV - VIOLATION OF ERISA:**

131. Plaintiff fully incorporates by reference Paragraphs 1-130 as if fully stated herein.

132. Defendants' systematic failure to reimburse Plaintiff for valid medical claims constitutes a violation of the Employee Retirement Income Security Act (ERISA).

133. As a health insurance corporation providing coverage under employer-sponsored health plans, Defendants is subject to ERISA's fiduciary duty requirements to process claims accurately and promptly.

134. Defendants' willful denial of reimbursement claims and improper handling of claims is a breach of its fiduciary duties under ERISA.

135. Plaintiff, as a provider of services under ERISA-governed plans, is entitled to damages resulting from Defendants' ERISA violations, which includes the value of unpaid claims and other related losses.

**COUNT XVI - CONSPIRACY TO VIOLATE CIVIL RIGHTS:**

136. Plaintiff fully incorporates by reference Paragraphs 1-135 as if fully stated herein.

137. Plaintiff contends that Defendants engaged in an intentional, coordinated scheme to deprive healthcare providers of fundamental Constitutional protections. Specifically, when faced with the prospect of civil actions and liability for its own alleged misconduct, Defendants conspired with federal prosecutors to manufacture feigned criminal prosecutions against targeted providers like Plaintiff. Defendants collaborated to supply prosecutors with misleading and deceptive information aimed at spurring baseless criminal investigations as retribution for potential civil claims, though Plaintiff had engaged in no criminal wrongdoing whatsoever.

138. By intentionally weaponizing the criminal justice process to deter and obstruct providers' lawful pursuit of civil remedies, Defendants blatantly violated their First Amendment rights to petition the government for redress of grievances. Furthermore, Defendants'

calculated scheme to deny providers equal justice under law flies in the face of Fourteenth Amendment guarantees of due process and equal protection. In short, Defendants sought to manipulate the machinery of criminal prosecution for the unlawful purpose of denying providers' civil rights to fair legal process.

139. This coordinated obstruction of Constitutional safeguards is the epitome of an insidious conspiracy against rights. Such abuse of prosecutorial mechanisms for the purpose of denying Constitutional rights amounts to a direct violation of civil rights under color of law.

140. Plaintiff alleges that Defendants engaged in an intentional, coordinated scheme to deprive healthcare providers of their Constitutional rights by conspiring with federal prosecutors to manufacture contrived criminal prosecutions against providers in retaliation for potential civil claims against Defendants.

141. Defendants' coordinated scheme to obstruct Constitutional safeguards through prosecutorial collusion constitutes an egregious conspiracy against civil rights through the denial of due process.

142. Plaintiff alleges Defendants conspired with prosecutors to devise meritless criminal allegations against providers in direct response to and in anticipation of their lawful civil claims against Defendants, in order to obstruct providers' civil rights to access the courts and receive equal justice under law.

**COUNT XIX - ANTITRUST VIOLATIONS**

143. Plaintiff fully incorporates by reference Paragraphs 1-142 as if fully stated herein.

144. Defendants have monopolistic control over the health insurance market in Massachusetts. It uses this dominance to impose unreasonable reimbursement restrictions and unfair claim

procedures on network providers. This amounts to illegal restraint of trade and reduction of competition among insurers and in the healthcare market generally.

145. Evidence unequivocally demonstrates that Defendants, wielding monopolistic control over the health insurance market in Massachusetts, have systematically exploited this supremacy to impose egregiously unreasonable reimbursement restrictions and propagate patently unfair claim procedures upon the providers within its network.

146. These practices, amounting to a calculated manipulation of the market dynamics, blatantly disregard the principles of free competition and market equilibrium that antitrust laws are specifically designed to protect.

147. Defendants' continuous abuse of its dominant position have wrought a palpable restraint on trade that is both patently illegal and in flagrant violation of the fundamental principles of competition enshrined in antitrust laws.

148. By engaging in these anticompetitive maneuvers, Defendants have willfully diminished the potential for fair competition among insurers and have exacerbated the overall deterioration of competition within the broader healthcare landscape.

149. In light of these egregious actions, Defendants' culpability in violating antitrust laws is irrefutable, as evidenced by their calculated attempts to stifle competition, inhibit market fluidity, and perpetuate their own monopolistic control to the detriment of providers like Plaintiff.

150. The resulting damages accrued by Plaintiff as a direct consequence of Defendants' flagrant antitrust violations merit just compensation, underscoring the necessity for legal intervention to rectify the injustices perpetrated upon Plaintiff and other similarly affected providers.

**COUNT XX - CONSUMER PROTECTION VIOLATIONS**

151. Plaintiff fully incorporates by reference Paragraphs 1-150 as if fully stated herein.

152. Defendants engaged in unfair and deceptive practices by making misleading and deceptive representations to induce providers to join its network, then manipulating improper justifications to avoid rendering payment. These fraudulent acts violate Massachusetts consumer protection laws.

153. Defendants' conduct, marked by its consistent pattern of deceit and unfairness, constitutes an egregious violation of Massachusetts consumer protection laws, underscoring its wanton disregard for the ethical treatment of healthcare providers.

154. By adopting an approach characterized by misleading and deceptive representations, Defendants willfully misled providers, including Plaintiff, into joining its network under the false pretense of ethical business conduct and equitable reimbursement practices.

155. However, far from adhering to its promises, Defendants intentionally manipulated and distorted its reimbursement procedures, utilizing unfounded justifications to evade its duty to render rightful payments to providers for services rendered.

156. Defendants' blatant disregard for ethical and lawful business practices directly contradicts the essence of consumer protection laws, which were explicitly enacted to shield individuals and entities from deceptive trade acts and practices.

157. The actions of Defendants embody a calculated strategy designed to mislead providers into a false sense of security, only to exploit their trust and reap the financial benefits while unfairly withholding the due reimbursement.

158. By perpetuating this cycle of deception, manipulation, and breach of trust, Defendants have unequivocally engaged in fraudulent acts that flagrantly contravene the principles of Massachusetts consumer protection laws.

159. The damages incurred by Plaintiff as a result of Defendants' pervasive consumer protection violations are not only monetary but extend to the realm of reputational harm, underscoring the urgency for legal intervention to rectify the extensive injustices perpetrated upon Plaintiff and other providers similarly affected by Defendants' unscrupulous practices.

**COUNT XXI - FRAUDULENT INDUCEMENT**

160. Plaintiff fully incorporates by reference Paragraphs 1-159 as if fully stated herein.

161. Defendants made misleading and deceptive representations to Plaintiff, including promises of prompt reimbursement and full subscriber access, to induce Plaintiff to continue to provide services to its Members and remain an in-network provider through its provider agreement.

162. Defendants had knowledge of the falsity of these promises, as evidenced by past breaches of identical promises to other providers in its network.

163. Plaintiff relied on Defendants' misleading and deceptive representations and suffered financial harms as a result of remaining an in-network provider and participant in the provider agreement.

**COUNT XXII - CONCERTED ACTION**

164. Plaintiff fully incorporates by reference Paragraphs 1-163 as if fully stated herein.

165. Defendants acted in concert with federal prosecutors, exchanging misleading and deceptive information, fabricating evidence, and influencing the prosecution to initiate sham investigations against Plaintiff and other providers.

166. Defendants conspired with federal prosecutors to violate Plaintiff's constitutional rights and retaliate against providers who asserted their legal rights for proper reimbursement.

167. Other providers similarly suffered retaliation through Defendants' connections with prosecutors, establishing a pattern of concerted action.

**COUNT XXIII - JOINT ENTERPRISE**

168. Plaintiff fully incorporates by reference Paragraphs 1-167 as if fully stated herein.

169. Defendants and federal prosecutors engaged in a joint enterprise with a common purpose and design to retaliate against troublesome providers through improper criminal charges.

170. Defendants and prosecutors cooperated and coordinated efforts to initiate fraudulent investigations and fabricate evidence against Plaintiff and other targeted providers. Examples of other providers similarly targeted further substantiate the existence of a joint enterprise and its pattern of operation.

**COUNT XXIV - DECEPTIVE BUSINESS PRACTICES**

171. Plaintiff fully incorporates by reference Paragraphs 1-170 as if fully stated herein.

172. Defendants engaged in deceptive business practices by deceptively representing to providers that they would be properly reimbursed for services rendered, inducing them to join Defendants' network.

173. After providers joined the network, Defendants manipulated improper justifications to avoid rendering payment, continuing its deceptive practices to maximize its financial gains.

174. Defendants' deceptive practices violated Massachusetts consumer protection laws and caused harm to providers, including Plaintiff.

**COUNT XXV - VIOLATION OF MASSACHUSETTS INSURANCE LAWS**

175. Plaintiff fully incorporates by reference Paragraphs 1-174 as if fully stated herein.

176. Defendants violated Massachusetts insurance laws by engaging in unfair and deceptive reimbursement practices, failing to fulfill contractual obligations, and retaliating against providers who sought rightful reimbursements.

177. Defendants' actions contravened the principles of good faith and fair dealing required under Massachusetts insurance laws, causing financial harm to Plaintiff.

**COUNT XXVI - BREACH OF FIDUCIARY DUTY**

178. Plaintiff fully incorporates by reference Paragraphs 1-177 as if fully stated herein.

179. As a health insurance corporation, Defendants owed a fiduciary duty to providers in its network, including Plaintiff, to act in their best interests regarding claims processing and reimbursement.

180. Defendants breached its fiduciary duty by systematically withholding proper payments, imposing unreasonable reimbursement restrictions, and using improper claim procedures to favor its financial interests over the providers' interests.

**COUNT XXVII - RETALIATION AGAINST WHISTLEBLOWER**

181. Plaintiff fully incorporates by reference Paragraphs 1-180 as if fully stated herein.

182. Defendants retaliated against Plaintiff as a whistleblower who asserted his contractual rights and reported Defendants' fraudulent practices to regulatory authorities.

183. In response to Plaintiff's demands for payment and threats of litigation, Defendants terminated Plaintiff from its provider network in or around December 2020, showing direct retaliation for whistleblowing.

**COUNT XXVIII - VIOLATION OF FEDERAL AND STATE PRIVACY LAWS**

184. Plaintiff fully incorporates by reference Paragraphs 1-183 as if fully stated herein.

185. Defendants violated federal and state privacy laws by sharing misleading and deceptive information about Plaintiff's alleged fraudulent activities with third parties, including patients and others in the community, without valid legal basis.

186. Defendants' actions harmed Plaintiff's reputation and violated his privacy rights, leading to economic and reputational damages.

**COUNT XXIX - TORTIOUS INTERFERENCE WITH CURRENT AND PROSPECTIVE CONTRACTUAL RELATIONS**

187. Plaintiff fully incorporates by reference Paragraphs 1-186 as if fully stated herein.

188. Defendants tortiously interfered with Plaintiff's contractual relationships with patients by deceptively representing that Plaintiff engaged in fraudulent overbilling and providing medically unnecessary services.

189. Defendants' misleading and deceptive fraud allegations were intentional and malicious, aiming to harm Plaintiff's reputation and deter patients from seeking his services.

**COUNT XXX - VIOLATION OF HEALTHCARE PROVIDER ANTI-RETALIATION LAWS**

190. Plaintiff fully incorporates by reference Paragraphs 1-189 as if fully stated herein.

191. Defendants violated healthcare provider anti-retaliation laws by terminating Plaintiff from its network in retaliation for asserting his contractual rights and pursuing proper reimbursements.

192. Plaintiff's termination was directly linked to his demands for payment and threats of litigation, demonstrating clear retaliation by Defendants.

**COUNT XXXI - FRAUDULENT MISREPRESENTATION**

193. Plaintiff fully incorporates by reference Paragraphs 1-192 as if fully stated herein.

194. Defendants, through its authorized representatives, knowingly made numerous false statements of material fact to Plaintiff regarding the terms of the provider agreement and reimbursement of claims.

195. These false representations included that Defendants would reimburse claims within 30 days of receipt, provide prompt pre-authorization decisions, give full access to all insured patients, and process all claims in good faith pursuant to contractual guidelines.

196. At the time these promises and representations were made, Defendants knew they were false and had no intention of complying with them.

197. Defendants made the false representations with the intent of fraudulently inducing Plaintiff to comply with the provider agreement and to continue providing services to Defendants' insured patients.

198. Plaintiff justifiably relied on Defendants' misrepresentations by entering into the agreement, rendering services to patients, and expending costs for staff and operations.

199. As a direct result of its reasonable reliance on Defendants' fraudulent statements, Plaintiff have suffered damages through lost income, unpaid reimbursement, and operational costs.

200. Defendants is liable for fraudulent misrepresentation under Massachusetts law. Plaintiff is entitled to damages and equitable relief due to Defendants' intentional deception.

**COUNT XXXII - PATIENT ACCESS COMPROMISE AND IMPAIRMENT OF MEDICAL PRACTICE**

201. Plaintiff reasserts and incorporates by reference Paragraphs 1-200 as if fully set forth herein.

202. Optum and MGBHP have consistently employed a calculated approach, systematically denying valid medical claims and implementing restrictive measures on provider

networks. As a direct consequence of these actions, patients' ability to access high-quality healthcare has been severely compromised, resulting in suboptimal treatment outcomes and detrimental effects on their well-being.

203. This oppressive strategy has further coerced medical practitioners into engaging in ceaseless battles for rightful compensation, detrimentally impacting their capacity to offer effective medical care to those in need. Optum's relentless approach to forcing doctors into such onerous circumstances exacerbates the challenges faced by healthcare providers in delivering optimal care to patients.

**COUNT XXXIII - MONOPOLISTIC EXPLOITATION AND UNCONSCIONABLE REIMBURSEMENT TERMS**

204. Plaintiff reasserts and incorporates by reference Paragraphs 1-203 as if fully set forth herein.

205. Plaintiff contends that Optum, leveraging its monopolistic dominance, has engaged in an unethical and exploitative strategy by imposing unconscionable reimbursement terms on network providers. These terms serve to unjustly restrict providers' ability to practice medicine and obtain rightful compensation for their services.

206. This monopolistic exploitation is further compounded by Optum's unrelenting acquisition of additional mental health benefits from multiple insurers. Such actions inflate Optum's profits and enhance its market control, perpetuating a cycle of monopolistic dominance to the detriment of providers, patients, and overall competition within the healthcare landscape.

**COUNT XXXIV - ANTICOMPETITIVE PRACTICES AND MONOPOLISTIC ABUSE**

207. Plaintiff reasserts and incorporates by reference Paragraphs 1-206 as if fully set forth herein.

208. Plaintiff alleges that Optum's anticompetitive practices, encompassing the systematic denial of valid claims, restrictive provider networks, imposition of unconscionable reimbursement terms, and strategic acquisitions of mental health benefits, flagrantly violate established antitrust laws.

209. By perpetuating these practices, Optum has unabashedly engaged in monopolistic abuse, thwarting fair competition, stifling market equilibrium, and perpetuating its dominance to the detriment of providers, patients, and the broader healthcare industry.

## VI. PRAYER FOR RELIEF

WHEREFORE, Plaintiff prays for judgment against Defendants as follows:

a) Plaintiff seeks comprehensive redress, including restitution for breach of contract, the imposition of statutory multiple damages, punitive damages as a deterrent, the cessation of selective provider restrictions, and the establishment of mandated coverage parity for mental health services.

b) Actual, compensatory, and consequential damages in excess of $18 million;

c) Double or treble damages under M.G.L. c. 93A;

d) Plaintiff seeks an injunction prohibiting Defendants from further unfair claims practices, arguing that without such injunctive relief it will suffer irreparable harm, the balance of equities favors Plaintiff, and the public interest would be served.

e) Restitution and disgorgement of any ill-gotten gains obtained by Defendants as a result of their unlawful conduct;

f) Compensatory, incidental, and punitive damages in an amount to be determined at trial, but expected to substantially exceed One Hundred Million Dollars ($100,000,000);

g) Creation of a non-profit foundation, funded with the largest portion of the relief awarded in this case, in the amount of One Hundred Million Dollars ($100,000,000), to disburse funds to healthcare providers who have been victims of Optum and MGBHP's abuses, providing financial compensation for their losses;

h) The non-profit foundation shall also provide legal assistance to healthcare providers victims at no cost, ensuring that affected individuals have access to the legal representation necessary to protect their rights;

i) In seeking such relief, Plaintiff aims to rectify the injustices caused by Optum and MGBHP's anticompetitive practices and monopolistic abuse, thereby fostering a more equitable and competitive healthcare landscape for providers, patients, and the industry at large.

j) Plaintiff also seeks a separate injunction reinstating its status as an in-network provider, arguing irreparable harm from loss of patient relationships, balance of equities in its favor, and service of the public interest.

k) Costs, interest, and reasonable attorney's fees; and

l) Such other and further relief as the Court deems just and proper.

## IX. DEMAND FOR JURY TRIAL

The Plaintiff demands a trial by jury on all issues so triable.

I, Gustavo Kinrys, the Plaintiff in the above-captioned action, hereby verify under the pains and penalties of perjury that the facts set forth in the foregoing Complaint are true and correct to the best of my knowledge, information, and belief.

Dated: 10/03/2023

Respectfully submitted.

/s/ Gustavo Kinrys

Plaintiff's signature
Self-represented

Name: Gustavo Kinrys
Address: 4 Goose Cove Way
Nantucket, MA 02554
Telephone No.: 617-953-8282

# EXHIBIT A

# Fee Schedule Update Policy

## Policy

**Annual Updates to Physician and Outpatient Hospital Reimbursement**

Mass General Brigham Health Plan reviews its physician and outpatient fee schedules quarterly, to ensure that they are current, comprehensive, and consistent with industry standards, to the extent supported by its systems. In most cases, changes involve adding fees for new or existing codes to supplement the fees already on the fee schedule.

Mass General Brigham Health Plan updates its Commercial physician, ambulance, drug, DME, laboratory, radiology, and outpatient hospital fee schedules to incorporate new codes, effective January 1, each year.

For Commercial plans, existing CPT and HCPCS codes will be updated annually, effective July 1, to incorporate RVU changes.

Mass General Brigham Health Plan updates its Medicare Advantage fee schedules as directed by CMS.

With a few exceptions, Mass General Brigham Health Plan will continue to base fees on the Centers for Medicare & Medicaid Services (CMS) and MassHealth fee schedules, adjusted to achieve the contracted level of reimbursement.

### Commercial and Medicare Advantage Physician Fee Schedules

- Mass General Brigham Health Plan bases physician reimbursement on CMS RVUs and Mass General Brigham Health Plan's conversion factors.
- Mass General Brigham Health Plan bases drug, vaccine, and toxoid reimbursement on CMS Part B levels, as indicated on the CMS Part B drug quarterly notices. If no CMS pricing is available, drug pricing will be set in relation to average wholesale price (AWP). Reimbursement for drugs, vaccines and toxoids will continue to be updated on a quarterly basis.
- Mass General Brigham Health Plan updates its Medicare Advantage physician fee schedules as directed by CMS.

Mass General Brigham
Health Plan

# Provider Payment Guidelines

## Commercial and Medicare Advantage Outpatient Fee Schedules

- Mass General Brigham Health Plan bases reimbursement on a combination of CMS OPPS, ancillary and surgical fee schedules.
- Mass General Brigham Health Plan will continue to base drug, vaccine, and toxoid reimbursement on CMS Part B levels, as indicated on the CMS Part B drug quarterly notices. If no CMS pricing is available, drug pricing is set in relation to average wholesale price (AWP). Reimbursement for drugs, vaccines and toxoids will continue to be updated on a quarterly basis.
- Mass General Brigham Health Plan updates its Medicare Advantage outpatient fee schedules as directed by CMS.

## Medicaid Fee Schedules

- Mass General Brigham Health Plan bases physician reimbursement on MassHealth published rates, where a published rate exists. If no MassHealth published rate exists for a covered & payable service, Mass General Brigham Health Plan establishes pricing in relation to CMS.
- Mass General Brigham Health Plan updates its Medicaid physician, ambulance, drug, DME, laboratory, radiology, and outpatient hospital fee schedules to incorporate new codes and rates, within 30 days of receipt of notification of rate change from MassHealth.

If you have questions or would like to obtain a copy of your commercial or MassHealth fee schedule, please contact your Mass General Brigham Health Plan Provider Network Account Executive. For Medicare Advantage fee schedule questions, refer to CMS .

## Reimbursement

Providers are reimbursed in accordance with the plan's network provider reimbursement or contracted rates. Claims are subject to payment edits that are updated at regular intervals.

Covered services are defined by the member's benefit plan. The manner in which covered services are reimbursed is determined by the Mass General Brigham Health Plan Payment Policy and by the provider's agreement with Mass General Brigham Health Plan. Member liability amounts may include but are not limited to copayments; deductible(s); and/or co-insurance; and will be applied dependent upon the member's benefit plan.

Various services and procedures require referral and/or prior authorization. Referral and prior authorization requirements can be located here.

# Provider Payment Guidelines

Please reference procedure codes from the current CPT, HCPCS Level II, and ICD-10-CM manuals, as recommended by the American Medical Association (AMA), the Centers for Medicare & Medicaid Services (CMS), and the American Hospital Association. CMS and the AMA revise HIPAA medical codes on a pre-determined basis, including changes to CPT, HCPCS, and ICD-10 codes and definitions.

Please refer to the CMS or CPT guidelines for requisite modifier usage when reporting services. The absence or presence of a modifier may result in differential claim payment or denial.

Mass General Brigham Health Plan reviews claims to determine eligibility for payment. Services considered incidental, mutually exclusive, integral to the primary service rendered, or part of a global allowance, are not eligible for separate reimbursement. Please refer to General Coding and Billing for more information.

All claims are subject to audit services and medical records may be requested from the provider.

Mass General Brigham Health Plan reimbursement is based online of business. Unless otherwise specified within the medical policies, please follow the guidelines based on membership type:

## Related Documents

General Coding and Billing
CMS Resources
CMS Physician Fee Schedule

## Publication History

| Topic: Fee Schedule Update Policy | Owner: Network Management |
|---|---|

| | |
|---|---|
| ***February 1, 2018*** | *Original documentation* |
| ***January 1, 2019*** | *Document restructure; codes, code descriptor and references updated* |
| ***January 1, 2020*** | *Code update date* |
| ***January 1, 2023*** | *Document rebrand; included Medicare Advantage* |

Mass General Brigham
Health Plan

# Provider Payment Guidelines

This document is designed for informational purposes only. Claims payment is subject to member eligibility and benefits on the date of service, coordination of benefits, referral/authorization/notification and utilization management guidelines when applicable, adherence to plan policies and procedures, claims editing logic, and provider contractual agreement. In the event of a conflict between this payment guideline and the provider's agreement, the terms and conditions of the provider's agreement shall prevail. Payment policies are intended to assist providers in obtaining Mass General Brigham Health Plan's payment information. Payment policy determines the rationale by which a submitted claim for service is processed and paid. Payment policy formulation takes into consideration a variety of factors including: the terms of the participating providers 'contract(s); scope of benefits included in a given member's benefit plan; clinical rationale, industry-standard procedure code edits, and industry-standard coding conventions.

Mass General Brigham Health Plan includes Mass General Brigham Health Plan, Inc., and Mass General Brigham Health Plan Insurance Company.

# Provider Payment Disputes

## Policy

The terms of this policy set forth the guidelines for reporting the provision of care rendered by Mass General Brigham Health Plan participating providers, including but not limited to, use of standard diagnosis and procedure codes in compliance with HIPAA (Health Information Portability and Accountability Act) medical transaction code set standards.

## Reimbursement

Providers are reimbursed in accordance with the plan's network provider reimbursement or contracted rates. Claims are subject to payment edits that are updated at regular intervals.

Covered services are defined by the member's benefit plan. The manner in which covered services are reimbursed is determined by the Mass General Brigham Health Plan Payment Policy and by the provider's agreement with Mass General Brigham Health Plan . Member liability amounts may include but are not limited to copayments; deductible(s); and/or co-insurance; and will be applied dependent upon the member's benefit plan.

Various services and procedures require referral and/or prior authorization. Referral and prior authorization requirements can be located here.

Please reference procedure codes from the current CPT, HCPCS Level II, and ICD-10-CM manuals, as recommended by the American Medical Association (AMA), the Centers for Medicare & Medicaid Services (CMS), and the American Hospital Association. CMS and the AMA revise HIPAA medical codes on a pre-determined basis, including changes to CPT, HCPCS, and ICD-10 codes and definitions.

Please refer to the CMS or CPT guidelines for requisite modifier usage when reporting services. The absence or presence of a modifier may result in differential claim payment or denial.

Mass General Brigham Health Plan reviews claims to determine eligibility for payment. Services considered incidental, mutually exclusive, integral to the primary service rendered, or part of a global allowance, are not eligible for separate reimbursement. This is the General Coding and Billing PPG. All claims are subject to audit, and Mass General Brigham Health Plan may request medical records from the provider.

### Requesting an Administrative Appeal

As described in the Billing Guidelines Section of the Provider Manual, providers can request a review and possible adjustment of a previously processed claim within 90 days of the Explanation of Payment (EOP) date on which the original claim was processed. If the provider is not satisfied with the outcome of the request, an appeal can be submitted to Mass General Brigham Health Plan's Appeals and Grievances Department.

An appeal is a request for reconsideration of a claim denial by to Mass General Brigham Health Plan. Appeal requests must be submitted in writing within one of the following timeframes:

- 90 days of receipt of the Mass General Brigham Health Plan Explanation of Payment (EOP)
- 90 days of receipt of the EOP from another insurance, when applicable
- 90 days of the date of the claim's adjustment letter

The appeal must include additional, relevant information and documentation to support the request. Requests received beyond the 90-day appeal requests filing limit will not be considered.

When submitting a provider appeal, please use the *Request for Claim Review Form*

### Provider Audit Appeals/General Claims Audit Appeal Requests

For claims audited and adjusted post-payment, if the provider disagrees with the reason for the adjustments, a letter of appeal or a completed Mass General Brigham Health Plan Provider Audit Appeal Form may be submitted to Mass General Brigham Health Plan's Appeals Department within 90 days of the EOP.

The request must be accompanied by comprehensive documentation to support the dispute of relevant charges. To the extent that the provider fails to submit evidence of why the adjustment is being disputed, the provider will be notified of Mass General Brigham Health Plan ' inability to thoroughly review the request. The provider can resubmit the appeal within the 90 days EOP window. The appeal's receipt date will be consistent with the date Mass General Brigham Health Plan received the additional documentation.

Mass General Brigham Health Plan will review the appeal and, when appropriate, consult with Mass General Brigham Health Plan clinicians or subject matter experts in the areas under consideration. The

appeal request will be processed within 30 calendar days from Mass General Brigham Health Plan's receipt of all required documentation.

The appeal determination will be final. If the appeal request is approved, Mass General Brigham Health Plan will adjust the claims in question within 10 calendar days of the provider's notification of the final determination.

### Claim Adjustments/Requests for Review

Request for a review and possible adjustment of a previously processed claim (not otherwise classified as an appeal) should be submitted to the Claim Adjustment Requests mailbox within 90 days of the EOP date on which the original claim was processed. All such requests should be submitted by completing a Request for Review Form and including any supporting documentation, with the exception of electronically submitted corrected claims. When submitting a provider appeal, please use the *Request for Claim Review Form*

### Corrected Claims and Disputes of Duplicate Claim Denials

Mass General Brigham Health Plan accepts both electronic and paper corrected claims, in accordance with guidelines of the National Uniform Claim Committee (NUCC) and HIPAA EDI standards. Corrected claims must be submitted with the most recent version of the claim to be adjusted. must be received no later than 60 days from the date of the original adjudication. Any payment disputes received after that time will not be considered. Mass General Brigham Health Plan will not accept handwritten claims, or handwritten corrected claims.

Provider payment disputes that require additional documentation must be submitted on paper, using the Request for Review Form. *Request for Claim Review Form*

### Appealing a Behavioral Health Service Denial

Optum is Mass General Brigham Health Plan ' Behavioral Health Partner and is delegated all Behavioral Health (BH) related matters, including grievances/complaints and appeals. All BH related grievances/complaints and appeals must be submitted to Optum directly
For more information, please refer to the Behavioral Health provider manual or contact Optum

### Late Charges

Mass General Brigham Health Plan accepts corrected claims to report services rendered in addition to the services described on an original claim. Mass General Brigham Health Plan will not accept separate

claims containing only late charges. Mass General Brigham Health Plan will not accept Late Charge claims from institutional (facility) providers, including, but not limited to hospitals; ambulatory surgery centers; skilled nursing facilities (SNF); hospice; home infusion agencies; or home health agencies.

### Filing Limit Adjustments

To be considered for review, requests for review and adjustment for a claim received over the filing limit must be submitted within 90 days of the EOP date on which the claim originally denied. Disputes received beyond 90 days will not be considered.

If the initial claim submission is after the timely filing limit and the circumstances for the late submission are beyond the provider's control, the provider may submit a request for review by sending a letter documenting the reason(s) why the claim could not be submitted within the contracted filing limit and any supporting documentation. Documented proof of timely submission must be submitted with any request for review and payment of a claim previously denied due to the filing limit. A completed Request for Review Form must also be sent with the request. *Request for Claim Review Form*

### Related Mass General Brigham Health Plan Payment Guidelines

General Coding and Billing
Inpatient Hospital Admissions
Modifiers
Provider Manual/Section8_Billing Guidelines (Commercial)
Provider Manual/Section10_Appeals And Grievances (Commercial)
Provider Manual/Section3_Provider Management (Commercial)

### References

American Medical Association (AMA) Current Procedural Terminology (CPT)
CMS/HIPAA Information Series
HCPCS Level II
ICD-10-CM

### Publication History

| Topic: Provider Payment Disputes | Owner: Network Management |
|---|---|
| *December 24, 2020* | *Original Documentation* |
| *January 17, 2023* | *Document rebrand* |

This document is designed for informational purposes only. Claims payment is subject to member eligibility and benefits on the date of service, coordination of benefits, referral/authorization/notification and utilization management guidelines when applicable, adherence to plan policies and procedures, claims editing logic, and provider contractual agreement. In the event of a conflict between this payment guideline and the provider's agreement, the terms and conditions of the provider's agreement shall prevail. Payment policies are intended to assist providers in obtaining Mass General Brigham Health Plan's payment information. Payment policy determines the rationale by which a submitted claim for service is processed and paid. Payment policy formulation takes into consideration a variety of factors including: the terms of the participating providers 'contract(s); scope of benefits included in a given member's benefit plan; clinical rationale, industry-standard procedure code edits, and industry-standard coding conventions.

Mass General Brigham Health Plan includes Mass General Brigham Health Plan, Inc., and Mass General Brigham Health Plan Health Partners Insurance Company.

# EXHIBIT B

***PROVIDER SDF***

HEALTH CARE PROVIDER SUMMARY DISCLOSURE FORM

OPTUM

**OPTUM PARTICIPATING PROVIDER**

## I. Compensation and Payment

Manner of Payment: **Fee for Service/Per Diem**

Reimbursement Methodology: **Please reference Article 3 – Payment Provisions of the Agreement or reference additional information on reimbursement methodology located in the Optum Network Manual. You can locate the Network Manual on Provider Express (www.providerexpress.com).**

Fee Schedule Information: **Please reference provided Outpatient Fee Schedule/Fee Maximum or Standard Payment Appendix.**

Reimbursement Policies: **Please reference Article 3 – Payment Provisions of the Agreement or reference additional information on reimbursement polices located in the Optum Network Manual. You can locate the Network Manual on providerexpress.com.**

## II. List of Networks

☒ HMO
☒ Commercial Plan other than HMO
☒ Medicare
☒ Medicaid
☒ Workers' Compensation
☒ Network Rental/Lease Arrangements

☒ Narrow Network Relationship

## III. Duration of Contract & Termination

**Duration:**

**Provider Participation Agreement – The Agreement shall begin on the Effective Date and it shall remain in effect for one year, and shall automatically renew for successive 1-year terms until it is terminated according to Article 8 of the Agreement.**

**Termination:**

**Please reference Article 8 of the Agreement. The Agreement may be terminated by Optum or Provider upon at least 90 days notification to the other party.**

## IV. Identity of person responsible for processing claims

Optum and/or its Affiliates.
Refer to Member ID Card for mailing and electronic submission of claims.

## V. Dispute Resolution Process

Refer to Appeals and Provider Dispute Resolution in the **Optum Network Manual.**

## VI. Subject and Order of Addenda

| | |
|---|---|
| ☒ Appendix 1 – Standard Payment Appendix, Outpatient Fee Schedule/Fee Maximum | ☒ Medicare Regulatory Appendix<br>☒ Medicaid Regulatory Appendix<br>☒ Ohio Regulatory Appendix |



This summary disclosure form is for informational purposes only and does not constitute a term and condition of the Provider Agreement. This form; however, does reasonably summarize the applicable Provider Agreement provisions as required under Ohio law.

OPTUM®

# 2022 Claims Provider Manual

# Table of contents

# Chapter 1: Overview

## Purpose and use of this guide

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 Care 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 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 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 Care's expectation remains that FDRs, and their employees, are 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.

We have 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's (UHG's) Code of Conduct at unitedhealthgroup.com > About > Ethics & Integrity > UnitedHealth Group's 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 employees and contractors of the FDR 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:

- Health and Human Services – Office of the Inspector General OIG List of Excluded Individuals and Entities (LEIE) at oig.hhs.gov/.
- General Services Administration (GSA) System for Award Management at sam.gov/sam.
- 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 as well as Part D plans. The preclusion list is comprised of a list of prescribers and individuals or entities who:

- Are revoked from Medicare, are under an active reenrollment bar, and CMS has determined that the underlying conduct that led to the revocation is detrimental to the best interests of the Medicare program; or
- Have engaged in behavior for which CMS could have revoked the prescriber, individual or entity to the extent possible if they had been enrolled in Medicare and that the underlying conduct that would have led to the revocation is detrimental to the best interests of the Medicare program.
- Have been convicted of a felony under federal or state law within the previous 10 years and that CMS deems detrimental to the best interests of the Medicare program.
- Care providers receive a letter from CMS notifying them of their placement on the preclusion list. They 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 rejector deny a care provider's claims due to precluded status. Once the claim-rejection date is effective, a precluded care provider's claims will no longer be paid, pharmacy claims will be rejected, and the care provider will be terminated from the Optum Care Network. Additionally, the precluded care provider must hold Medicare beneficiaries harmless from financial liability for services provided on or after the claim rejection.

# Medicare compliance expectations and training continued

## Reporting Misconduct

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

## Privacy

You must make reasonable efforts to limit Protected Health Information (PHI) as defined under the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule to the minimum necessary when using or disclosing PHI. 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

OCN 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 (EDI)

Optum Care's 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 hassle and expenses of printing, stuffing 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 the business practices that take place on a daily basis. There is no charge from Optum Care for submitting claims electronically to the network. Providers are able to use any major clearinghouse.

For electronic claim submissions, use **Payer ID: LIFE1**. Claim submissions should be in a HIPAA-compliant 837 I or P format.

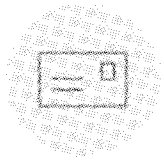
EDI has a standardized format, which ensures that data can be sent quickly and is interpreted on both sides. EDI transactions adhere to HIPAA regulations and American National Standards Institution (ANSI) standards. The EDI specifications are like a blueprint for the data that guides the data to make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

Click here for additional information regarding CMS HIPAA EDI submission requirements.

**Benefits of EDI:**

- Reduces costs
- No more handling, sorting, distributing, or searching 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
- Enhanced information is available quicker
- Ensures fast, reliable, accurate, secure and detailed information

# Paper claims , reconsideration, and refund submissions



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

| | |
|---|---|
| Midwest<br>• Indiana<br>• Ohio | Optum Care Claims<br>P.O. Box 30781<br>Salt Lake City, UT 84130 |

| | |
|---|---|
| Mountain West<br>• Arizona<br>• Colorado<br>• Nevada<br>• New Mexico<br>• Utah | Optum Care Claims<br>P.O. Box 30539<br>Salt Lake City, UT 84130 |

| | |
|---|---|
| Northeast<br>• Connecticut | Optum Care Claims<br>P.O. Box 2500<br>Rancho Cucamonga, CA 91719<br>Attn: Claims Intake/Claims Manager |

| | |
|---|---|
| Pacific Northwest<br>• Oregon<br>• Washington | Optum Care Claims<br>P.O. Box 30788<br>Salt Lake City, UT 84130 |

| | |
|---|---|
| Tristate<br>• New York | Optum Care Claims<br>P.O. Box 30781<br>Salt Lake City, UT 84130 |

# How to complete the 1500 claim form

## Patient information

**Box 1a:** Members External ID

**Box 2-6:** Member demographics to include 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 corrected claim to one previous sent)

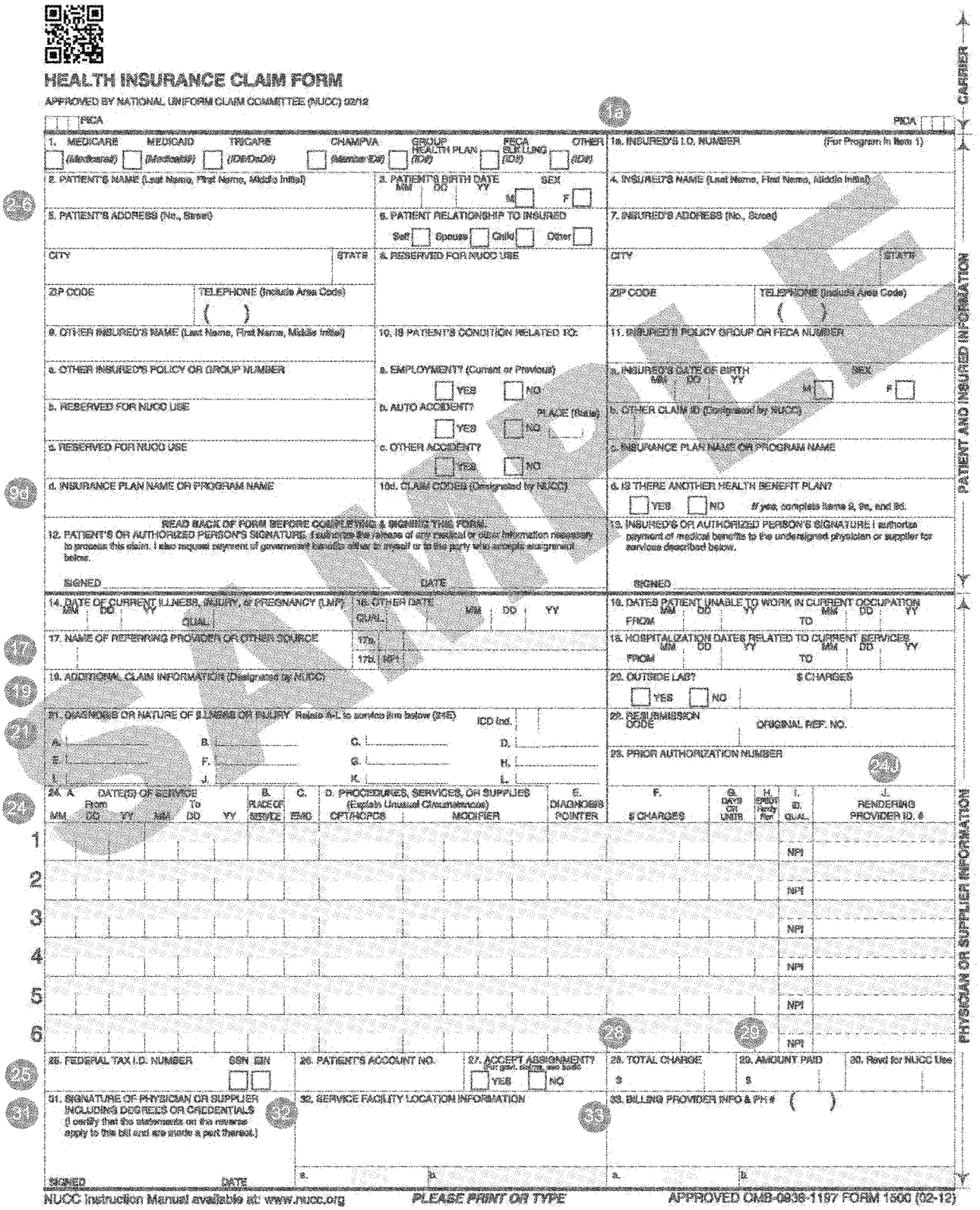
**Box 24A-G, 28, 29:** Line Item details/charges about services rendered by Provider

**Box 24J, 25, 31:** Rendering Provider Info

**Box 32:** Location services were rendered

**Box 33:** Billing Provider—Sometimes Provider Group info

# 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? YES NO PLACE (State)

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 MM DD YY QUAL.

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

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

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

33. BILLING PROVIDER INFO & PH # ( )

a. 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

# How to complete the UB04 (1450) claim form

**Box 1:** Provider Name and Address

**Box 2:** Pay-To Name and Address—if different than 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

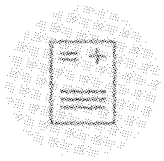
**Box 30:** Accident Date

**Box 31-34:** Occurrence Codes and Dates

**Box 35-36:** Occurrence Span

**Box 39-41:** Value Codes

**Line items**



**Box 42-49:** Contain the claim lines with information on services and charges provided
**Box 56:** Facility NPI

**Patient insured information:**

**Box 58-62:** This could have additional information as far as External ID listed that can be used to validate the member

**Box 67 A-Q:** Diagnosis Codes

**Other providers**

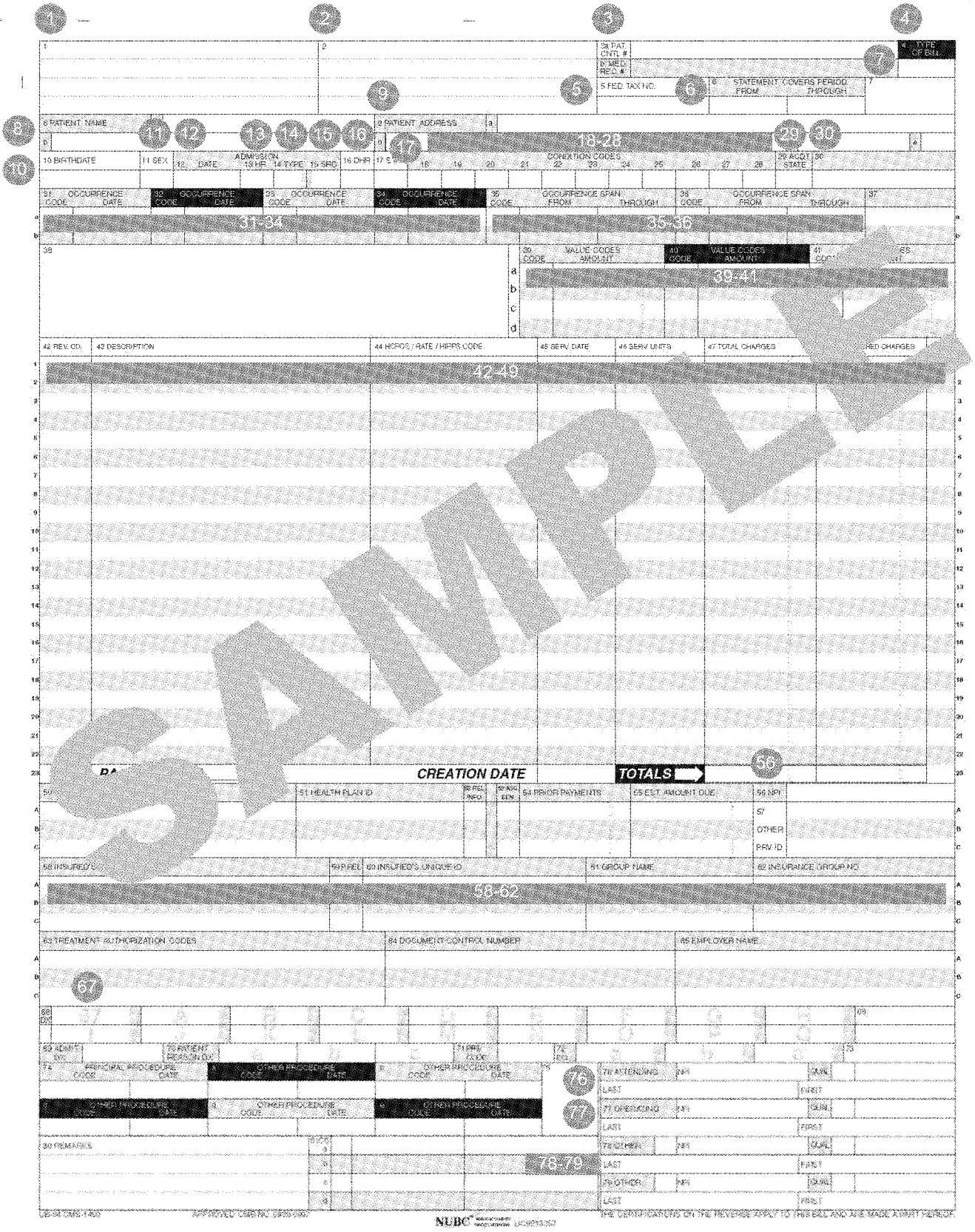
**Box 76:** Attending (Admitting) Name

**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.

# UB04 (1450) claim type image



# Chapter 3: Timely filing guidelines

## Submission timeframes

Keep in mind that when submitting claims, whether it is electronic or paper, there are required time frames that must be kept by all parties involved.

**Submitter:** Timely filing limit is 90 days or per the provider contract. A claim submitted after this time frame may be denied.

If you dispute a claim that was denied due to timely filing, you will be asked to show proof you filed your claim within your timely filing limits. Please see the provider dispute section of this manual for the necessary supporting documentation needed for proof of timely fling when filing a dispute.

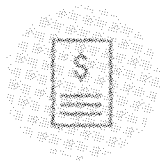
**Some examples of claims that may be denying as untimely include:**

- Resubmitted claims in which the original claim was denied for additional information or processed incorrectly.
- Resubmitted corrected claims for reprocessing (e.g., additional/reduced charges, updated fee schedule).
- Submitted claims where the members' insurance info was outdated and Optum Care was either the primary or secondary payer.

## Reconsiderations and payment disputes

**Submitter:** Timely filing limit is typically 60 days or per the provider contract. A request submitted after this time frame 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 control.

# Chapter 4: Common billing errors



## Corrected claims

- Professional (1500) bill type:
  - Resubmission code of 7 required in box 22 with the original reference/claim number
- Facility (1450) bill type:
  - Resubmission code of 7 (type of bill) required in box 4
- Include all codes for rendered services that should be considered for payment
- Resubmission code of 8 required in box 22 for a voided claim
- The billing terms of the contractual agreement, if applicable, along with federal and state statutes and regulations shall control

# Common billing errors continued

## Helpful billing and claims tips

Things to remember when billing and submitting claims:

- EDI submission is Optum Care's 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 will support with accurate payment processing.
- Provide accurate data and complete all required fields on the claim.
- If the provider has time limits for claims submission in the contract, be sure to know what they are and submit accordingly.
- Know the contract(s). Be sure all billing staff is familiar with current billing and contract requirements.
- To verify and view claims status, go to the Optum Care provider portal at: secure.optumcare.com/provider/account/logon or contact the Optum Care provider service center.

# Chapter 5: Common denial codes

| 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—Expenses 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 Code(s). | 246—This non-payable code is for required reporting only. | Not applicable |
| 0IT | 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 invalid Part B Diagnosis. | 50—These are non-covered services because this is not deemed a 'medical necessity' by the payer. | N115—This decision was based on a Local Coverage Determination (LCD). |

# Chapter 6: Reconsideration requests

## Provider dispute resolution

### Definition of a provider dispute

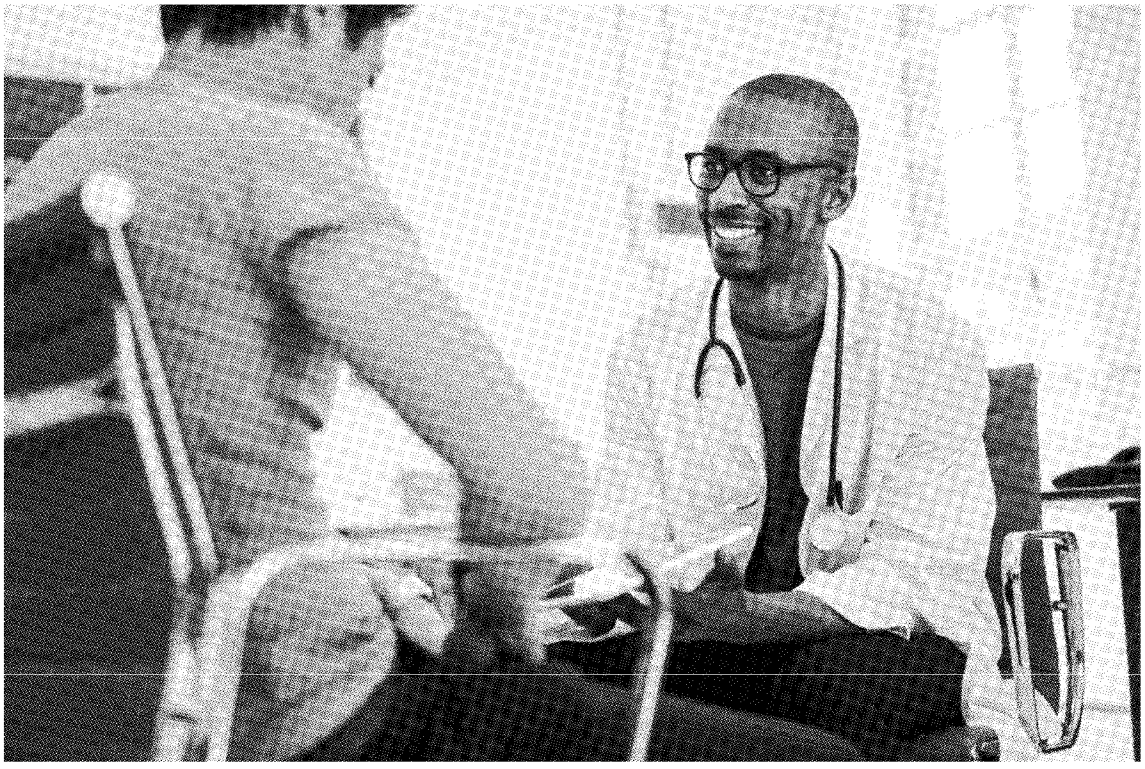
A provider dispute is a provider's written notice challenging and requesting the reconsideration of a claim (or a bundled group of substantially similar multiple claims that are individually numbered) that has been denied, adjusted or contested; or disputing a request for reimbursement of an overpayment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

Each provider dispute must contain the following information:

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

If the provider dispute concerns a claim or reimbursement of an overpayment of a claim from Optum Care the following must be provided:

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



# Provider dispute resolution continued

If the provider dispute is not concerning a claim the following must be provided:

- Clear explanation of the issue
- Provider's position on such issue

**Helpful provider dispute submission tips**

- Provider dispute forms must be completed in full and included with the dispute.
- All required information must be included; disputes that are missing information will be returned to the submitter.

**To submit a provider dispute:**

- Contact the Optum Care service center at:
  - Midwest Indiana:
    - 1-866-565-3361– Monday – Saturday, 8 a.m. - 9 p.m., EST
  - Midwest Ohio:
    - 1-866-566-4715 – Monday – Saturday, 8 a.m. – 8p.m., EST
  - Mountain West Arizona/Utah:
    - 1-877-370-2845 – Monday – Saturday, 8 a.m. – 8 p.m., MST
  - Mountain West Colorado:
    - 1-888-685-8491– Monday – Saturday, 8 a.m. – 8 p.m., MST
  - Mountain West Nevada:
    - 1-855-893-2297 – Monday – Saturday, 8 a.m. – 8 p.m., MST
  - Mountain West New Mexico:
    - 1-800-620-6768 – Monday – Saturday, 8 a.m. – 8 p.m., MST
  - Northeast Connecticut:
    - 1-888-556-7048 – Monday – Saturday 8 a.m. – 8 p.m., EST
  - Pacific Northwest Oregon:
    - 1-866-565-3664 – Monday – Friday, 8 a.m. – 5 p.m., PST
  - Pacific Northwest Washington:
    - 1-877-836-6806 – Monday – Friday, 8 a.m. – 5 p.m., PST
  - Tri-State New York:
    - 1-866-565-3468 – Monday – Saturday, 8a.m. – 8p.m., EST

# Provider dispute resolution continued

- Or send an email to our claims team at :
  - Mountain West Region (AZ/CO/NV/NM/UT) – claimdispute@optum.com
  - Midwest & Tri-State Region (IN/OH & NY) – ocTSMWDispute@optum.com
  - North-East Region (CT) – occtclaimsdispute@optum.com
  - Pacific Northwest Region (OR/WA)– ocndisputewa@optum.com
- Download a copy of the Optum Care provider dispute resolution request form; visit the resources section at the following website: professionals.optumcare.com.

**Examples of types of disputes:**

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

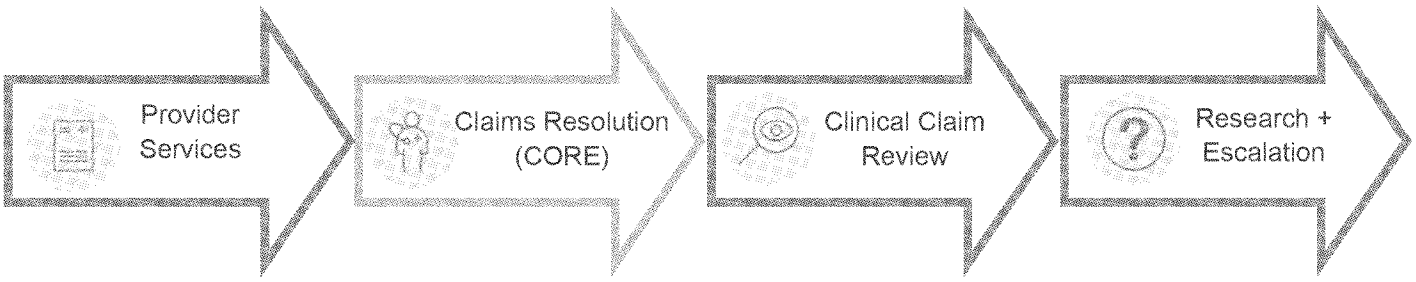
**Dispute escalations**

In the event a provider has not been able to achieve timely or reasonable resolution on a submitted dispute they can escalate to Optum Care 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

In order to submit a request to the Research and Escalation team, it is required to complete the standard dispute submission process first and include the original dispute tracking number provided by the Provider Services or Claims Resolution departments with your escalation request.

Send an email to our Market Operations Research and Escalation department at opshelp@optum.com.



# Provider escalation process

1. Market Operations receives provider and claim escalations disputes via email from internal and external customers. Examples may include: incorrect rates, provider contract status, incorrect claim denials.
2. Research Analysts are responsible for triaging and researching inquiries to determine root cause and identify potential trends.
3. Once the root cause is identified the Research Analyst will engage the appropriate operational team to assist with resolution. A communication is extended to the submitter to notify of findings and next steps for resolution.
4. Upon confirming resolution, the Research Analyst validates the issue has been remediated, and documents findings.
5. Research Analyst communicates resolution to the submitter.

# Chapter 7: Out-of-network 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

Mail appeal request 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
- A Waiver form can be obtained on http://www.humana.com/resources/support center/forms.aspx
- A copy of the original claim
- A copy of the remittance notice showing the claim denial Any additional information, clinical records, or documentation

# Humana appeal language continued

Fax or mail the appeal request to:

Humana Inc Appeals and Grievance Department
P.O. Box 14165
Lexington, KY 40512-4165
Fax: 1-800-949-2961

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
- A copy of the remittance notice showing for the claim payment

Any additional information, clinical records, or documentation to support the dispute fax or mail the payment dispute to:

Humana Inc Appeals and Grievance Department
P.O. Box 14165
Lexington, KY 40512-4165
Fax: 1-800-949-2961

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.

# Anthem 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)

# Anthem appeal language continued

- 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

Anthem Nevada only:

Anthem Blue Cross and Blue Shield Medicare Advantage
Mail stop: OH0205-A537
4361 Irwin Simpson Rd.
Mason, OH 45040

**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

Mail payment dispute to:

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

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
Mail: Optum Care Provider Dispute Resolution, P.O. Box 30539, Salt Lake City, UT 84130
Email via our secure web portal: https://professionals.optumcare.com/portal-login.html

# 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 on: https://www.cms.gov/Medicare/Appeals-and-Grievances/MMCAG/Downloads /Appendix-7- Waiver-of-Liablility-Notice.pdf)
- a copy of the original claim
- a copy of the remittance notice showing claim denial
- any additional information, clinical records or documentation

Washington only mail the appeal request to:

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

**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.

Washington only mail the payment dispute to:

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

# Premera appeal language continued

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

Phone: 877-836-6806

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

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 by using the following address:

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

The request for Health Plan dispute review must be received 120 calendar days from the determination date of the initial dispute.

# Chapter 8: Claims edit system (CES)

Optum Care uses the Claims Edit System® from Optum to automatically 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.

The system also detects coding errors related to unbundling, modifier appropriateness, diagnoses and duplicate claims. The medical necessity edits help plans detect procedures billed without supporting diagnoses, or not medically necessary, based on local and national coverage determinations (LCD/NCD).

As a critical prepayment application and key contributor to payment integrity, it is essential that health plans carefully manage the Claims Edit System updates. With today's dynamic environment and resource constraints, your organization may be challenged to keep the edit system current.

# Chapter 9: Payment integrity programs

## OrthoNet program overview

OrthoNet is a vendor partner to the Optum Care Payment Integrity program, providing Focused Claims Review (FCR) on professional claims for high-cost procedures and surgeries. Post-service, pre and post-pay claims reviews are completed by specialty physician reviewers for accurate claim coding.

### Records requests

Upon receipt of a records request from OrthoNet, please be aware that they are performing the review at the direction of Optum Care Payment Integrity. Providers are encouraged to fulfill all records 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 result in a delay of the review, or, denial of the claim line charges due to services not supported. Services denied as not supported will result in adjustment and recoupment of any previously paid charges.

At times there may be a records request for a procedure that was authorized prior. OrthoNet requests are separate from prior authorization review, as these reviews are an attempt to verify services billed and documented.

### Review findings

Upon completion of the review, you will receive a findings letter from OrthoNet. This letter will include the procedure for repayment, as well as, reconsideration, if applicable.

Should you believe the review findings are incorrect, you must submit a request for reconsideration in writing within 120 days of receipt of the findings letter. Your reconsideration request should include the reason(s) you feel the claim findings are incorrect, as well as, any supporting additional documentation that was not included with your original records response to OrthoNet. Peer-to-Peer reviews are available and should be documented within your written reconsideration request.

OrthoNet does not provide appeals review, please do not request an appeal in association with their review findings.

### Submitting medical records

- Visit https://provider.orthonet-online.com/ProviderDocumentPortal/
- Fill in the form with the claim information.
    - Contract: Optum Care PrePay
    - Claim Number
    - Service Date From

# OrthoNet program overview continued

- Complete the verification question
- Click on the 'Locate the Claim' button
- Drag file from your local computer then drop on to Upload Queue area of the screen or select files from your computer to upload
- Read and click the acknowledgement
- Click 'Upload' button
- Click on the 'Done' button to go back to the Home screen and continue uploading records for other claims
    - Maximum of 5 separate files can be uploaded per claim Maximum file size of 14.5 MB can be accepted Allowed file types: pdf, tif, tiff, gif, png, bmp, jpg, jpeg, xls, xlsx, rtf, dox, docx, txt

Fax: 1-844-811-5245

Mailing Address:

OrthoNet LLC
PO Box 5046
White Plains, NY 10602-5046

Review Dispute Resolution

Phone: 1-833-685-0458
Fax: 1-844-811-5245

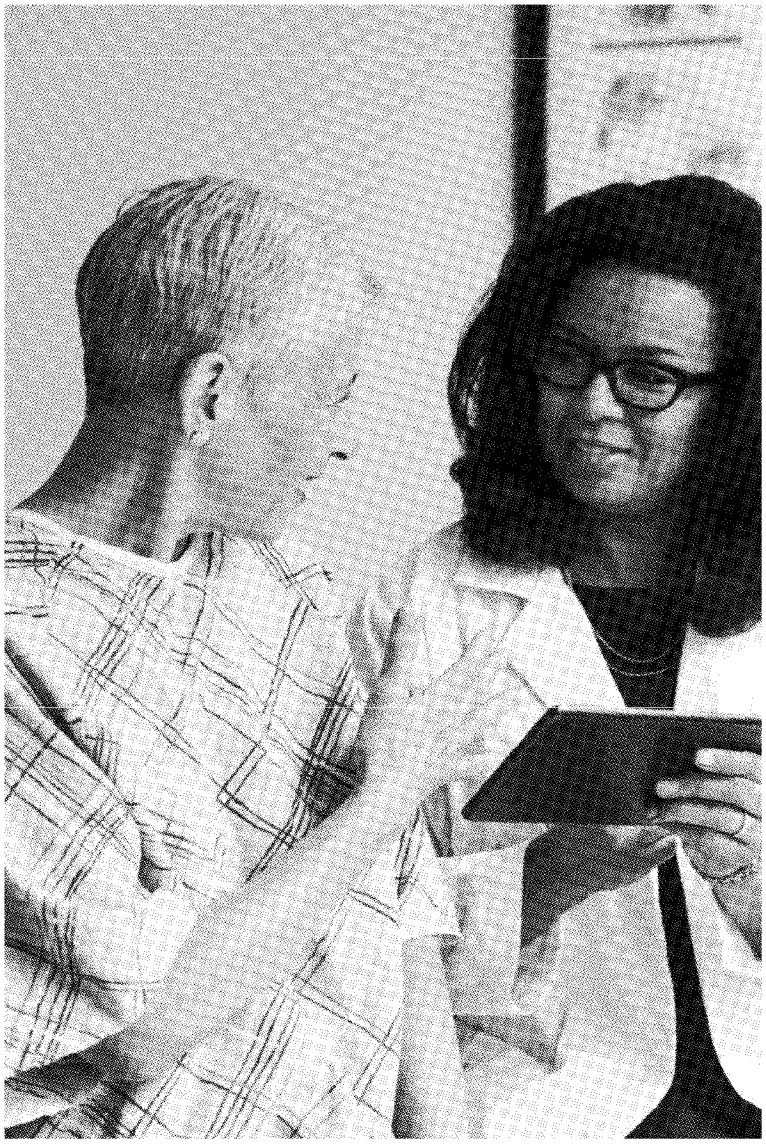
Mailing Address:

OrthoNet LLC
PO Box 5046
White Plains, NY 10602-5046

Should you need to call and discuss a review finding, please have the below information available for reference:

Member Name
Member Date of Birth
Procedure Date of Service

Please do not utilize the Optum Care as-signed claim ID for review inquiries. OrthoNet assigns a different reference number in their system for tracking purposes and does not leverage Optum Care claim ID assignment.



# Equian program overview

Equian is a vendor partner to the Optum Care Payment Integrity program, providing pre and post-pay reviews on DRG Coding and Compliance, Outpatient Facility, and Itemized Bill Review.

### DRG coding and compliance

Post-pay claim reviews for appropriate DRG coding. Equian works directly with the Facility providers, and adjustments are made upon receiving agreement of findings from the Facility.

### Outpatient facility

Post-pay claim reviews for appropriate OPPS coding. Equian works directly with the Facility providers, and adjustments are made upon receiving agreement of findings from the Facility.

### Itemized bill review (IBR)

Pre-pay claim reviews for DRG claims which have hit an outlier status. Equian works directly with the Facility providers to obtain the itemized bill and assures all outlier charges are billed appropriately.

### Records request

Upon receipt of a records request from Equian, please be aware that they are performing the review at the direction of Optum Care Payment Integrity. Providers are encouraged to fulfill all records 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 result in a delay of the review, or, denial of the claim line charges due to services not supported. Services denied as not supported will result in adjustment and recoupment of any previously paid charges.

At times there may be a records request for a procedure that was authorized prior. Equian requests are separate from prior authorization review, as these reviews are an attempt to verify services billed and documented.

### Review findings

Upon completion of the review, you will receive a findings letter from Equian. This letter will include the procedure for repayment, as well as, reconsideration, if applicable.

Should you be in agreement with the review findings, please sign the attached acknowledgement document and return to Equian via the correspondence submission options listed. Please review for all of the appropriate boxes to be checked on this form.

Should you believe the review findings are incorrect, you must submit a request for reconsideration in writing within 30 days of receipt of the findings letter. Your reconsideration request should include the reason(s) you feel the claim was paid correctly, as well as, any supporting additional documentation.

# Equian program overview continued

Please note, you cannot resubmit the initial clam or a revised claim directly to Optum Care in an attempt to get repaid. All review disputes must go through the reconsideration process. Any claims resubmissions will be denied as a duplicate. All adjustments to Equian reviewed claims must come from Equian and the Optum Care Payment Integrity departments.

**DRG coding and outpatient facility**

Submitting Medical Records

Phone: 1-877-787-2310
Fax: 1-781-240-0509

Mailing Address:

Equian LLC
Attn: DRG Validation
500 Unicorn Park Drive
Woburn, MA 01801

It is requested you do not submit records to Optum Care directly. Records submission to Equian directly via the above submission options is required to ensure delivery to the correct department and assigned reviewer.

Review Dispute Resolution

Phone: 1-877-787-2310
Fax: 1-781-240-0509
Email: reconsiderations@equian.com

Mailing Address:

Equian LLC
Attn: DRG Validation
500 Unicorn Park Drive
Woburn, MA 01801

Please identify the correspondence as a formal dispute, include the documentation and explanations necessary to clarify the questioned charges, and send the formal written dispute via the submission options listed above.

# Equian program overview continued

**Itemized bill review**

Submitting Medical Records

Fax: 1-866-700-5769

Mailing Address:

Equian LLC
Attn: Claims Disputes
600 12th Street
Suite 300
Golden, CO 80401

It is requested you do not submit records to Optum Care directly. Records submission to Equian directly via the above submission options is required to ensure delivery to the correct department and assigned reviewer.

Review Dispute Resolution

Phone: 1-888-895-2254
Fax: 1-866-700-5769
Email: reconsiderations@equian.com

Mailing Address:

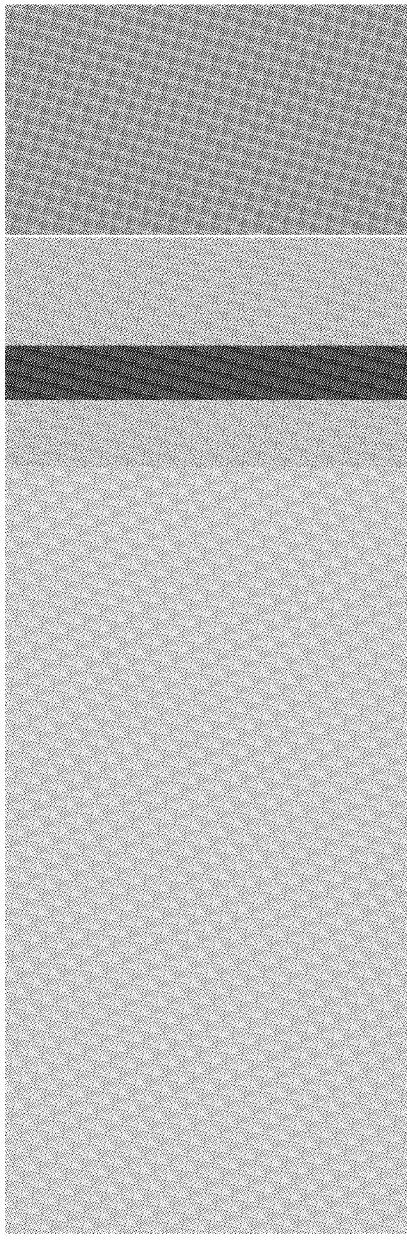
Equian LLC
Attn: Claims Disputes
600 12th Street
Suite 300
Golden, CO 80401

Please identify the correspondence as a formal dispute, include the documentation and explanations necessary to clarify the questioned charges, and send the formal written dispute via the submission options listed above.

Should you need to call and discuss a review finding, please have the below information available for reference:

- Member Name
- Member Date of Birth
- Procedure Date of Service

Please do not utilize the Optum Care assigned claim ID for review inquiries. Equian assigns a different reference number in their system for tracking purposes and does not leverage Optum Care claim ID assignment.



OPTUM®

# EXHIBIT C

**Public Mental Health System Rates**

**Effective 07/01/2023**

| | Provider types/ enrollment requirements: | | PT20 must have Specialty 52 or 53 | PT20 and PT23, PT80 | PT23 with PMH and PT24 each must have category of Service 1A | PT15 | PT94 and PTCC | PTMC |
|---|---|---|---|---|---|---|---|---|
| Procedure Code | Service Description | Units | Psychiatrist | Psychiatrist, NP, CRNP, APRN must have Psychiatric Mental Health Certification (PMH) | NP, CRNP, APRN must have Psychiatric Mental Health Certification (PMH) | Licensed Psychologist (PHD or PsyD) | LCSW-C, LCPC, LCADC, LCMFT | OMHC |
| OUTPATIENT/OFFICE PROFESSIONAL SERVICES | | | Community Setting | Facility Setting | Community Setting | Community Setting | Community Setting | Community Setting |
| 90791 | Psychiatric diagnostic evaluation | | $211.85 | | $151.05 | $172.50 | $151.05 | $242.66 |
| 90791-UA | C&A Psychiatric diagnostic evaluation | | $211.85 | | $151.05 | $172.50 | $151.05 | $271.02 |
| 90792 | Psychiatric diagnostic evaluation with medical services | | $211.85 | | $151.05 | | | $242.66 |
| 90792-UA | C&A Psychiatric diagnostic evaluation with medical services | | $211.85 | | $151.05 | | | $271.02 |
| 90832 | Individual psychotherapy (30 min)-Outpatient | | $69.91 | | $49.83 | $57.11 | $49.83 | $71.31 |
| 90832-UA | C&A Individual psychotherapy (30 min)-Outpatient | | $69.91 | | $49.83 | $57.11 | $49.83 | $84.33 |
| 90833 | 30 min Psychotherapy add on | | $69.91 | | $49.83 | | | $71.31 |
| 90833-UA | C&A 30 min Psychotherapy add on | | $69.91 | | $49.83 | | | $84.33 |
| 90834 | Individual psychotherapy (45 min)-Outpatient | | $127.03 | | $90.86 | $103.49 | $90.86 | $129.57 |
| 90834-UA | C&A Individual psychotherapy (45 min)-Outpatient | | $127.03 | | $90.86 | $103.49 | $90.86 | $149.88 |
| 90836 | 45 min Psychotherapy add on | | $127.03 | | $90.86 | | | $129.57 |
| 90836-UA | C&A 45 min Psychotherapy add on | | $127.03 | | $90.86 | | | $149.88 |
| 90837 | Individual psychotherapy (60 min) | | | | | | | $129.57 |
| 90837-UA | C&A Individual psychotherapy (60 min) | | | | | | | $149.88 |
| 90838 | 60 min Psychotherapy add on | | | | | | | $129.57 |
| 90838-UA | C&A 60 min Psychotherapy add on | | | | | | | $149.88 |
| 90839 | Psychotherapy for crisis, first 60 min | | | | | | | $142.60 |
| 90839-UA | C&A Psychotherapy for crisis, first 60 min | | | | | | | $168.64 |
| 90840 | Psychotherapy for crisis--additional 30 min | | | | | | | $77.15 |
| 90840-UA | C&A Psychotherapy for crisis-- additional 30 min | | | | | | | $88.00 |
| 90846 | Family psychotherapy without patient present | | $118.75 | | $76.68 | $99.68 | $76.68 | $128.44 |
| 90846-UA | C&A Family psychotherapy without patient present | | $118.75 | | $76.68 | $99.68 | $76.68 | $148.35 |
| 90847 | Family psychotherapy with patient present (45-60 min) | | $132.27 | | $93.53 | $108.86 | $93.53 | $134.94 |
| 90847-UA | C&A Fam psychoth with patient present (45-60 min) | | $132.27 | | $93.53 | $108.86 | $93.53 | $153.33 |
| 90847-UA-52 | C&A Family psychotherapy with patient present--Abbrev | | $81.93 | | $58.65 | $66.71 | $58.65 | $83.56 |
| 90849 | Multiple family group psychotherapy 45 - 60 minutes | | | | | | | $56.74 |
| 90849-UA | C&A Multiple family group psychotherapy 45 - 60 minutes | | | | | | | $59.81 |
| 90849-52 | Multiple family group psychotherapy--Abbrev | | | | | | | $50.93 |
| 90849-UA-52 | C&A Multiple family group psychotherapy--Abbrev | | | | | | | $54.91 |
| H2027 | Family psycho-education with consumer present | | | | | | | $76.68 |
| H1011 | Family psycho-education without consumer present | | | | | | | $76.68 |
| 90853 | Group psychotherapy (not multi-family.) 45-60 minutes | | $34.58 | | $35.29 | $35.29 | $35.29 | $55.19 |
| 90853-UA | C&A Group psychotherapy (not multi-family.) 45-60 minutes. | | $34.58 | | $35.29 | $35.29 | $35.29 | $58.26 |
| 90853-21 | Group psychotherapy prolonged (More than 75 minutes) | | | | | | | $72.05 |
| 90853-UA-21 | C&A Group psychotherapy prolonged (More than 75 minutes) | | | | | | | $72.05 |

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| OUTPATIENT/OFFICE PROFESSIONAL SERVICES | | | Community Setting | Facility Setting | Community Setting | Community Setting | Community Setting | Community Setting |
| 99202 | Evaluation and Management, including Rx -Straight forward, new patient | | $79.65 | $52.72 | $79.65 | | | $79.65 |
| 99202-UA | C&A Evaluation and Management, including Rx -Straight forward, new patient | | $79.65 | $52.72 | $79.65 | | | $79.65 |
| 99203 | Evaluation and Management, including Rx -Low complexity, new patient | | $122.30 | $90.06 | $122.30 | | | $122.30 |
| 99203-UA | C&A Evaluation and Management, including Rx -Low complexity, new patient | | $122.30 | $90.06 | $122.30 | | | $122.30 |
| 99204 | Evaluation and Management, including Rx -Moderately complex, new patient | | $181.53 | $145.50 | $181.53 | | | $181.53 |
| 99204-UA | C&A Evaluation and Management, including Rx - Moderately complex, new patient | | $181.53 | $145.50 | $181.53 | | | $181.53 |
| 99205 | Evaluation and Management, including Rx -Highly complex, new patient | | $239.94 | $197.46 | $239.94 | | | $239.94 |
| 99205-UA | C&A Evaluation and Management, including Rx -Highly complex, new patient | | $239.94 | $197.46 | $239.94 | | | $239.94 |
| 99211 | Evaluation and Management, including Rx -Minimal | | $25.44 | $9.51 | $25.44 | | | $25.44 |
| 99211-UA | C&A Evaluation and Management, including Rx -Minimal | | $25.44 | $9.51 | $25.44 | | | $25.44 |
| 99212 | Evaluation and Management, including Rx -Straight forward | | $61.84 | $39.08 | $61.84 | | | $61.84 |
| 99212-UA | C&A Evaluation and Management, including Rx -Straight forward | | $61.84 | $39.08 | $61.84 | | | $61.84 |
| 99213 | Evaluation and Management, including Rx -Low complexity | | $98.58 | $71.65 | $98.58 | | | $98.58 |
| 99213-UA | C&A Evaluation and Management, including Rx -Low complexity | | $98.58 | $71.65 | $98.58 | | | $98.58 |
| 99214 | Evaluation and Management, including Rx -Moderately complex | | $138.61 | $104.86 | $138.61 | | | $138.61 |
| 99214-UA | C&A Evaluation and Management, including Rx - Moderately complex | | $138.61 | $104.86 | $138.61 | | | $138.61 |
| 99215 | Evaluation and Management, including Rx -Highly complex | | $195.63 | $156.18 | $195.63 | | | $195.63 |
| 99215-UA | C&A Evaluation and Management, including Rx -Highly complex | | $195.63 | $156.18 | $195.63 | | | $195.63 |
| 90875 | Indiv psychophysio therapy incl biofdbk (20-30 min) | | $69.91 | | $49.83 | $57.11 | $49.83 | $71.31 |
| 90876 | Indiv psychophysio therapy incl biofdbk (45-50 min) | | $127.03 | | $90.86 | $103.49 | $90.86 | $129.57 |
| 90889 | Outpatient Discharge (CMS 1500) | | | | | | | $29.11 |
| 0929 | Outpatient Discharge (UB) | | | | | | | $29.11 |
| 96130 | Psychological Testing Evaluation services by a Physician or other qualified professional. Treatment planning and Report and Interactive feed back to the patient, family members and caregiver's (first hour) | | | | | $161.25 | | $161.25 |
| 96131 | Psychological Testing, Evaluation and Feedback by Physician or other qualified professional (each additional hour) | | | | | $122.54 | | $122.54 |
| 96136 | Psychological Test administration and scoring by a Physician or other qualified professional (first 30 minutes) | | | | | $66.49 | | $66.49 |
| 96137 | Test administration and scoring by a Physician or other qualified professionals (each additional 30 minutes) | | | | | $61.99 | | $61.99 |
| 96138 | Psychological test administration and scoring by a Technician (first 30 minutes) | | | | | $55.37 | | $55.37 |
| 96139 | Psychological test administration and scoring by a Technician (each additional 30 minutes) | | | | | $55.37 | | $55.37 |

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| OUTPATIENT/OFFICE PROFESSIONAL SERVICES | | | Community Setting | Facility Setting | Community Setting | Community Setting | Community Setting | Community Setting |
| 99242 | Office Consultation - also used for H&P for PHP (20 min) | | $94.39 | $72.01 | $94.39 | | | |
| 99243 | Office Consultation - also used for H&P for PHP (30 min) | | $129.98 | $101.53 | $129.98 | | | |
| 99244 | Office Consultation - also used for H&P for PHP (40 min) | | $193.14 | $162.03 | $193.14 | | | |
| 99245 | Office Consultation - also used for H&P for PHP (55 min) | | $235.44 | $200.55 | $235.44 | | | |
| 99417 | Prolonged outpatient evaluation and management service, with or without direct patient contact; each 15 minutes of total time | Each 15 minutes | $34.21 | $33.08 | $34.21 | | | $34.21 |
| INPATIENT HOSPITAL SERVICES | | | Community Setting | Facility Setting | Community Setting | Community Setting | Community Setting | Community Setting |
| 99221 | Initial hospital care (30 min) (MD only) | | | $107.43 | | | | |
| 99221-UA | C&A Initial hospital care (30 min) (MD only) | | | $107.43 | | | | |
| 99222 | Initial hospital care (50 min) (MD only) | | | $143.81 | | | | |
| 99222-UA | C&A Initial hospital care (50 min) (MD only) | | | $143.81 | | | | |
| 99223 | Initial hospital care (70 min) (MD only) | | | $210.42 | | | | |
| 99223-UA | C&A Initial hospital care (70 min) (MD only) | | | $210.42 | | | | |
| 99231 | Subsequent IP or observation care (25 min) (MD only) | | | $41.22 | | | | |
| 99231-UA | C&A Subsequent IP or observation care (25 min) (MD only) | | | $41.22 | | | | |
| 99232 | Subsequent IP or observation care (35 min) (MD only) | | | $75.61 | | | | |
| 99232-UA | C&A Subsequent IP or observation care (35 min) (MD only) | | | $75.61 | | | | |
| 99233 | Subsequent IP or observation care (50 min) (MD only) | | | $108.61 | | | | |
| 99233-UA | C&A Subsequent IP or observation care (50 min) (MD only) | | | $108.61 | | | | |
| 99238 | Hospital IP or observation discharge day mgmt (30 min or less) (MD only) | | | $76.55 | | | | |
| 99238-UA | C&A Hospital IP or observation discharge day mgmt (30 min or less) (MD only) | | | $76.55 | | | | |
| 99239 | Hospital IP or observation discharge day mgmt (>30 min) (MD only) | | | $111.73 | | | | |
| 99239-UA | C&A Hospital IP or observation discharge day mgmt (>30 min) (MD only) | | | $111.73 | | | | |
| 99252 | Initial inpatient or observation consultation (35 min) (MD only) - also used for H&P for Inpatient Non Psych Physician | | | $78.08 | | | | |
| 99253 | Initial inpatient or observation consultation (45 min) (MD only) - also used for H&P for Inpatient Non Psych Physician | | | $121.70 | | | | |
| 99254 | Initial inpatient or observation consultation (60 min) (MD only) - also used for H&P for Inpatient Non Psych Physician | | | $175.05 | | | | |
| 99255 | Initial inpatient or observation consultation (80 min) (MD only) - also used for H&P for Inpatient Non Psych Physician | | | $211.91 | | | | |
| 99418 | Prolonged inpatient evaluation and management service with or without direct patient contact; each 15 minutes of total time | Each 15 minutes | | $41.30 | | | | |

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|---|---|---|---|---|---|---|---|---|
| **Procedure Code** | **Service Description** | **Units** | **Psychiatrist** | **Psychiatrist, NP, CRNP, APRN must have Psychiatric Mental Health Certification (PMH)** | **NP, CRNP, APRN must have Psychiatric Mental Health Certification (PMH)** | **Licensed Psychologist (PHD or PsyD)** | **LCSW-C, LCPC, LCADC, LCMFT** | **OMHC** |
| **OBSERVATION CARE (POS 22)** | | | **Community Setting** | **Facility Setting** | **Community Setting** | **Community Setting** | **Community Setting** | **Community Setting** |
| 99231 | Subsequent IP or observation care (25 min) (MD only) | | | $41.22 | | | | |
| 99231-UA | C&A Subsequent IP or observation care (25 min) (MD only) | | | $41.22 | | | | |
| 99232 | Subsequent IP or observation care (35 min) (MD only) | | | $75.61 | | | | |
| 99232-UA | C&A Subsequent IP or observation care (35 min) (MD only) | | | $75.61 | | | | |
| 99233 | Subsequent IP or observation care (50 min) (MD only) | | | $108.61 | | | | |
| 99233-UA | C&A Subsequent IP or observation care (50 min) (MD only) | | | $108.61 | | | | |
| 99238 | Hospital IP or observation discharge day mgmt (30 min or less) (MD only) | | | $76.55 | | | | |
| 99238-UA | C&A Hospital IP or observation discharge day mgmt (30 min or less) (MD only) | | | $76.55 | | | | |
| 99239 | Hospital IP or observation discharge day mgmt (>30 min) (MD only) | | | $111.73 | | | | |
| 99239-UA | C&A Hospital IP or observation discharge day mgmt (>30 min) (MD only) | | | $111.73 | | | | |
| 99252 | Initial inpatient or observation consultation (35 min) (MD only) - also used for H&P for Inpatient Non Psych Physician | | | $78.08 | | | | |
| 99253 | Initial inpatient or observation consultation (45 min) (MD only) - also used for H&P for Inpatient Non Psych Physician | | | $121.70 | | | | |
| 99254 | Initial inpatient or observation consultation (60 min) (MD only) - also used for H&P for Inpatient Non Psych Physician | | | $175.05 | | | | |
| 99255 | Initial inpatient or observation consultation (80 min) (MD only) - also used for H&P for Inpatient Non Psych Physician | | | $211.91 | | | | |
| **EMERGENCY ROOM SERVICES (POS 23)** | | | **Facility Setting** | **Facility Setting** | **Facility Setting** | **Facility Setting** | **Facility Setting** | **N/A** |
| **Procedure Code** | **Service Description** | | **Psychiatrist** | **ER Physician Groups, rendering providers may be Psychiatrist, ER Physican, Nurse Practitioner without PMH** | **NP, CRNP, APRN must have Psychiatric Mental Health Certification (PMH)** | **Licensed Psychologist (PHD or PsyD)** | **LCSW-C, LCPC, LCADC, LCMFT rendering under a Physician ER Group** | **OMHC** |
| 90791 | Psychiatric diagnostic evaluation | | $211.85 | | $151.05 | $172.50 | $151.05 | |
| 90791-UA | C&A Psychiatric diagnostic evaluation | | $211.85 | | $151.05 | $172.50 | $151.05 | |
| 90792 | Psychiatric diagnostic evaluation with medical services | | $211.85 | | $151.05 | | | |
| 90792-UA | C&A Psychiatric diagnostic evaluation with medical services | | $211.85 | | $151.05 | | | |
| 99281 | ER Visit | | | $23.52 | $23.52 | | | |
| 99282 | ER Visit | | | $45.59 | $45.59 | | | |
| 99283 | ER Visit | | | $77.62 | $77.62 | | | |
| 99284 | ER Visit | | | $130.68 | $130.68 | | | |
| 99285 | ER Visit | | | $189.83 | $189.83 | | | |
| **MISCELLANEOUS** | | | **Community Setting** | **Facility Setting** | **Community Setting** | **Community Setting** | **Community Setting** | **Community Setting** |
| **Procedure Code** | **Service Description** | | **Psychiatrist** | **Psychiatrist, NP, CRNP, APRN must have Psychiatric Mental Health Certification (PMH)** | **NP, CRNP, APRN must have Psychiatric Mental Health Certification (PMH)** | **Licensed Psychologist (PHD or PsyD)** | **LCSW-C, LCPC, LCADC, LCMFT** | **OMHC** |
| 00104 | Anesthesia for ECT | | $134.58 | | | | | |
| 90870 | ECT single seizure w/ monitoring (Physician only) | | $134.73 | | | | | |
| 36415 | Collection of blood by venipuncture | | | | | | | $19.80 |
| 96372 | Therapeutic injection | | | | | | | $21.39 |

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| **SPECIAL SERVICES** | | | **Community Setting** | **Facility Setting** | **Community Setting** | **Community Setting** | **Community Setting** | **Community Setting** |
| S9480 | Intensive OP psych svcs, per diem (clinic model) | | | | | | | $184.78 |
| S9480-UA | C&A Intensive OP psych svcs, per diem (clinic model) | | | | | | | $219.67 |
| H0032 | Interdisciplinary team tx planning w/patient present | | | | | | | $118.07 |
| H0046 | Therapeutic Nursery | | | | | | | $60.13 |
| GAMDC | Gambling Discharge, effective 1/1/2022: The State will pay for gambling discharge only **if** the gambling treatment was state funded. In order to be reimbursed, at least one treatment session beyond assessment must have occurred, and the provider must have submitted the gambling data form. | | $106.01 | | $106.01 | $106.01 | $106.01 | $106.01 |
| **OCCUPATIONAL THERAPY (MA COVERS UNDER 21 ONLY, STATE REQUIRES AUTH)** | | | **Community Setting** | **Facility Setting** | **Community Setting** | **Community Setting** | **Community Setting** | **Community Setting** |
| 97150 | Therapeutic procedure(s) group (2 or more) | | | | | | $24.22 | |
| 97530 | Therapeutic activities, direct patient contact, per 15 min | Each 15 minutes | | | | | $15.68 | |
| 97535 | Self-care/home mgmt trng, per 15 min. | Each15 minutes | | | | | $15.68 | |
| 97537 | Community/work reintegration trng, direct contact, per 15 min | Each 15 minutes | | | | | $15.68 | |
| **THERAPEUTIC BEHAVIORAL SERVICES** | | | **Community Setting** | **Facility Setting** | **Community Setting** | **Community Setting** | **Community Setting** | **Community Setting** |
| 96156 | Health Behavior Assessment or Re-Assessment Non Timed | | $150.37 | | | | | |
| 96158 | Health Behavior Intervention, Individual, Face to Face, Initial 30 Minutes | | $32.59 | | | | | |
| 96159 | Health Behavior Intervention, Individual, Face to Face, Each additional 15 minutes | Each additional 15 minutes, Max 40 | $16.29 | | | | | |
| **TRANSCRANIAL MAGNETIC STIMULATION (TMS)** | | | **Community Setting** | **Facility Setting POS 22** | **Community Setting** | **Community Setting** | **Community Setting** | **Community Setting** |
| 90867 | Therapeutic repetitive TMS Treatment, Initial | | $206.93 | $206.93 | | | | |
| 90868 | Therapeutic repetitive TMS Treatment, Subsequent Delivery and Management (per session) | | $189.79 | $189.79 | | | | |
| 90869 | Therapeutic repetitive TMS Treatment, Subsequent Re Determination with Delivery and Management | | $518.34 | $518.34 | | | | |
| 99202-25 | Evaluation and Management, including Rx -Straight forward, new patient | | $79.65 | $79.65 | | | | |
| 99203-25 | Evaluation and Management, including Rx -Low complexity, new patient | | $122.30 | $122.30 | | | | |
| 99204-25 | Evaluation and Management, including Rx -Moderately complex, new patient | | $181.53 | $181.53 | | | | |
| 99205-25 | Evaluation and Management, including Rx -Highly complex, new patient | | $239.94 | $239.94 | | | | |
| 99211-25 | Evaluation and Management, including Rx -Minimal | | $25.44 | $25.44 | | | | |
| 99212-25 | Evaluation and Management, including Rx -Straight forward | | $61.84 | $61.84 | | | | |
| 99213-25 | Evaluation and Management, including Rx -Low complexity | | $98.58 | $98.58 | | | | |
| 99214-25 | Evaluation and Management, including Rx -Moderately complex | | $138.61 | $138.61 | | | | |
| 99215-25 | Evaluation and Management, including Rx -Highly complex | | $195.63 | $195.63 | | | | |

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|---|---|---|---|---|---|---|---|---|
| Procedure Code | Service Description | Units | Psychiatrist | Psychiatrist, NP, CRNP, APRN must have Psychiatric Mental Health Certification (PMH) | NP, CRNP, APRN must have Psychiatric Mental Health Certification (PMH) | Licensed Psychologist (PHD or PsyD) | LCSW-C, LCPC, LCADC, LCMFT | OMHC |
| OTHER PROFESSIONAL SERVICES FOR Mental Health IOP, Mental Health PHP and Crisis Residential Services | | | Community Setting | Facility Setting | Community Setting | Community Setting | Community Setting | Community Setting |
| 90791 | Psychiatric diagnostic evaluation | | $211.85 | | $151.05 | $172.50 | $151.05 | $242.66 |
| 90791-UA | C&A Psychiatric diagnostic evaluation | | $211.85 | | $151.05 | $172.50 | $151.05 | $271.02 |
| 90792 | Psychiatric diagnostic evaluation with medical services | | $211.85 | | $151.05 | | | $242.66 |
| 90792-UA | C&A Psychiatric diagnostic evaluation with medical services | | $211.85 | | $151.05 | | | $271.02 |
| 99202 | Evaluation and Management, including Rx -Straight forward, new patient | | $79.65 | $52.72 | $79.65 | | | $79.65 |
| 99203 | Evaluation and Management, including Rx -Low complexity, new patient | | $122.30 | $90.06 | $122.30 | | | $122.30 |
| 99204 | Evaluation and Management, including Rx -Moderately complex, new patient | | $181.53 | $145.50 | $181.53 | | | $181.53 |
| 99205 | Evaluation and Management, including Rx -Highly complex, new patient | | $239.94 | $197.46 | $239.94 | | | $239.94 |
| 99211 | Evaluation and Management, including Rx -Minimal | | $25.44 | $9.51 | $25.44 | | | $25.44 |
| 99212 | Evaluation and Management, including Rx -Straight forward | | $61.84 | $39.08 | $61.84 | | | $61.84 |
| 99213 | Evaluation and Management, including Rx -Low complexity | | $98.58 | $71.65 | $98.58 | | | $98.58 |
| 99214 | Evaluation and Management, including Rx -Moderately complex | | $138.61 | $104.86 | $138.61 | | | $138.61 |
| 99215 | Evaluation and Management, including Rx -Highly complex | | $195.63 | $156.18 | $195.63 | | | $195.63 |
| 90832 | Individual psychotherapy (30 min) MD Only | | $61.15 | | $61.15 | | | $62.37 |
| 90834 | Individual psychotherapy (45 min) MD Only | | $114.97 | | $114.97 | | | $117.27 |
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| * Reimbursable using POS 12 for follow-up visits by an OMHC M.D. in a Crisis Bed | | | | | | | | |